Cognitive Behavioral Intervention for Trauma in Schools

CONNECTICUT'S EVIDENCE-BASED
TREATMENT COORDINATING CENTER

Child Health and Development Institute

CONNECTICUT Children & Families

FISCAL YEAR 2024
ANNUAL REPORT

Connecticut CBITS/BB 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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CONTENTS

I. EXECUTIVE SUMMARY

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Bounce Back (BB) treatment models are short-term, evidence-based, manualized group interventions for young children or youth reporting post-traumatic reactions due to exposure to violence, abuse, and other forms of trauma. The Connecticut CBITS Coordinating Center ("Coordinating Center") is located at the Child Health and Development Institute (CHDI). Funded by the Department of Children and Families (DCF), the initiative represents a partnership between DCF, CHDI, Sharon Hoover, Ph.D. (National CBITS Trainer), Wheeler Clearinghouse, and participating school-based health centers, schools, school districts, and community providers.

The Coordinating Center now supports a network of 33 teams that have been implementing CBITS and/or BB. Given the increase in demand for children's behavioral health services, CBITS and BB providers ensured strong access, quality, and outcomes for Connecticut youth. This report summarizes the work of the Coordinating Center for state fiscal year (FY) 2024 (July 1, 2023 through June 30, 2024).

KEY FINDINGS OF FY24:

2,120 students were screened for trauma exposure and associated symptoms.

745 students received CBITS or BB across **102 CBITS** and **80 BB** groups.

Children receiving CBITS and BB were more likely than the general population to be Black/African-American or Hispanic descent.

116 schools and **7** other community-based organizations offered CBITS and/or BB.

High satisfaction with CBITS/BB treatment among children **(86%)** and caregivers **(94%)**.

47 new clinicians were trained in CBITS and **34** new clinicians in BB.

Most youth receiving CBITS and BB experienced reliable PTSD symptom reduction (**67.4%** and **68.7%** of children, respectively)

More than **80%** of children successfully completed CBITS/BB treatment.

For CBITS, older youth experienced greater improvement in trauma symptoms.

KEY RECOMMENDATIONS:

- Examine the reason a lower percentage of male children engage in CBITS by targeting site visit consultation to include child demographics to increase the percentage of males served in CBITS.
- Grow the capacity of Bounce Back by 5% through targeted goal setting and resource sharing with teams working with younger children.
- Expand practices that complement CBITS/BB, such as Supporting Transition Resilience of Newcomer Groups (STRONG) to better serve newcomer youth in Connecticut not eligible for CBITS/BB treatment in school settings.

II. INTRODUCTION

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS)[1] model is a short-term, manualized, trauma-focused group intervention designed for children in grades 5 through 12 that are experiencing post-traumatic reactions due to exposure to violence, abuse, and other forms of trauma. Bounce Back (BB) is an adaptation of CBITS for elementary-aged children[2] in kindergarten through grade 5. Recognizing the need to provide school with resources for supporting students exposed to trauma in 2014, DCF partnered with CHDI to serve as the CBITS Coordinating Center. By the end of FY24, the network consisted of 33 providers. The figure below illustrates the goals and primary activities of the Coordinating Center[3]

1. Jaycox, L.H., Langley, A.K., Hoover, S.A. (2018). Cognitive Behavioral Intervention for Trauma in Schools, second edition (revised). Santa Monica, CA: RAND Corporation
2. Langley, A. K., Gonzalez, A., Sugar, C. A., Solis, D. & Jaycox, L. (2015). Bounce back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. *Journal of Consulting and Clinical Psychology*, 83(5), 853-865. Doi: 10.1037/ccp0000051.
3. A detailed accounting of these activities during FY24 can be found in Appendix A

CBITS/BB COORDINATING CENTER GOALS AND ACTIVITIES

EQUITY

ACCESS

Increase Access to CBITS/BB

Activities: Maintaining a statewide network of provider agencies and school districts, training new clinicians in CBITS/BB, and supporting systems screening for trauma.

Measured by: Children receiving CBITS or BB over time and across the state.

Do all groups have equal access to CBITS/BB?

QUALITY

Ensure Quality of CBITS/BB

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 CBITS/BB treatment?

OUTCOMES

Improve Outcomes for Children Receiving CBITS/BB

Activities: Ongoing quality improvement work with agencies and school districts 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 benefiting from CBITS/BB?

This FY24 report is framed across access, quality, outcome, and equity goals. Summary, conclusions, and recommendations are shared to guide future work.

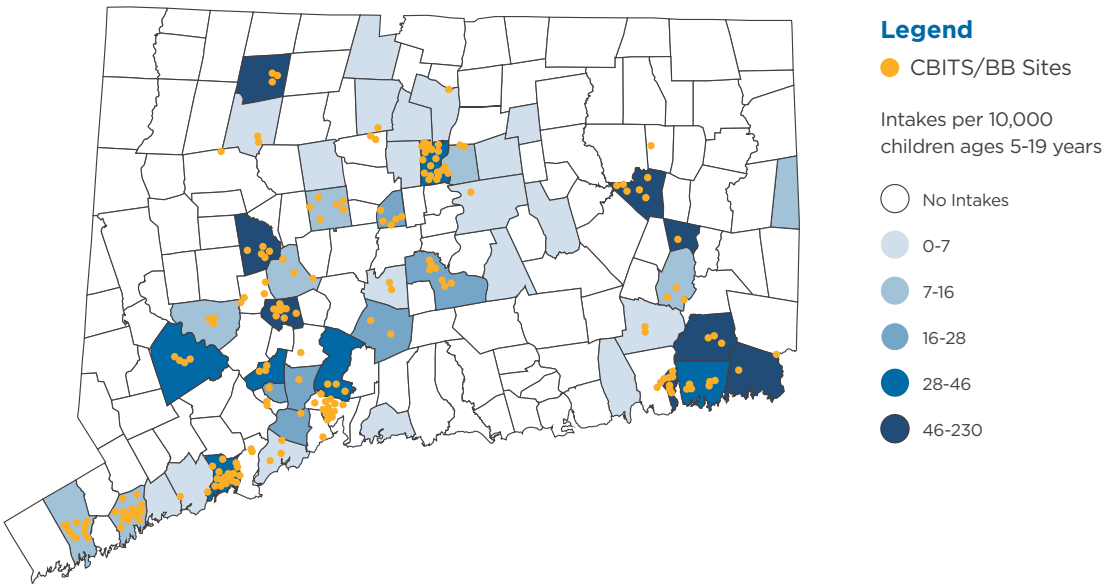
III. ACCESS TO CBITS/BB IN CONNECTICUT

The CBITS Coordinating Center aims to increase access to CBITS and BB for youth in Connecticut. This includes growing and sustaining the provider network across the state and monitoring child characteristics to ensure equitable access to both treatment models.

Service Availability Across the State

During FY24, CBITS was available at 70 schools and four community-based settings across 28 different providers; BB was available at 52 schools and five community-based settings across 19 different providers. A total of 102 CBITS and 80 BB groups were held in FY24.

Figure 1. Map of CBITS/BB Sites and Children Served



This year, providers trained 47 CBITS and 34 BB clinicians, which was a decrease from last year. Schools and agencies continue to struggle with staffing and were more selective with who was trained. Teams were smaller this fiscal year compared to last, but a higher percentage of clinicians on a team implemented a group. To support high quality service delivery, 53 CBITS and 34 BB clinicians attended booster trainings and 21 CBITS and 10 BB clinicians achieved certification. The number of clinicians certified in CBITS continues to grow, showing a growing mastery of the models by the CBITS/BB initiative members. Tables 1 and 2 show details about CBITS and BB teams.

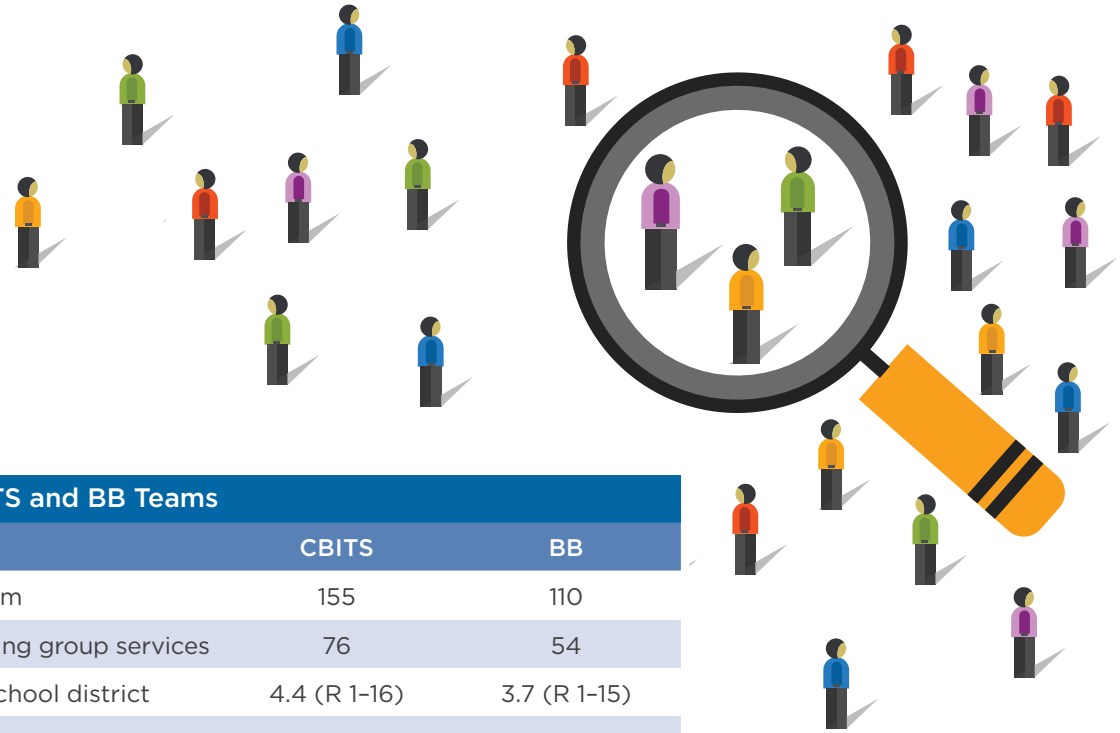


Table 1. FY24 CBITS and BB Teams		
	CBITS	BB
# of clinicians on team	155	110
# of clinicians providing group services	76	54
Average team size-school district	4.4 (R 1–16)	3.7 (R 1–15)
Average team size-community based	3.6 (R 1–10)	2.3 (R 1–5)

Table 2. Trends in CBITS/BB Provider Network					
	FY 2021	FY 2022	FY 2023	FY 2024	Cumulative Since 2015
Schools					
CBITS	43	58	62	**70**	260*
BB	35	47	55	**52**	
School Districts					
CBITS	16	26	26	**29**	44*
BB	17	20	21	**21**	
Community-Based Settings**					
CBITS	3	10	2	**4**	20*
BB	4	5	2	**5**	
Newly Trained Clinicians					
CBITS	49	57	61	**47**	746*
BB	42	39	42	**34**	
# Newly Certified					
CBITS	1	6	11	**21**	90*
BB	2	4	10	**10**	
Clinicians Providing Treatment					
CBITS	50	69	80	**76**	446*
BB	43	56	62	**54**	

*Unique total (only counted once if trained in/certified in/provided both models, or if site provides both models)
**Community based settings include outpatient clinical and extended day treatment settings

The demographic characteristics of the 155 clinicians on a CBITS team and 110 clinicians on a BB team this year are presented in Table 3. CBITS and BB clinicians were primarily female and mostly White; 19% of CBITS clinicians and 18% of BB clinicians spoke Spanish. The current workforce does not adequately reflect the children being served. CHDI is working to support diversifying the workforce. A stipend for bilingual clinicians is now being provided to teams. There has also been an increase in targeted conversations with leadership about who is being trained and promoted.

Table 3. Demographics of CBITS/BB Staff

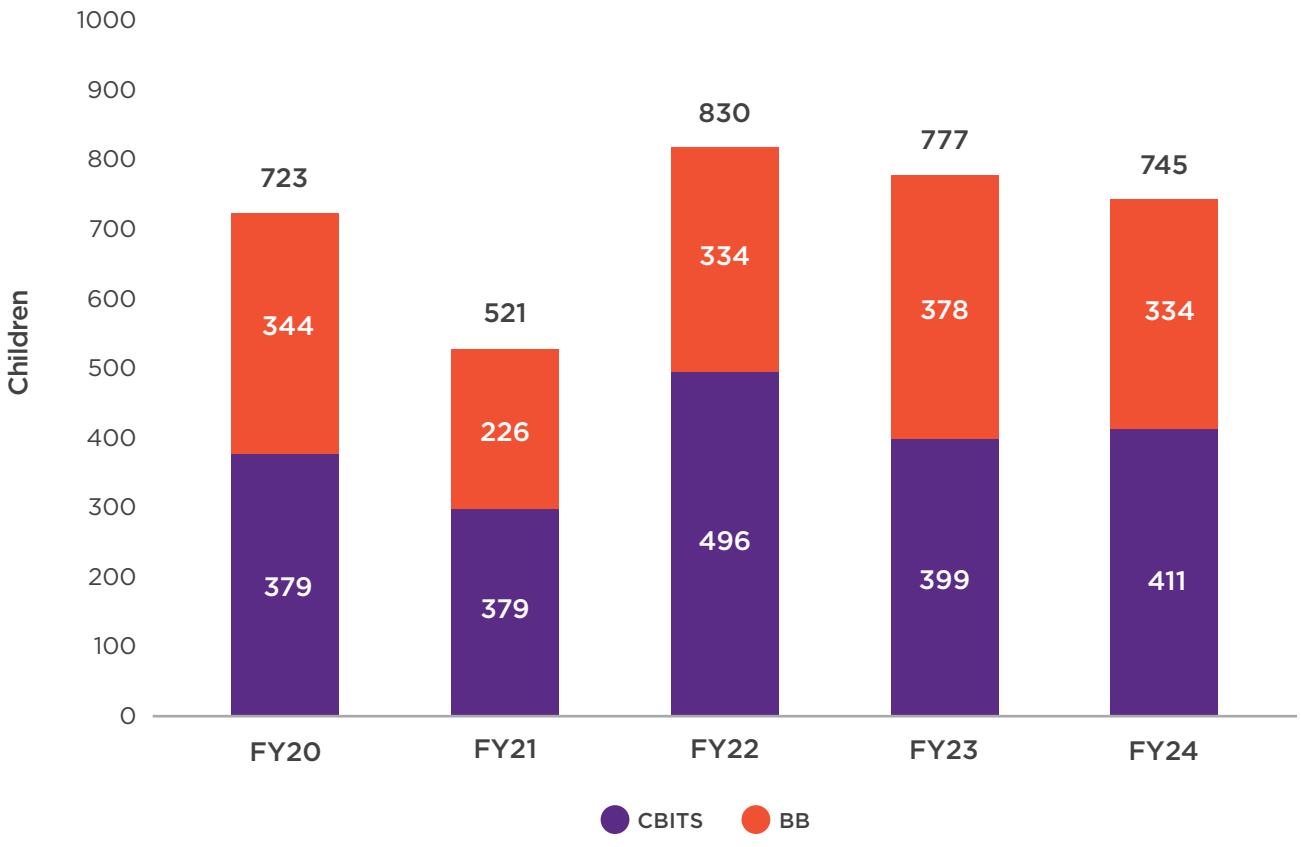
	CBITS % (n=155)	BB % (n=110)
Sex (Male)	**7.7**	**8.2**
Race		
Black or African American	16.8	7.3
Hispanic, Latino, or Spanish (any race)	18.1	16.4
White	61.3	71.8
Other Race/Ethnicity	3.2	4.5
Missing	0.6	0
Languages Spoken		
Spanish	18.7	18.2
Other	4.5	2.7

Children who Received CBITS/BB

In FY24, 2,120 children were screened for trauma exposure and traumatic stress and 936 were eligible to participate in a group. Of the children screened that were found eligible, 79% (745 of 936 children) participated in treatment. This is an increase from FY23, where 69% of children received treatment. Of the 2,120 children who were screened, the percent referred to other services, such as individual treatment or out-of-school treatment increased from 9% to 24% and the number of youth that declined services decreased from 6% to 4%. Supporting Transition Resilience of Newcomer Groups (STRONG) was piloted to better serve newcomer youth in Connecticut not eligible for CBITS/BB treatment in school settings. It is important to note that while 24 clinicians were trained in STRONG this year, there is a need for further piloting to confirm the outcome findings.

During the year, 411 children received CBITS, and 334 children received BB. The average number of youth in a CBITS group increased slightly to 4.0 from 3.95 last year. The average number of children in BB groups also increased slightly to 4.16 from 4.11 last year. The number of children receiving CBITS who were referred to higher levels of care this fiscal year decreased from 4.4% to 1.1%. As a result of this decrease, more youth are being referred to treatment from among those who were screened compared to last year. Children reported an average of 7.5 (CBITS) and 5.5 (BB) of 18 types of traumatic exposures. Figure 2 shows the number of children who have received CBITS and BB since FY20.

Figure 2. Children served since FY20



Child Demographics

Table 3 provides descriptive statistics for children who received CBITS and BB, as well as comparisons to those served in schools [as reported on Edsight.gov] and the general child population in Connecticut. In comparison to last year, the average age of youth receiving CBITS is 13.5 (SD=2.22), and 8.4 (SD=1.72) for those receiving BB. Children receiving CBITS and BB were more likely than the general child population and the Connecticut school population to be Black/African American or Hispanic descent. This is consistent with previous years.

Table 3. Characteristics of children receiving CBITS (n=411) and BB (n=334) with comparisons

	CBITS		BB		CT Schools[i]	CT Pop[ii]
	N	%	N	%	%	%
Sex (Male)	**155**	**37.7**	**168**	**50.3**	**51.5**	**51.2**
Race						
American Indian or Alaska Native	0	0.0	2	0.6	0.2	0.3
Asian	0	0.0	0	0.0	5.2	4.8
Black or African American	125	30.4	68	20.4	12.5	11.9
Native Hawaiian or Pacific Islander	0	0.0	0	0	0.1	0.1
White	221	53.8	220	65.9	46.2	53.4
Another Racial Group (includes multiracial/ethnic)	65	15.8	44	13.2	4.7	29.6
Non Disclosed/Missing	0	0.0	0	0.0	N/A	N/A
Hispanic, Latino, or Spanish (Any Race)	**200**	**48.7**	**141**	**42.2**	**31.1**	**27.5**
Age (Years)						
Under 6 years	0	0	15	4.5	N/A	29.9
6–11 years	77	18.7	316	94.6	N/A	32.9
12–17 years	321	78.1	3	0.9	N/A	37.2
18 and older	13	3.2	0	0.0	N/A	N/A
Grade						
Elementary	29	7.1	315	94.3	43.7	N/A
Middle	213	51.8	12	3.6	22.9	N/A
High	169	41.1	0	0.0	33.4	N/A

Table 3. Characteristics of children receiving CBITS (n=411) and BB (n=334) with comparisons						
	CBITS		BB		CT Schools[i]	CT Pop[ii]
Child Welfare Involvement During Treatment	46	11.2	38	11.4	N/A	3.4[iii]
	N	%	N	%	%	%
Juvenile Justice Involvement During Treatment	1	0.2	2	0.6	N/A	N/A
Child Primary Language						
Spanish	19	4.6	17	5.1	N/A	13.4
Neither Spanish nor English	4	0.8	1	0.3	N/A	8.7
Caregiver Speaks English (No)	44	10.7	42	12.6	N/A	N/A

[i]Data obtained from CT Dept. of Education: edsight.ct.gov for 2022-23 school year. Age and language spoken not available
[ii]American Community Survey 2022 1 yr. estimates. Caution should be used with comparison to CT schools and CBITS/BB child demographics. Census language is only available by language spoken, not primary language. Age is percentage of children 0–17 years.
[iii]Based on FY20 CT Data for total number of CPS reports and 2020 U.S. Census estimates for 0–19 year olds.

ACCESS AND EQUITY:

411 children received CBITS and **334** children received BB.

Child welfare involvement was **11%** for **CBITS/BB,** and **3%** for the general child population.

Children receiving CBITS and BB were more likely than the general child population and the CT school population to be **Black/African-American** or **Hispanic descent**.

37.7% of children served in CBITS were male, an increase from **34.1%** last year.

IV. QUALITY: CLINICAL IMPLEMENTATION AND IMPROVEMENT

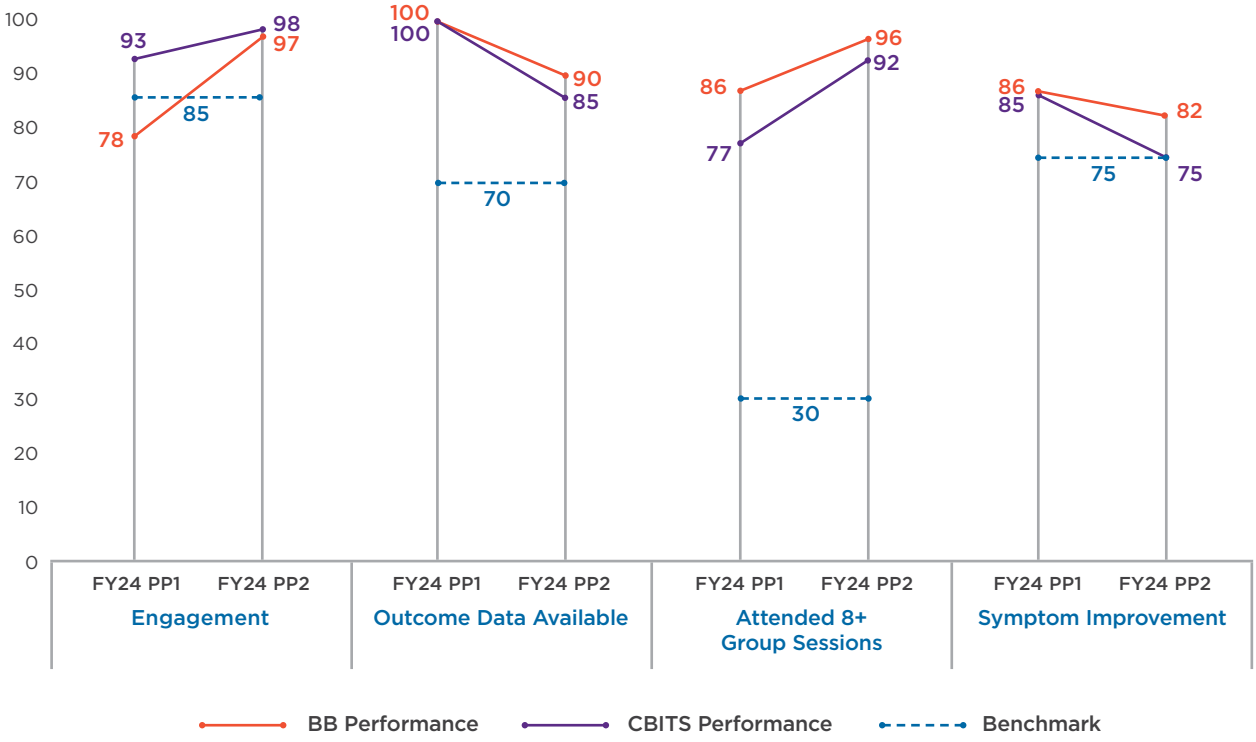
Treatment Dose and Duration

A total of 80 BB and 102 CBITS groups ran during this state fiscal year. The CBITS and BB models include 10 group sessions and 1-3 individual sessions. Youth receiving CBITS completed an average of 9.1 (SD=2.0) group and 1.4 (SD=.96) individual sessions over an average of 2.7 months. Youth receiving BB completed 9.3 (SD=1.6) group and 2.0 (SD=1.2) individual sessions over an average of 2.9 months.

Quality Improvement Indicators

In FY24, all or nearly all children receiving CBITS/BB had a baseline assessment (100% CBITS; 98% BB), and most had both baseline and post-group assessment data available (82% CBITS; 83% BB). Quality improvement (QI) indicators demonstrate progress across the statewide initiative during the fiscal year. Two of the QI indicators (engagement and attending 8+ group sessions) demonstrated improvement and were above the benchmark by the end of the year for both models. The other two QI indicators (outcome data available and symptom improvement) showed decreases in PP2; however, performance was still at or above the benchmark for both models at the end of the year, with BounceBack achieving a higher performance rate in PP2 from three out of four QI benchmarks compared to last fiscal year. (see Appendix D for additional QI Indicators information). There were no differences for the QI indicators by race, ethnicity or sex.

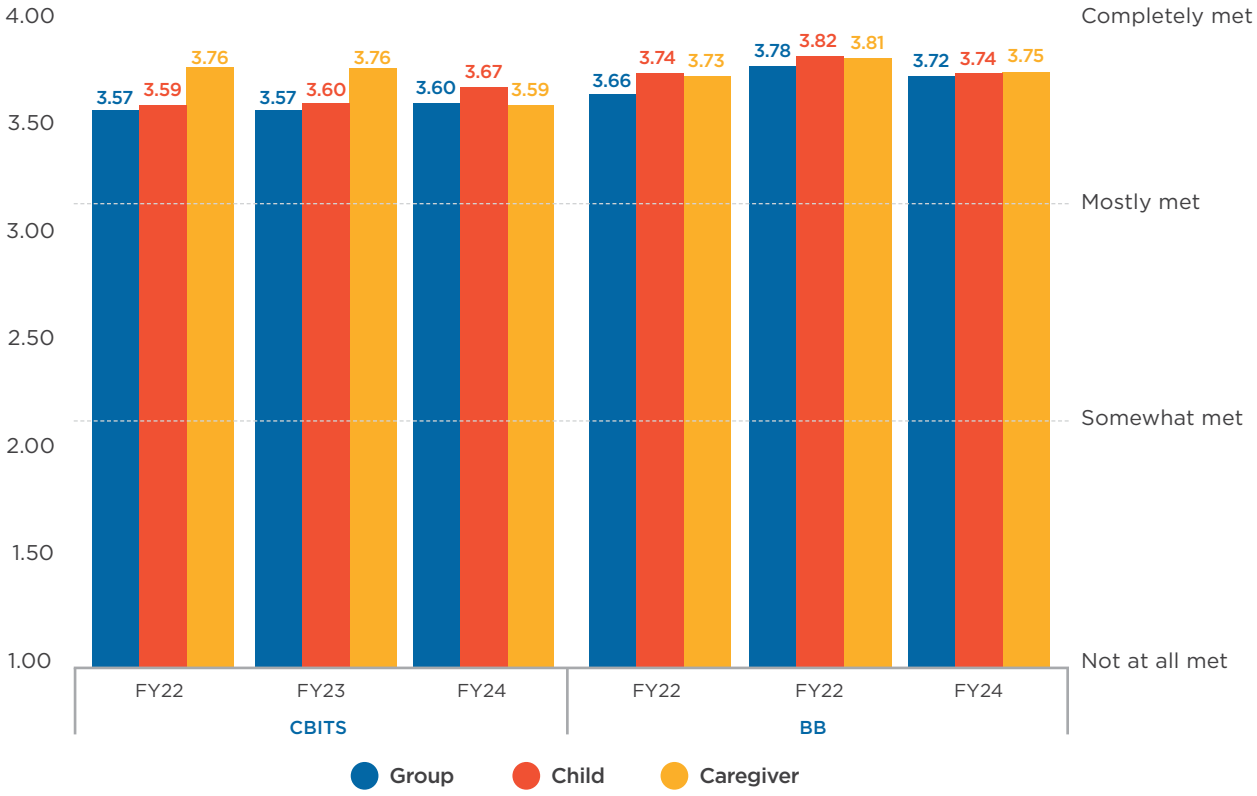
Figure 3. FY24 QI Indicators



Session Ratings by Clinicians

Clinicians rate session objective completion for group, child, and caregiver session on a four-point Likert scale. Clinicians rated all session objectives as "mostly met" or above for both models, see Figure 4.

Figure 4. Group, Child, and Caregiver Session Objectives-Average Ratings Over Time



QUALITY AND EQUITY:

86% percent of children and 94% of caregivers reported being moderately or extremely satisfied with treatment.

There were no differences for the QI indicators by race, ethnicity, or sex.

V. OUTCOMES: IMPROVEMENT FOR CHILDREN RECEIVING CBITS/BB

Discharge Reason

A total of 434 children in CBITS and 330 youth in BB completed their treatment episode in FY24. Successful completion was the most common discharge reason for both treatment models (82.7% CBITS, 87.6% BB). This is an increase for CBITS from FY23, when only 74.7% of children successfully completed treatment. Activity-based resources and engagement strategies to support clinical staff who serve older children were implemented to expand the number of children served in CBITS.

Other common discharge reasons for CBITS included “other” (3.9%), and administrative discharge (CHDI-level discharge) (6.9%). Family discontinued was reported as the discharge reason for 3% of CBITS episodes, and referral to a higher level of care or other treatment was reported for 1.1% of CBITS episodes.

For BB, administrative discharge was reported for 4.5% of episodes. Family discontinued was reported for 1.5% of BB episodes, and 0.3% of children were referred to a higher level of care or other treatment.

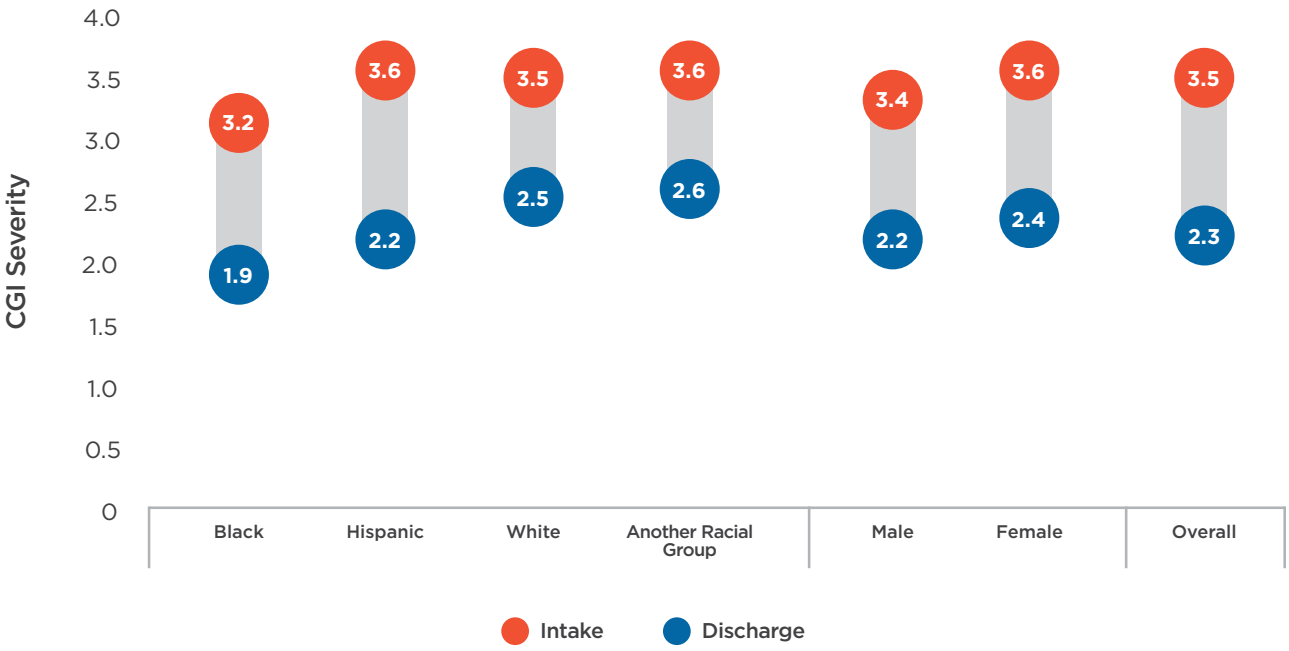
Another Race youth were less likely to successfully complete treatment compared to White youth for BB. (See Appendix B, Table B9).

Clinical Global Impressions (CGI) Scale

The clinical severity and overall improvement of children receiving CBITS and BB were measured using the CGI Severity (CGI-S) and Improvement (CGI-I) scales. These brief scales are not symptom-specific and are completed by the clinician at the start and end of treatment. On the CGI-I, clinicians reported symptom improvement for 90.4% of youth receiving CBITS (n=244) and 92.0% of youth receiving BB (n=195). On the CGI-S, 61.1% of youth receiving CBITS (n=124) and 69.9% of children who received BB (n=130) changed from a more severe to a less severe category by the end of treatment. Figure 5 shows improvement in CGI-S by subgroup.

For BB, Hispanic youth showed greater change on the CGI-S compared to White youth.

Figure 5. CGI Severity at Intake and Discharge by Subgroup



Symptom Improvement

Children consistently experienced improvements in symptoms and levels of functioning across reporters and measures (Appendix B, Tables B1 and B2). For a full description of the measures used and how change is calculated in CBITS/BB, please see Appendix E.

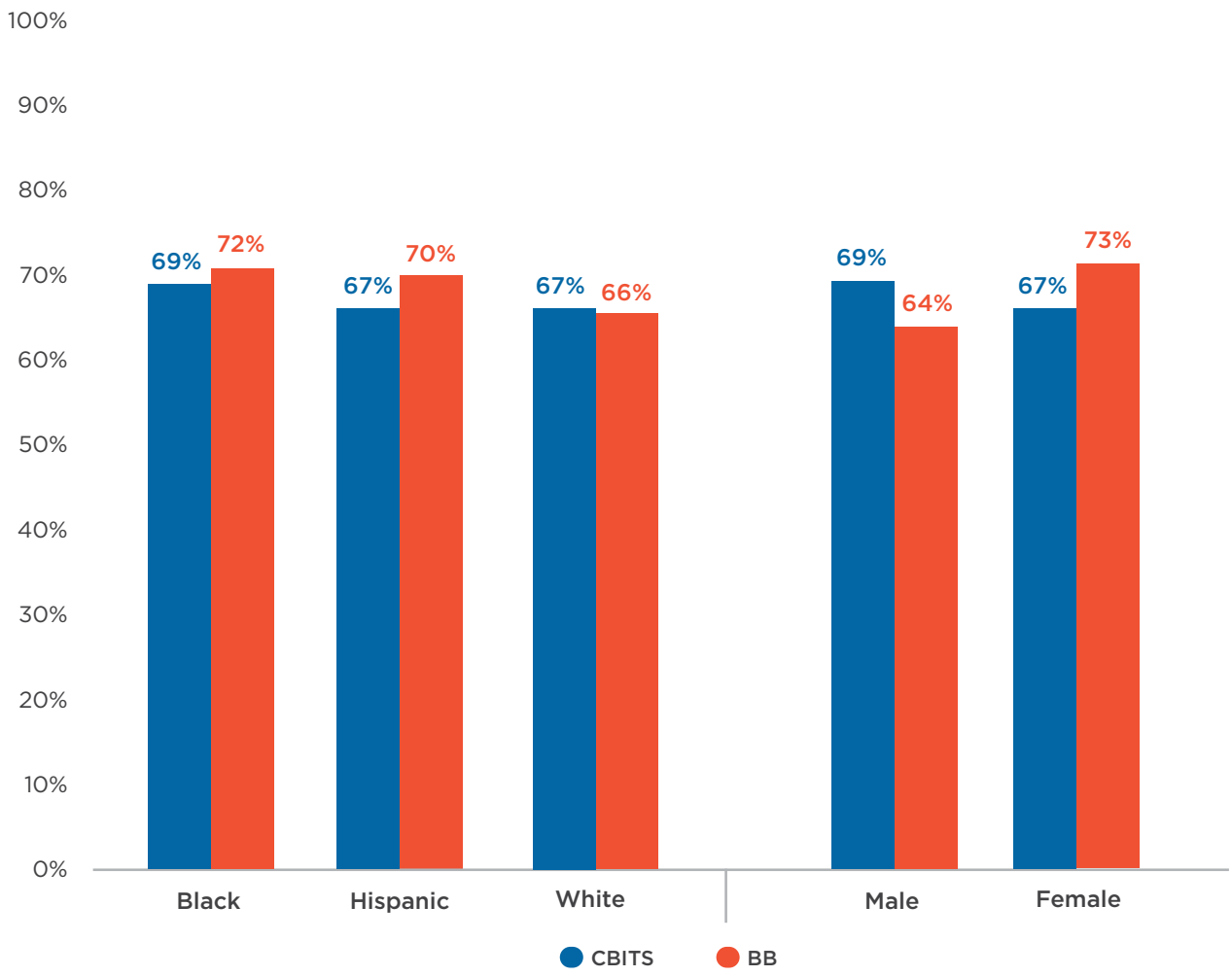
Overall Clinical Improvements Across Groups

For CBITS, older youth had higher rates of reliable improvement across any measure. There were no differences in improvement by race, ethnicity, or sex. **(See Appendix B, Table B5).**

Improvements within Subgroups

Improvement scores were calculated when children were assessed at two or more time points, and the Reliable Change Index values determined the percentage of children who experienced reliable improvement (see Appendix C). Over two-thirds of all youth (67.4% CBITS, 68.7% BB) showed improvement in posttraumatic stress symptoms. The increases were higher than those of FY23 (64.4% CBITS, 64.9% BB). Figure 6 shows the rates of improvement by subgroup.

Figure 6. Percentage of Children that Show Reliable Improvements in Posttraumatic Stress Symptoms



Note: Another non-Hispanic race group was removed from the analysis due to low n

OUTCOMES AND EQUITY:

For CBITS, older youth had **higher rates of reliable improvement** across any measure. (See Appendix B, Table B5).

There were **no differences in improvement** by race, ethnicity, or sex.

Another Race youth were **less likely to successfully complete treatment** compared to White youth. (See Appendix B, Table B8).

For BB, Hispanic youth showed **greater change** on CGI Severity compared to White youth.

VI. SUMMARY AND RECOMMENDATIONS

During FY24, network providers screened over 2,100 youth for trauma exposure and provided care to 745 youth in CBITS or BB. While CBITS and BB were widely used, just under half of all trained clinicians provided CBITS/BB treatment services; however, this was still an increase from last fiscal year (43%).

Both CBITS and BB demonstrated strong outcomes. Youth completed approximately 91% of group sessions in less than three (3) months, and the average session ratings were marked as nearly "Completely met" by clinicians. Within the year, all the Quality Improvement (QI) indicators met or exceeded benchmarks. Finally, most youth (86%) and nearly all caregivers (94%) reported satisfaction or high satisfaction with services.

Approximately 83% of youth receiving CBITS and 88% of youth receiving BB had completed the group successfully. Over two-thirds of youth had clinically meaningful reductions in post-traumatic stress symptoms in both CBITS and BB treatment models, 67.4% and 68.7%, respectively. According to the CGI, overall improvements by the end of treatment were high for both models (CBITS, 90.4%; BB, 92.0%).

Child characteristics, service experiences, and providing quality care to all eligible children are important factors in determining equity in access, quality, and outcomes. Access was high for Black and Hispanic youth, who made up nearly twice the proportion of all youth served in CBITS/BB when compared to overall Connecticut school and population rates. Regarding outcomes, for CBITS, older youth experienced greater improvements

in symptoms across any measure compared to White youth, while for BB, Another Race youth were less likely to successfully complete treatment compared to White youth. Hispanic youth also showed greater CGI severity change than White youth. Screening for trauma among children slightly decreased this year, with about 90 fewer youth screened than in FY23. Among the children eligible for treatment, 79% of children received CBITS/BB, an increase from last year. Engagement and retention efforts of eligible CBITS/BB youth should remain a focus for youth in care.

Recommendations

Over the past fiscal year, work has been carried out to address the recommendations from the FY23 annual report.

Recommendations met include:

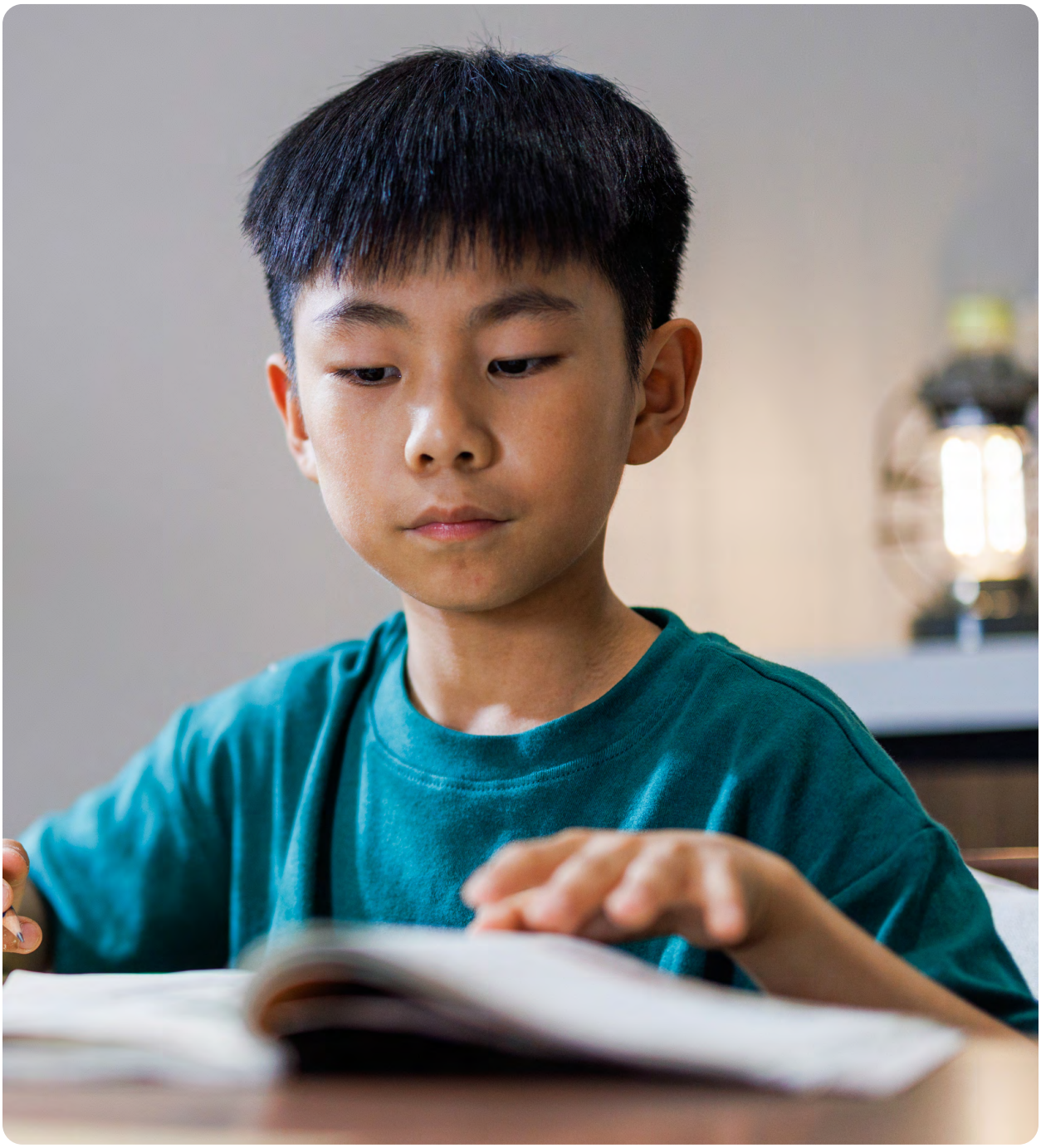
- **EdSight data** is now being used to gather information about where CBITS/BB is conducted in order to establish whether there is a proportional rate of youth being served compared to the schools' general population.

  This effort will be continued and enhanced by an updated screening survey, which is intended to provide a more accurate comparison between the demographics of the children who have been screened, those who have been referred to treatment, and those who have been served).

- **SMARTIE (Specific, Measurable, Attainable, Relevant, Time-bound, Inclusive, and Equitable)** goals were established in partnership with providers to ensure equitable access to CBITS/BB, which included exploring the annual disproportionality rates across race and sex during CBITS/BB site-based consultation.

The following recommendations will strengthen access, quality, and outcomes for youth served within the CBITS/BB statewide network:

- **Grow the capacity of Bounce Back by 5%** through targeted goal setting and resource sharing with teams working with younger children.
- **Examine the reason a lower percentage of male children engage in CBITS** by targeting site visit consultation to include child demographics to increase the percentage of males served in CBITS.
- **Explore the ability to expand the options for collecting gender identity data** in intake processes and the EBP Tracker database to better align with best practices and enhance equitable care.
- **Investigate racial and ethnic disparities** between the children in the schools' general population, the children being screened for CBITS/BB, the children screening in, and the children served.
- **Examine the reason a higher percentage of children that screened in for CBITS/BB were referred to another service,** such as individual treatment or out-of-school treatment instead of being treated with CBITS/BB.
- **Expand practices that complement CBITS/BB,** such as Supporting Transition Resilience of Newcomer Groups (STRONG) to better serve newcomer youth in Connecticut not eligible for CBITS/BB treatment in school settings.
- **Work to diversify the workforce** through the implementation of a Bilingual Stipend and targeted conversations with team leadership about who they are choosing to train in an EBP.



Conclusion

Both CBITS and BB resulted in symptom improvement among many youth served, notably older youth in CBITS with greater improvement in trauma-related symptoms. While progress in serving youth equitably has grown, efforts to ensure that children eligible for CBITS/BB receive access and that the completion of treatment, particularly among males remains an essential focus of strong future service delivery.

VII. APPENDIX A: ACTIVITIES AND DELIVERABLES

In FY24, the Coordinating Center has supported CBITS/BB implementation goals through the following activities.

1. Training, Consultation, & Credentialing

- Coordinated two CBITS and two BB statewide new clinician trainings for 47 CBITS and 34 BB staff.
- Coordinated four CBITS Booster trainings and three Bridgeport-specific CBITS Booster trainings for 53 clinical staff and four BB Booster trainings for 40 clinical staff.
- Coordinated five CBITS clinical consultation call groups with 54 total calls for 60 clinical staff.
- Coordinated four BB clinical consultation call groups with 48 total calls for 40 clinical staff.
- Developed, executed, and managed contracts for Site Based Trainers (SBT) to conduct statewide trainings and consultation calls to increase Initiative sustainability.
- Maintained a training and certification record database to track training and consultation attendance of all CBITS/BB providers.
- Conducted a two-day STRONG training for 24 clinical staff.
- Convened the 16th annual EBP and Best Practice conference in person consisting of 34 workshops with 61.8% meeting the cultural competency CE requirement. A total of 410 unique participants from community providers, DCF, CSSD, and other partners attended the conference.

2. Implementation Support, Quality Improvement, & Technical Assistance

- Conducted 136 site visits and 41 non-clinical consultation calls (virtual or telephonic).
- Onboarded 2 new provider teams; Chaplin Elementary School and Fairfield Public Schools.
- Convened quarterly Senior Leader Call Series to support treatment fidelity, implementation, and network community-building.
- Provided monthly Data Dashboard, quarterly RBA, and annual reports.

3. Data Systems

- Continued development and maintenance of a secure, HIPAA compliant, online database that meets the needs of the increasing number of CBITS/BB providers and the children and families they serve, EBP Tracker.
- Maintained a public directory site that provides a searchable, public listing of CBITS and BB providers through EBP Tracker (https://ebp.dcf.ct.gov/ebpsearch/).
- Monitored, maintained, and provided technical assistance for online data entry for all CBITS and BB providers via the use of ebptrackerhelpdesk@chdi.org.
- 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 $325,000 in performance-based sustainment funds to agencies.

VIII. APPENDIX B: REGRESSION TABLES

Table B1. Descriptives and Change Scores for All Assessment Measures (CBITS)

Assessment Name	Construct	Above Clinical Cutoff	First Score Mean (S.D.)	Last Score Mean (S.D.)	Change Score	T-Score	Effect Size (Cohen's d)	Remission
CPSS 5 Child (n=330)	Post-traumatic stress symptoms	201	36.26	23.29	-12.86**	-18.152	Large	116/201
		60.9%	(14.54)	(14.88)			0.99	57.7%
Ohio Problem Severity Child (n=293)	Severity of internalizing/ externalizing behaviors	155	27.60	18.70	-8.39**	-11.458	Medium	91/155
		52.9%	(15.61)	11.99			0.70	58.7%
Ohio Fuwnctioning Child (n=293)	Child's adjustment and functioning	65	52.19	57.76	5.44**	8.522	Medium	43/65
		22.2%	(11.68)	(11.68)			.50	66.2%

**p < .001, * p < .01
Effect sizes were derived using Cohen's D as follows: .2 = small, .5 = medium, .8 = large
CPSS 5 and Ohio Caregiver statistics suppressed due to low n
Outliers were found and corrected for the following first scores: CPSS 5 Child, Ohio PS child, Ohio Functioning Child
Outliers were found and corrected for the following last scores: CPSS 5 Child, Ohio PS Child, Ohio Functioning Child
Outliers were found and corrected for the following change scores: CPSS 5 Child, Ohio PS Child, Ohio Functioning Child

Table B2. Descriptives and Change Scores for All Assessment Measures (BB)

Assessment Name	Construct	Above Clinical Cutoff	First Score Mean (S.D.)	Last Score Mean (S.D.)	Change Score	T-Score	Effect Size (Cohen's d)	Remission
CPSS 5 Child (n=245)	Post-traumatic stress symptoms	133	33.48	20.68	-12.61**	-13.920	Large	95/133
		54.3%	(13.59)	(12.74)			0.89	71.4%
Ohio Problem Severity Child (n=71)	Severity of internalizing/ externalizing behaviors	38	28.20	15.51	-12.08**	-10.637	Large	25/38
		53.5%	(13.89)	(10.06)			1.2	65.8%
Ohio Problem Severity Caregiver (n=49)		17	22.80	17.76	-5.04**	-3.531	Medium	6/17
		34.7%	(13.59)	(10.43)			0.5	35.3%
Ohio Functioning Child (n=71)	Child's adjustment and functioning	9	56.49	64.52	7.86**	7.972	Large	9/9
		12.7%	(10.82)	(8.28)			0.95	100%
Ohio Functioning Caregiver (n=49)		8	57.16	61.57	4.53*	3.130	Small	6/8
		16.3%	(11.25)	(10.22)			0.45	75.0%

**p < .001, * p < .01
Effect sizes were derived using Cohen's D as follows: .2 = small, .5 = medium, .8 = large
Outliers were found and corrected for the following first scores: CPSS 5 (child and caregiver), Ohio PS (child and caregiver), Ohio Functioning (child and caregiver)
Outliers were found and corrected for the following last scores: CPSS 5 Child, Ohio PS (child and caregiver), Ohio Functioning Child
Outliers were found and corrected for the following change scores: CPSS 5 Child, Ohio PS (child and caregiver), Ohio Functioning Child

Table B3. Multiple Regression Analyses of Selected Demographic Variables on Child CPSS5 Change Scores (CBITS)			
Variable	β	*SE*	*95%CI*
Constant	-3.888	5.545	(-14.797, 7.021)
Trauma Exposure-TEC Child	-0.214	0.214	(-0.636, 0.207)
Child Discharged "Successful"	-0.291	2.344	(-4.904, 4.321)
Hispanic	-0.367	1.745	(-3.800, 3.065)
Black Non-Hispanic	-1.157	2.099	(-5.286, 2.973)
Another Non-Hispanic	0.408	4.208	(-7.870, 8.686)
Sex (Male)	-1.322	1.510	(-4.239, 1.649)
Child age	-0.458	0.341	(-1.128, 0.212)
R^2	-0.008		
F	0.606		

*p<.05 As compared to White Females
**p<.01 Outliers were found and corrected for CPSS5 Child change score
***p<.001

Table B4. Multiple Regression Analyses of Selected Demographic Variables on Child CPSS5 Change Scores (BB)			
Variable	β	*SE*	*95%CI*
Constant	-10.015	5.653	(-21.151, 0.122)
Trauma Exposure-TEC Child	**-1.163*****	0.321	(1.796, -0.529)
Child Discharged "Successful"	3.603	3.179	(-2.660, 9.867)
Hispanic	1.686	2.001	(-2.255, 5.627)
Black Non-Hispanic	-1.162	2.721	(-6.523, 4.199)
Another Hispanic	0.858	4.836	(-8.669, 10.385)
Sex (Male)	2.511	1.786	(-1.008, 6.030)
Child age	-0.169	0.562	(-1.277, .939)
R^2	0.045		
F	2.633		

*p<.05 As compared to White Females
**p<.01 Outliers were found and corrected for CPSS5 child change score
***p<.001

Table B5. Logistic Regression Analyses for Predicting Any Child Symptom RCI from Selected Background Characteristics (CBITS)

Predictors	*N*	*β*	*SE*	*Wald*	e^B *(95% CI)*
Hispanic	168	0.535	0.361	2.193	1.707 (0.841, 3.464)
Another Non-Hispanic	12	1.149	1.084	1.123	3.154 (0.377, 26.388)
Black Non-Hispanic	75	-0.083	0.398	0.043	0.921 (0.422, 2.008)
Sex (Male)	128	0.154	0.307	0.252	1.167 (0.639, 2.129)
Child Age	334	**0.139***	0.069	4.095	1.149 (1.004, 1.314)
Trauma Exposure from TEC	334	0.053	0.047	1.291	1.054 (0.962, 1.155)
Child Discharged as "Unsuccessful"	5	-0.241	1.189	0.041	0.785 (0.076, 8.082)
Constant		-0.991	0.982	1.018	0.371

*p<.05 As compared to White Females
**p<.01
***p< .001

Table B6. Logistic Regression Analyses for Predicting Any Child Symptom RCI from Selected Background Characteristics (BB)

Predictors	*N*	*β*	*SE*	*Wald*	e^B *(95% CI)*
Hispanic	119	-0.269	0.312	0.744	0.764 (0.414, 1.409)
Black Non-Hispanic	43	0.113	0.443	0.065	1.120 (0.470, 2.669)
Sex (Male)	133	-0.235	0.287	0.668	0.791 (0.450, 1.388)
Child Age	268	0.002	0.085	0.000	0.984 (0.848, 1.183)
Trauma Exposure from TEC	268	0.071	0.051	1.883	1.073 (0.970, 1.187)
Constant		0.938	0.758	1.532	2.556

*p<.05 As compared to White Females

**p<.01 "Another Non-Hispanic" removed due to small sample size. Only 1% were not successful, so 'child discharged as unsuccessful' predictor could not be included in model.

***p< .001

Table B7. Logistic Regression Analyses for Predicting Successful Discharge from Selected Background Characteristics (CBITS)

Variable	*N*	*β*	*SE*	*Wald*	*eB(95%CI)*
Hispanic	198	-.348	0.400	0.756	0.706 (0.322, 1.548)
Another Non-Hispanic	13	.246	1.096	0.050	1.278 (0.149, 10.963)
Black Non-Hispanic	85	.512	0.571	0.800	1.669 (0.545, 5.116)
Sex (Male)	147	-.032	0.351	0.008	0.968 (0.486, 1.928)
Child Age	398	-.088	0.078	1.272	0.916 (0.786, 1.067)
Trauma Exposure-TEC Child	398	.031	0.050	0.379	1.031 (0.935, 1.137)
Constant		3.249	1.171	7.702	25.77

*p<.05 As compared to White Females

**p<.01 "Another Non-Hispanic" removed due to small sample size. Only 1% were not successful, so 'child discharged as unsuccessful' predictor could not be included in model.

***p< .001

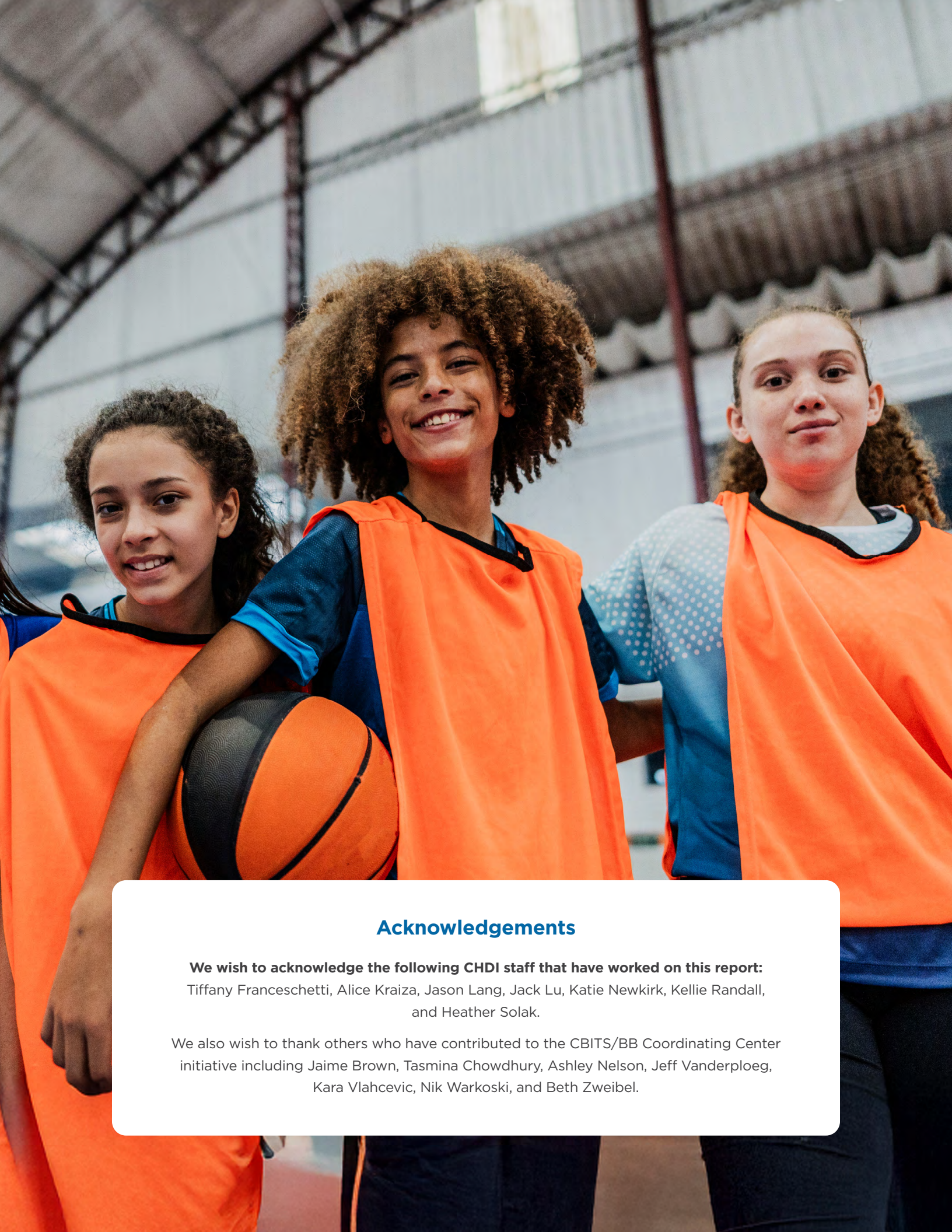
Table B8. Logistic Regression Analyses for Predicting Successful Discharge from Selected Background Characteristics (BB)

Variable	*N*	*β*	*SE*	*Wald*	*eB(95%CI)*
Hispanic	132	0.274	0.457	0.360	1.315 (0.537, 3.219)
Another Non-Hispanic	12	**-1.582***	0.691	5.238	0.206 (0.053, .797)
Black Non-Hispanic	47	1.611	1.058	2.321	5.009 (0.630, 39.815)
Sex (Male)	156	0.085	0.413	0.043	1.089 (0.484, 2.449)
Child Age	315	-0.030	0.132	0.052	0.970 (0.750, 1.257)
Trauma Exposure-TEC wChild	315	0.055	0.078	0.487	1.056 (0.906, 1.231)
Constant		2.157	1.118	3.722	8.642

*p<.05 As compared to White Females

**p<.01 "Another Non-Hispanic" removed due to small sample size. Only 1% were not successful, so 'child discharged as unsuccessful' predictor could not be included in model.

***p< .001



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