Connecticut's Outpatient Psychiatric Clinics for Children

FISCAL YEAR 2023 ANNUAL REPORT

CHDI® Child Health and Development Institute

DCF

Connecticut's Outpatient Psychiatric Clinics for Children

The authors retain full responsibility for all opinions and content.

CONTENTS

I. EXECUTIVE SUMMARY

The Outpatient Psychiatric Clinics for Children (OPCC) Quality Improvement (QI) Center includes 22 community-based behavioral health facilities licensed and funded by the Connecticut (CT) Department of Children and Families (DCF). OPCCs provide mental health services to youth under 18 years of age and their families. Funded by CT DCF, the Child Health and Development Institute (CHDI) provides continuous Quality Improvement within these OPCC providers. CHDI provides clinical training/workforce development, technical assistance and consultation about data collection, analysis, and reporting from the DCF Provider Information Exchange (PIE).

This report summarizes CHDI's work since 2018, highlighting performance during state fiscal year (FY) 2023 (July 1, 2022 through June 30, 2023). OPCC providers have had to navigate post-COVID challenges that impact service delivery including workforce difficulties and an increased demand for OPCC services. Despite these challenges, OPCC providers demonstrated strong results in access, quality, and outcomes.

KEY FINDINGS FY23:

OPCC providers served **27,497 children**, an **11%** increase over the last **5** years.

Sessions per treatment episode increased **7%** compared to the previous year, and children received an average of **21.3** sessions, suggesting increased engagement.

Almost half of children **(47.1%)** received an EBT and **197** OPCC clinicians were trained in DCF-supported evidence-based treatments (EBTs) or best practices.

The most common primary presenting problems among children served were Anxiety **(25.3%)**, Disruptive Behavior **(20.1%)**, Depressive Disorders **(18.2%)**, and Trauma/PTSD **(11.4%)**.

78.8% of children receiving treatment completed **4+ treatment** sessions and Black, Hispanic, and children of Another Race were less likely to complete **4+ sessions** than White children.

Clinicians reported that treatment goals were met for **61.4% of children** and those receiving EBTs were more likely to meet them compared to those who did not.

54%–60% of children experienced significant improvement in Ohio Scale Problem Severity across all reporters (Benchmark: **50%**) and children receiving EBTs had **26–44%** greater odds of symptom improvement.

KEY RECOMMENDATIONS:

• Further improve race and activity data collection rates by 50% through consulting and sharing information with providers, and facilitating cross-collaboration in OPCC network meeting.

• Promote the integration of evidence-based practices (EBPs) that are briefer, more compatible with telehealth formats, and flexible, such as the ARC, T-SBIRT, and single-session interventions, to improve access to outpatient trauma treatment in a shorter amount of time.

• Compare Clinical Global Impressions Scale (CGI) to current validated measures to help determine if CGI may replace longer assessments, help reduce data collection burden, and thereby increase outcome data availability.

• Due to increases in OPCC youth served, increase funds and resources that support workforce hiring, development, and retention strategies including funding for non-clinical professionals to support clinicians and clients.

The CT DCF contracts with CHDI to provide QI services to the OPCC network. CHDI creates centralized support for the statewide network of OPCC providers through the following:

1. Training and workforce development
2. Implementation support and QI consultation
3. Data collection, statistical analysis, and reporting
4. Administration of performance-based sustainment funds.

This report summarizes CHDI's QI work for FY 2023 (July 1, 2022 through June 30, 2023).

Background

The OPCC QI Center includes 22 DCF-licensed and funded community-based behavioral health facilities that are designed to provide mental health services to youth under 18 years of age and their families. OPCC services are designed to serve the general public and meet the following goals:

• Promote mental health and improve functioning in children and families
• Decrease the prevalence and incidence of mental illness, emotional disturbance, and social dysfunction[1]

These facilities utilize a multi-disciplinary team of professionals (e.g., psychiatrists, psychologists, social workers, marriage and family therapists) to provide diagnostic and treatment services to children and their families.

Goals

CHDI's primary goals for the OPCC contract include:

• Provide QI activities to the OPCC network
• Improve outpatient care, including the use of EBTs

These goals are framed in three domains in this report: providing equitable access, quality, and outcomes for children and families served in the OPCC network. The final section provides conclusions and recommendations to guide the work in future years.

1. Retrieved from the DCF website: https://portal.ct.gov/DCF/Licensing/Home#PsychClinics

Across the network of 22 OPCC providers, a total of **27,497 children** were served in FY23. Figure 1 provides a visual representation of outpatient episode volume across the state. The map indicates the rate of outpatient episodes in each town during FY23, relative to each town's child population (episodes per 10,000 children). Table 1 describes characteristics of the children served by OPCCs in FY23 with comparison rates of the general population. Overall, OPCCs primarily served children between ages 6–17 (90.4%) and children served were most likely to identify as White (49.2%). Compared to the general CT population, youth in OPCC services were more likely to identify as being Hispanic. The number of youth served by OPCC providers has increased by 15% in the last two years since a decline during the first year of the Covid-19 pandemic and now exceeds the number served prior to the pandemic by 11%, even with two fewer providers (Figure 2). Children served included 11,679 who initiated treatment during FY23, and 15,818 whose treatment episodes began prior to the FY.

Figure 1. Map of OPCC Sites and Children Served

OPCC Open Episodes per 10,000 Children SFY 2023

Legend

🟠 Outpatient Sites

Open Episodes Per 10,000 Children

⚪ No Children Served

0–87

87–177

177–269

269–359

359–513

513–1368
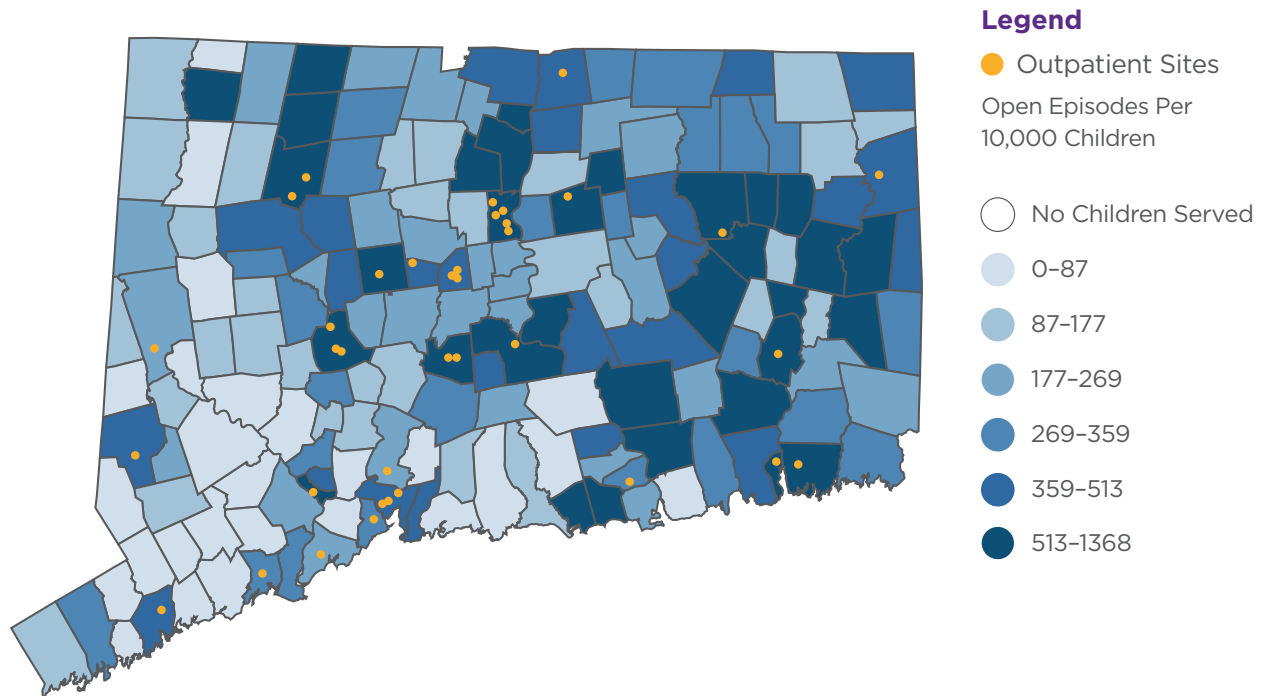
Table 1. Characteristics of children receiving OPCC services, with comparisons (n= 27,497)	OPCC		CT pop[2]
	N	%	%
Sex			
Male	13464	49.0	51.2
Female	14033	51.0	48.8
Race			
American Indian or Alaska Native	103	0.4	0.4
Asian	305	1.1	4.9
Black or African American	4175	15.2	11.7
Native Hawaiian or Pacific Islander	56	0.2	0.0
White	13529	49.2	53.5
Other Race/Ethnicity (includes multiracial/ethnic)	4036	14.7	29.4
Missing/Declined	**5293**	**19.2**	**—**
Hispanic, Latino, or Spanish (any race)	**9102**	**33.1**	**26.5**
Age[3] (years)			
Under 6 years	2643	9.6	29.8
6–11 years	11807	43.1	33.2
12–17 years	12974	47.3	37.0
Child Primary Language			
English	22239	80.9	78.4
Spanish	2723	9.9	13.8
Neither English nor Spanish	454	1.7	7.8
Nonverbal	253	0.9	—
Missing	1829	6.7	—
Child Welfare Involvement During Treatment	**2869**	**10.4**	**2.9[4]**
JJ Involvement During Treatment	**172**	**0.6**	**N/A**

Figure 2. Youth Served in OPCC FY19–FY23
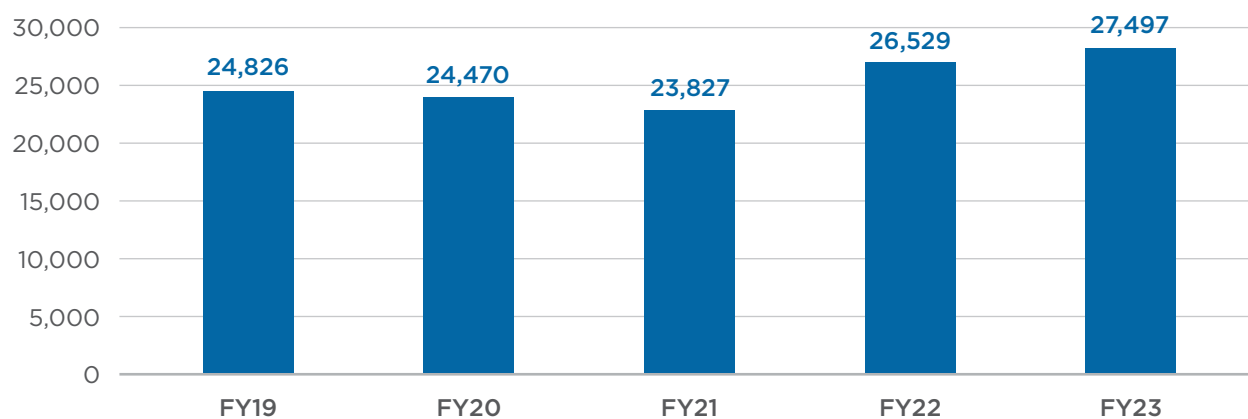
2. American Community Survey 2021 1-year estimates. Census language is only available by language spoken, not primary language.
3. Age is percentage of children 0–17 years.
4. Based on FY20 CT Data for total number of CPS reports and 2020 U.S. Census estimates for 0–19 year olds.

OPCC Youth Discharged in FY23

A total of 11,232 children ages 0-18 were discharged in FY23. Children who were referred for an evaluation only, or who a clinician indicated withdrew from treatment after less than four sessions and did not respond to attempts to re-engage made up 17.3% of children discharged. These episodes are considered "evaluation only," excluding them from most data collection requirements. Of the children discharged, 82.7% were categorized as having received treatment with data collection requirements. Youth with intakes prior to July 1, 2018 are also excluded from many data collection requirements. Figure 3 shows the flow of youth served through the OPCC network of providers, through discharge, and including data availability. The following are characteristics of the remaining 8,965 youth discharged from OPCC services with data collection required.

Trauma Exposure

At intake, clinicians report on trauma exposure across six different trauma types (see Figure 4). Of those discharged in FY23, over half (58.2%) of youth experienced at least one type of trauma and some youth experienced multiple types of trauma (the average number was 0.9). Though overall reports of trauma exposure have slightly decreased since FY20, child trauma exposures may be underreported. As there is not currently any required measure of traumatic stress or PTSD symptoms, the prevalence of children in OPCC experiencing symptoms associated with trauma exposure is unknown.

Black (64.4%), Hispanic (60.6%), and youth of Another Race or Ethnicity (57.8%) were more likely to report having any trauma exposure than White youth (54.2%). Female youth reported experiencing trauma exposure at higher rates (60.8%) than males (55.4%).

Figure 3. Flowchart of Youth Served in OPCC

11,679 Intakes

15,818 Continuing Treatment

27,497 Children and Youth Served

11,232 Discharges

1,941 designated as Evaluation Only (Data exempt)

326 discharges with intake prior to July 1, 2018

1,438 Evaluation Only Early Discontinuation Data Exemption

503 True Evaluation Only Data Exemptions

8,965 Discharges with Data Requirements

1,438 Youth Ohio Report Available at 2 Timepoints

2,493 Parent Ohio Report Available at 2 Timepoints

6,290 Worker Ohio Report Available at 2 Timepoints

Figure 4. Types of Trauma Exposure at Intake

Legend:
- Other
- Witness to Violence
- Disrupted Attachment
- Victim of Violence
- Sexual Victimization
- Recent Arrest of Caregiver

2021: Other 22.6%, Witness to Violence 24.6%, Disrupted Attachment 21.6%, Victim of Violence 10.1%, Sexual Victimization 7.6%, Recent Arrest of Caregiver 0.7%

2022: Other 22.1%, Witness to Violence 24.1%, Disrupted Attachment 20.6%, Victim of Violence 10.4%, Sexual Victimization 8.4%, Recent Arrest of Caregiver 0.7%

2023: Other 24.5%, Witness to Violence 22.1%, Disrupted Attachment 20.1%, Victim of Violence 9.5%, Sexual Victimization 8.4%, Recent Arrest of Caregiver 0.4%

Presenting Problem

Among children discharged in FY23, the most common presenting problem categories were Anxiety (25.3%) followed by Disruptive Behavior (20.1%), Depressive Disorders (18.2%), and Trauma (11.4%). From FY21 to FY23, rates of Anxiety increased and Disruptive behavior decreased (see Figure 5). Figure 6 shows the breakdown of primary presenting problem by race/ethnicity[5]
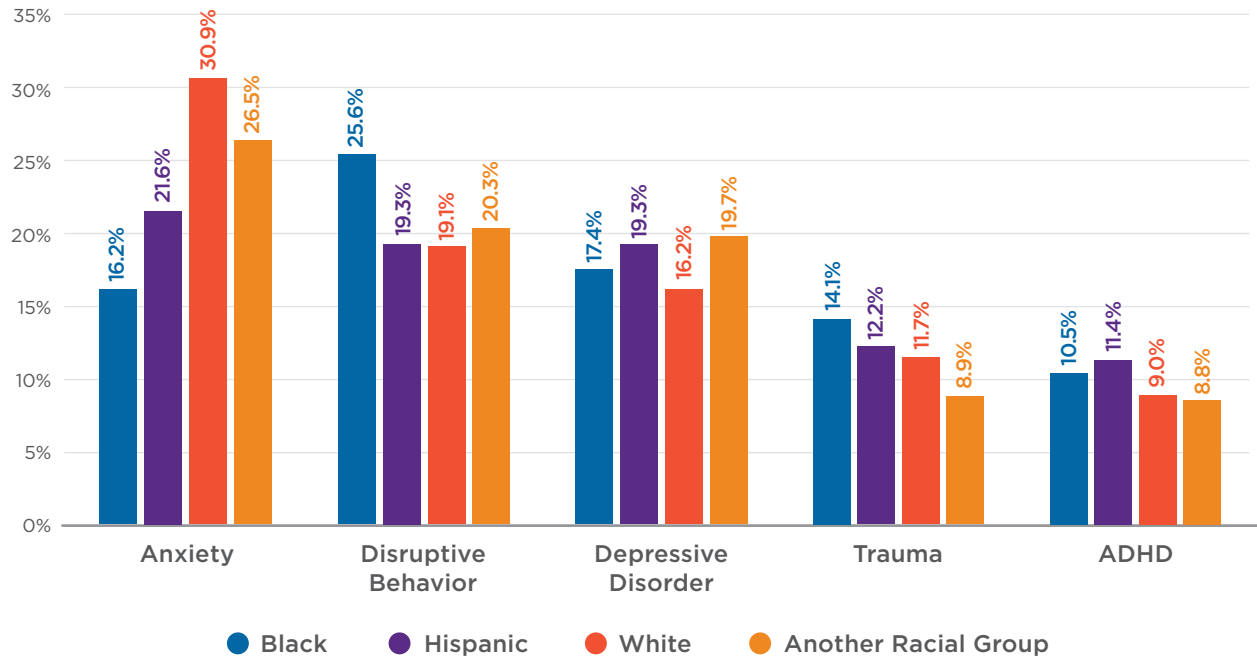
Figure 5. OPCC Primary Presenting Problem at Intake

Anxiety: 2021 21.7%, 2022 24.0%, 2023 25.3%
Disruptive Behavior: 2021 22.0%, 2022 19.1%, 2023 20.1%
Depressive Disorder: 2021 19.0%, 2022 19.8%, 2023 18.2%
Trauma: 2021 10.3%, 2022 10.7%, 2023 11.4%
Attention Deficit Hyperactivity Disorder: 2021 11.2%, 2022 10.4%, 2023 9.9%

Legend: 2021, 2022, 2023
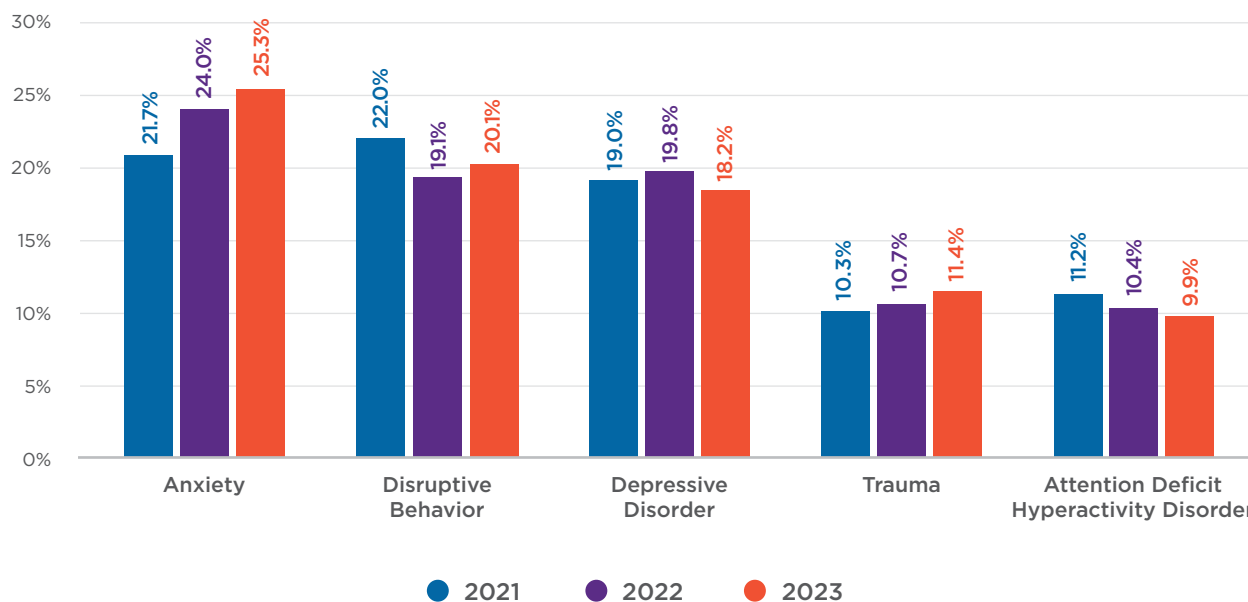
5. Please note "Another Racial Group" includes American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, Other, Multiracial, and Declined/Missing, with the largest groups being Declined/Missing (65%) and Asian (24%)

Figure 6. Racial/Ethnic Differences in Primary Presenting Problem

Legend: ● Black ● Hispanic ● White ● Another Racial Group

	Black	Hispanic	White	Another Racial Group
Anxiety	16.2%	21.6%	30.9%	26.5%
Disruptive Behavior	25.6%	19.3%	19.1%	20.3%
Depressive Disorder	17.4%	19.3%	16.2%	19.7%
Trauma	14.1%	12.2%	11.7%	8.9%
ADHD	10.5%	11.4%	9.0%	8.8%

DIFFERENCES IN PRIMARY PRESENTING PROBLEM BY RACE/ETHNICITY:

Anxiety: Highest rates for White youth, but all groups differed

ADHD: Hispanic youth had higher % than White or Another Race

Disruptive Behavior: Higher % for Black youth than for all other youth

Treatment Information

Activity data is date-based, session level information entered during the episode or at discharge about the type of treatment provided. Of the 8,865 discharged youth who received treatment with data requirements, 6,514 (72.7%) had at least one activity data record corresponding to a treatment session[6].

Number of Sessions

The overall number of treatment sessions quantifies the dose of treatment received by a child. Of the children discharged in FY23, the mean number of sessions was 21.3 (SD= 21.4) and the median (50th percentile) was 14 sessions.[7] This represented an increase in the typical number of sessions over FY22, which could suggest children and families are engaged for longer. There were no meaningful differences in number of treatment sessions by race/ethnicity, sex, or age. Youth involved with DCF had slightly fewer sessions (Appendix B Table B1).

Format of Sessions

Of all activity data reported for FY23, 32.5% were indicated as telehealth sessions, a decrease from FY22 (38.5%). While over half (52.9%) of youth discharged had only in-person treatment sessions, 37.7% had a hybrid of in-person and telehealth sessions, and 9.4% had telehealth sessions only. Youth receiving telehealth only were slightly older (12.6 years) compared to in-person only (10.9 years) and hybrid (11.0 years) youth. Youth receiving hybrid or telehealth-only episodes were less likely to have fewer than four sessions (including intake) compared to in-person only.

Black (15.3%) Another Race (14.9%) and **Hispanic (7.3%) youth** were more likely to have telehealth-only treatment than White youth (4.6%).

Use of EBTs

OPCC providers may identify whether any EBT was used by session, at the end of a treatment episode, or by opening an EBP episode in the PIE EBP data system (DCF-sponsored EBPs only). Though some discrepancies between these data points existed, across the information available on EBTs, 47.1% (n=4,224) of children received an EBT during their treatment. Of these, 3,412 (80.8%) received Cognitive Behavioral Therapy, 473 (11.2%) received Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and 482 (11.4%) received Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct problems (MATCH-ADTC). Children may have received more than one EBT during their treatment episode. No other EBT was used 5% or more of the time. One of the DCF-supported outpatient EBTs (MATCH-ADTC or TF-CBT) was provided according to best practice guidelines in 7.5% of OPCC episodes, with the rates ranging from 2.8%–21.2% across providers.

In analyses accounting for age, sex, and DCF involvement, youth across racial and ethnic identities had an equivalent likelihood of receiving a DCF-supported EBT (MATCH-ADTC, TF-CBT) according to best-practice guidelines. DCF-involved, older youth, and female youth were more likely to receive these

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6. Excludes cases with activity for an intake only with no subsequent treatment sessions

7. This excludes 136 cases that were extreme outliers (based on 3*Interquartile Range above the 75th percentile) with 94–331 sessions

treatments (Appendix B, Table B2). This suggests that, when DCF involvement, age, and sex are the same, youth had equivalent access to these EBTs. Descriptive analysis of youth served in TF-CBT and MATCH-ADTC broken out by race and sex show a slightly lower proportion of Black males and Hispanic males receiving TF-CBT, and a lower proportion of Hispanic males receiving MATCH-ADTC (Appendix D); however, the differences in odds of receiving these EBTs are not statistically significant except for a trend for Black males having lower odds of receiving TF-CBT.

Early Discontinuation

Early Discontinuation Data Exemptions
In FY23, a total of 11,232 children were discharged from outpatient treatment, and 17.3% (n=1,941) of all children were classified as evaluation only by their agency. The evaluation only designation exempts the episode from many of the data collection requirements. Therefore, these children are not included in other outcome indicators. The evaluation only category captures both children who were referred only for an evaluation and were not expected to receive treatment as well as those who the clinician indicated had fewer than four sessions. This latter group made up the largest percentage of evaluation only cases (74.3%, n=1,438), and will be referred to as early discontinuation exemptions. Of all discharged cases, 12.8% had early discontinuation exemptions. It is important to examine disparate rates, particularly since there are no additional outcomes and various factors (e.g., client characteristics, environmental factors, mental health literacy) may contribute to why families decline further care or were unable to continue treatment[8].

In FY23, rates of early discontinuation data exemptions were equivalent regardless of sex or DCF involvement. Black youth (19%), Hispanic (14.5%), and Another Race youth (12.5%) were all more likely than White youth (9%) to have early discontinuation exemptions, and DCF-involved youth less likely than those not involved with DCF (see Appendix B, Table B3).

Overall Early Discontinuation
Of note, 766 treatment episodes had less than four sessions and were not designated by the clinician as evaluation only, so those with early discontinuation exemptions do not include all episodes with early discontinuation. When combining early discontinuation exemptions with those non-exempted early discontinuation episodes (having less than 4 treatment sessions without the evaluation only designation), 2,208 episodes (19.7%) had early discontinuation. White youth (22.6%) were less likely to have fewer than four treatment sessions than Black (34.8%), Hispanic (29.7%) and youth of Another Race (27.8%), even when controlling for other demographic factors (Appendix B, Table B4).

> **White youth (22.6%) were less likely to have fewer than four treatment sessions than Black (34.8%), Hispanic (29.7%) and youth of Another Race (27.8%),** even when controlling for other demographic factors (Appendix B, Table B4).

8. Barrett, M. S., Chua, W. J., Crits-Christoph, P., Gibbons, M. B., Casiano, D., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. Psychotherapy (Chic), 45(2), 247–267

IV. QUALITY: TRAINING & WORKFORCE DEVELOPMENT

In collaboration with DCF, CHDI aims to expand the use of EBTs (some of which are funded through separate contracts) and to improve the quality of outpatient care. The EBTs of particular focus include Bounce Back (BB); Cognitive Behavioral Intervention for Trauma in Schools (CBITS); MATCH-ADTC; and TF-CBT. In addition to these EBTs, CHDI provides training for OPCC providers in the ARC model and Child Parent Psychotherapy (CPP) through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant and Adolescent Screening, Brief Intervention, and Referral to Treatment (A-SBIRT) and Wraparound Care Coordination though Connecticut's 1115(a) Demonstration Waiver. **In FY23, 156 OPCC clinicians were trained in one or more of these EBTs and an additional 41 were trained in other best practices (Figure 7).**

In addition to these EBTs, CHDI hosted the 2023 Evidence-Based Practice Conference, which provided 191 OPCC staff training from state and national experts to enhance their trauma-informed skills and best practice knowledge.

Figure 7. OPCC Clinicians Trained in EBTs and Best Practices in FY23
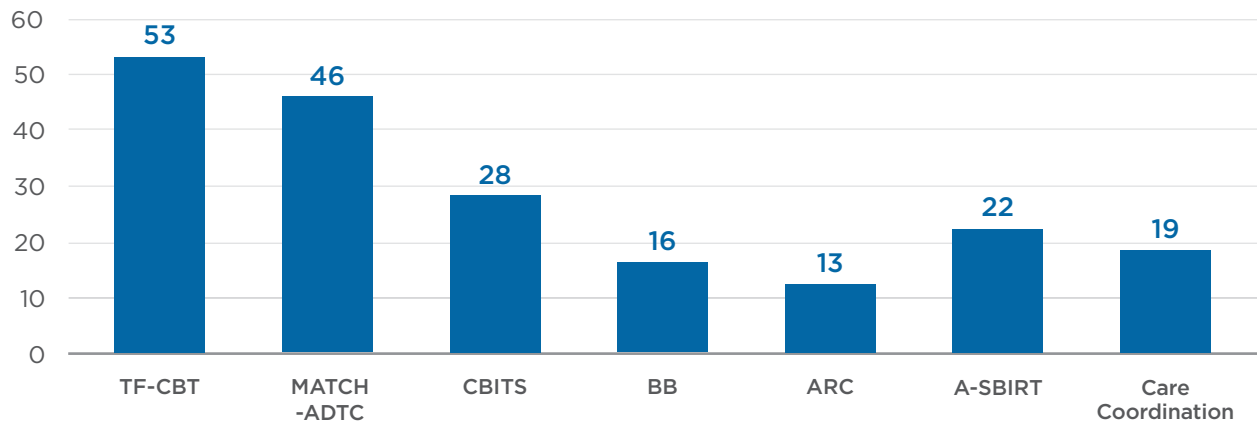
V. QUALITY: IMPLEMENTATION SUPPORT & CONSULTATION

CHDI staff work closely with DCF and OPCC agencies to coordinate QI activities across the OPCC network. Meetings and trainings have been conducted in a hybrid of virtual or conference call and in-person formats. The following outlines activities that strengthen and support outpatient services.

OPCC Statewide Provider Meetings

CHDI and DCF co-chair a monthly provider meeting of OPCC directors to discuss topics relevant to OPCC service delivery, and data management and reporting. These meetings regularly problem-solve service gaps, introduce expert presenters, share system-wide resources, and highlight successful strategies that improve access, quality, and outcomes. During FY23, CHDI co-chaired and coordinated 9 meetings. Consistent themes throughout the year were difficulty with hiring and retaining staff, limited access to higher levels of care, and a need for increased OPCC peer-to-peer networking to address these challenges.

Connecticut Provider Support Survey (CT-PSS)

CHDI conducted the annual CT-PSS in 2022. Respondents included clinicians, supervisors, and administrators within the OPCC network, as well as those who provide DCF-supported EBTs. There were 413 total respondents from the OPCC network representing a 60% overall completion rate. Topics covered within the survey fell into four main categories: (1) General Background Information, (2) EBTs, (3) Service Delivery, and (4) Organizational and Staff Wellness. Results from the survey can be found in the statewide report (Appendix E). Broadly, results showed that:

- Since COVID-19, there has been a slight increase in burnout and a slight decrease in perceived workplace supports for implementing EBTs, but perceptions of the work environment have largely returned to pre-pandemic levels.
- The top training topics of interest were (1) vicarious and secondary trauma, (2) intellectual developmental disability/autism, (3) single session/briefer EBT interventions, (4) first-episode psychosis, (5) structural determinants, and (6) cultural competency.
- Racial justice and equity remain a strong priority across the OPCC network.
- For all but one indicator, OPCC providers outperform nationwide estimates for measurement-based care among clinicians providing care as usual.

Results of the survey have been used to inform a number of initiatives, including what training topics to prioritize and our data and reporting needs.

Site Visits and Consultation

CHDI and DCF staff work closely with OPCC providers and meet regularly with each agency to provide QI consultation. The focus of these site visits varies based on statewide goals and the needs of individual agencies. CHDI staff co-develop individualized SMARTER (Specific, Measurable, Attainable, Relevant, Time-Bound, Evaluated & Reviewed) goals with OPCC agencies that target areas of growth or concern. In FY23, agencies invested a high amount of effort to ensure strong data collection and quality care. CHDI staff conducted quarterly site visits and consultations with all 22 OPCC agencies.

Data Reports

OPCC service data is collected and stored in DCF's PIE system. OPCC agency data is formatted and reported quarterly in agency-level dashboards and statewide summary reports. The reports are used to set SMARTER goals and support OPCC providers to meet benchmarks.

Data Quality

CHDI works with DCF staff and OPCC providers to monitor and improve data collection and quality. CHDI reports on outcome data collection rates for each agency and works with agencies as-needed to identify causes of low-rates of outcome data availability and develop SMARTER goals for improvement. In FY23, CHDI identified other data quality issues to improve upon, including:

- Rates of missing race data
- Linking *Clinical Global Impressions Scale* (CGI) scores to meeting treatment goals
- Duplicate Ohio scales at intake and discharge
- Inconsistent use of the "Evaluation Only" designation for episodes with fewer than four treatment sessions
- Completion of activity data and CGI data

CHDI shared these findings with providers, worked with providers and DCF to identify causes and potential solutions, and created an updated data guidelines document to clarify areas of confusion.
Rates of missing race data, rates of missing CGI scores, and duplicate Ohios all improved substantially over the course of FY23.

Data Availability

OPCC providers use several clinical scales to track client progress and outcomes for discharged episodes. As described on page 7, these measures are required for episodes with intakes after July 1, 2018 who are not designated as "Evaluation Only." In FY23 there were 8,965 youth discharged from OPCC services with data collection required.

Ohio Scales

The Ohio Scales include 40 items that measure the degree of problems a child is currently experiencing (Problem Severity) and the degree to which a child's problems affect their day-to-day activities (Functioning). There are three versions: Youth-report, Parent-report, and Worker-report completed by the clinician. Scales are administered at intake, 90 days after intake, and discharge. Completion of the Ohio Scales for baseline and outcome data is monitored, and performance across years on relevant benchmarks can be found in Appendix A.

Data is considered available for outcome analyses on the Ohio Problem Severity scale or the Ohio Functioning Scale when assessments are recorded for at least two time points. Interpretation of improvement trends may be impacted by rates of available data. DCF's benchmark for discharged children to have Ohio Worker outcome data is 90% and 50% for both Youth and Parent reports. Appendix A includes more details on performance over time.

Any data available, either Problem Severity or Functioning, is examined below. The availability rate was 33.0% for Youth report, 31.3% for Parent report, and 76.6% for Worker report. Figure 8 shows the percentage of youth with outcome data available for each of the three reporters by racial group.

**Figure 8.** Data Availability by Race and Ethnicity
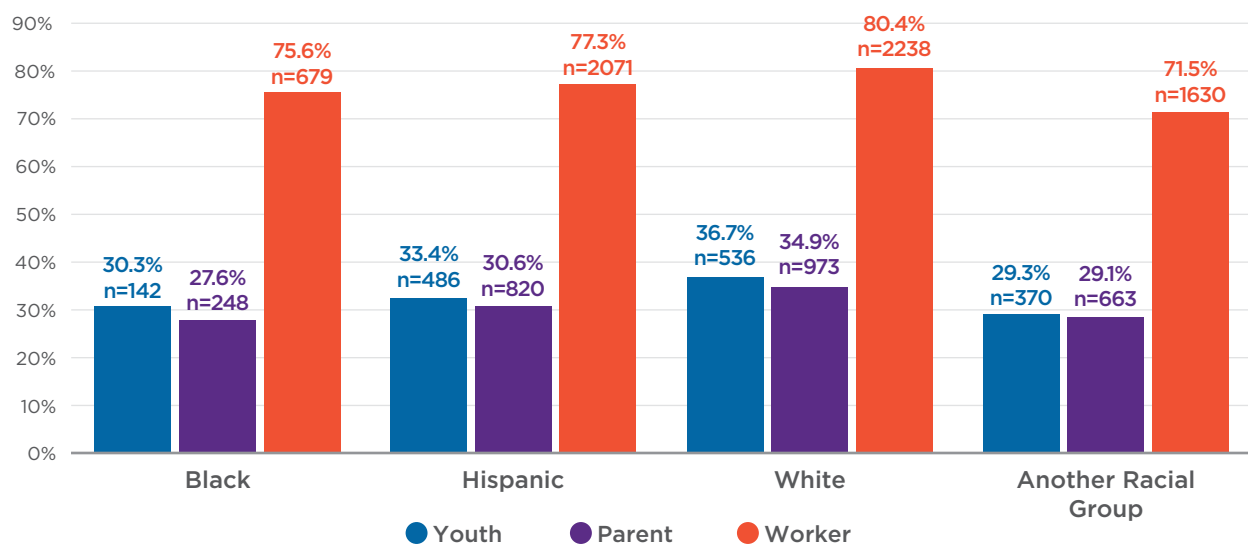
Availability of outcome data was lower for Black, Hispanic, and Another Race youth than for White youth across reporters (Figure 8), but these differences were no longer significant when controlling for other child characteristics, suggesting factors other than race are the primary drivers of these differences (Appendix B, Tables B5–B7). Older children were slightly less likely to have Parent and Worker data available, and youth with DCF involvement were less likely to have Youth data available.

Clinical Global Impressions Scale (CGI)

The CGI Severity scale (CGI-S), collected at intake and discharge, and Improvement scale (CGI-I), collected at discharge, were introduced in October 2020 and made required for all outpatient episodes in March 2021. Data collection of both the improvement and severity scales has increased over time; 79.6% of episodes discharged in FY23 had the CGI-I scale completed, and 65% had the CGI-S completed. Trends in CGI data completion can be found in Figure 9.

Figure 9. Percent of Discharges with CGI Completed (Intake 3/1/21/ or Later)
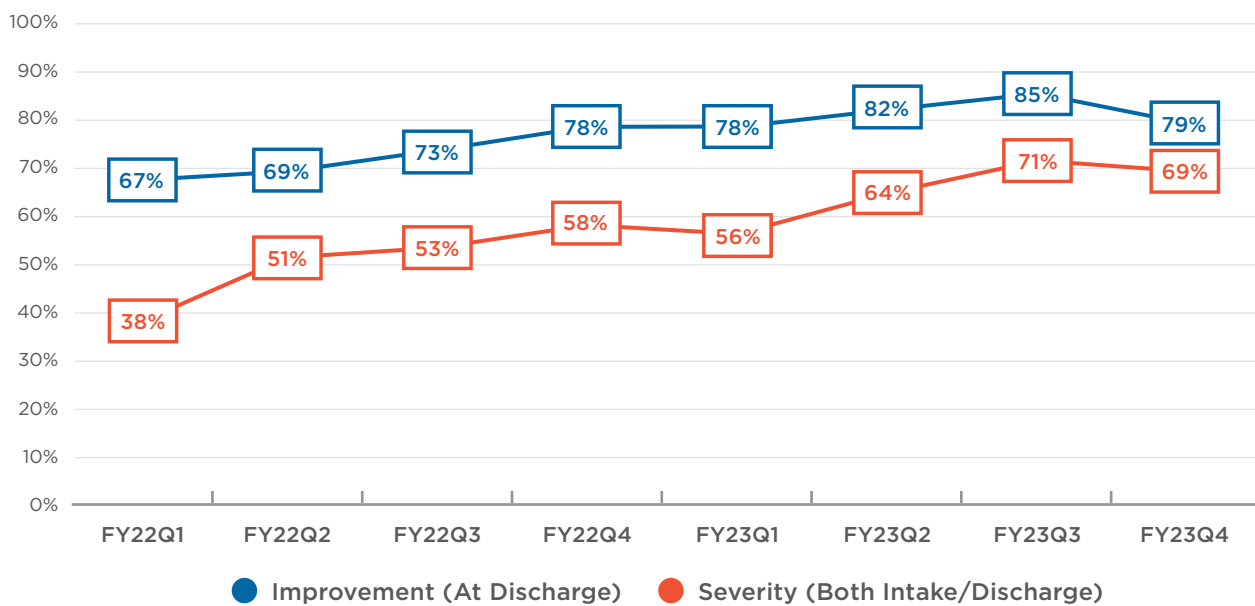
CGI-S is for those who completed at both intake and discharge

VII. OUTCOMES FOR CHILDREN RECEIVING OPCC SERVICES

Child improvement in OPCC treatment is measured across several indicators. Additionally, at the end of treatment the clinician indicates if the child has met treatment goals, defined as meeting all or most of the goals that were set. The CGI Improvement scale serves as another indicator of whether treatment goals were met, and the CGI Severity scale, shows change in symptom severity. The Ohio Scales for Youth[9] are administered at intake, 90 days after intake, and discharge to measure treatment progress. Outcomes across these categories are presented below; for each overall outcomes as well as relevant subgroup breakdowns are given.
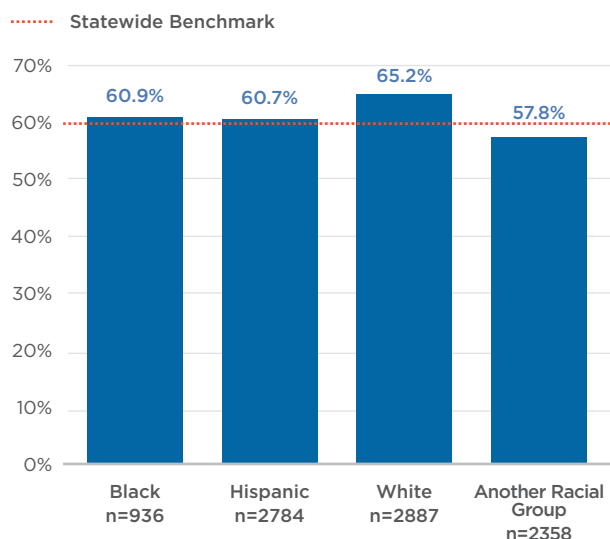

9. Ogles, B. M., Melendez, M. S., Davis, D. C., & Lunnen, K. M. (2001). The Ohio Scales: Practical Outcome Assessment. *Journal of Child and Family Studies*, 10, 199–212.

Treatment Goals

DCF's benchmark for met treatment goals for each individual agency in FY23 was 60%. This indicator is calculated from cases that did not have early discontinuation exemptions or other evaluation only designations and had an intake date after 7/1/2018. Statewide, 61.4% of children met treatment goals; 13 of 22 (49%) agencies met the benchmark, which is a 44% increase from FY22. Episodes of care in which a DCF-support EBT with fidelity was used met treatment goals 72.9% of the time compared to only 59.9% of the time for episodes with treatment as usual or another EBT. Figure 10 shows racial group percentages that met treatment goals.

Figure 10. Met Treatment Goal by Race/Ethnicity

.... Statewide Benchmark

	Black n=936	Hispanic n=2784	White n=2887	Another Racial Group n=2358
	60.9%	60.7%	65.2%	57.8%

Children who received a DCF-supported EBT with best practices (TF-CBT, MATCH-ADTC) had almost twice the odds of meeting treatment goals than those who any other treatment. DCF-involved children were less likely to have met treatment goals than those without DCF involvement (see Appendix B, Table B4). Likelihood of meeting treatment goals were equivalent across race and ethnicity, except that Youth of Another Racial Group were less likely to meet treatment goals than White youth. (see Appendix B, Table B8).

CGI

The CGI-Improvement is meant to determine whether a youth met their treatment goals at discharge, with improvement indicating treatment goals were met. As this was a change made in March of 2021, it is not always used in this way so it is reported separately here. Of the 7,132 cases where CGI-I was completed, clinicians reported that improvement was made in 71.6% of discharged episodes.

Of the 2,311 cases with CGI-S at intake and discharge, 43.7% changed from a "more severe" to a "less severe" category from intake to discharge. An additional 36.4% showed no change on the CGI-S. There were no differences in change in the CGI-S by race or sex, as seen in Figure 11. Clinicians reported symptom improvement for 69.1% of youth using the CGI-I.

Figure 11. Change in CGI Severity from Intake to Discharge by Subgroup
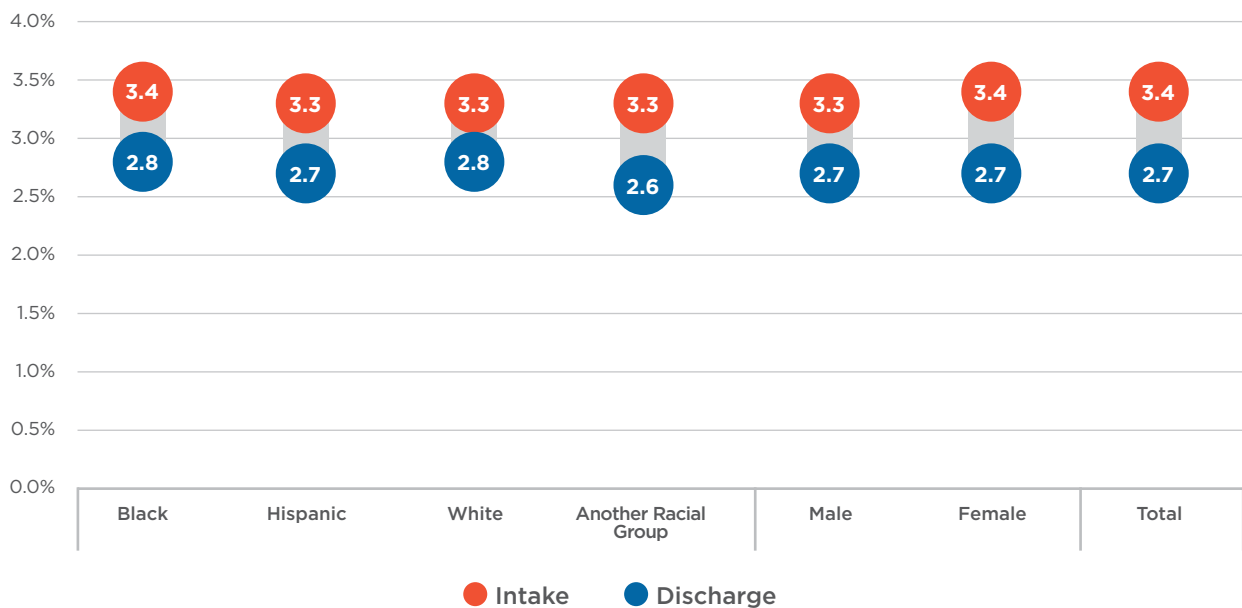
Ohio Scales

Treatment format impact on Problem Severity and Functioning
Availability of parent and worker reports were significantly lower for youth with only telehealth sessions; therefore, treatment format impact based on these reporters were less consistent. Rates of 5-point improvement in all Ohio scales were similar across treatment in-person, telehealth only, and hybrid formats.

5-point Improvement[10]
DCF's expectation is that at least 50% of youth who have outcome data (data available at two time points) will demonstrate improvement. For the Problem Severity scale, a reduction of 5 points or more from the first to last assessment is considered improvement. For the Functioning scale, an increase of 5 points or more from the first to last assessment is considered improvement.

10. A substantial portion of Ohio scale data showed identical responses to all items at both timepoints, suggesting an error. For Problem Severity there were 114 Youth, 234 Parent, and 426 Worker, and for Functioning there were 126 Youth, 198 Parent, and 429 Worker exact duplicates for all items. These cases were excluded from this and all subsequent analyses examining differences or change in Ohio scores from intake to discharge.

In FY23, rate of improvement for all reporters exceeded the 50% benchmark for Problem Severity and Functioning except for the Parent report on Functioning. Statewide results on these indicators are shared in Figure 12 below.

Figure 12. Rates of Improvement on Ohio Problem Severity and Functioning
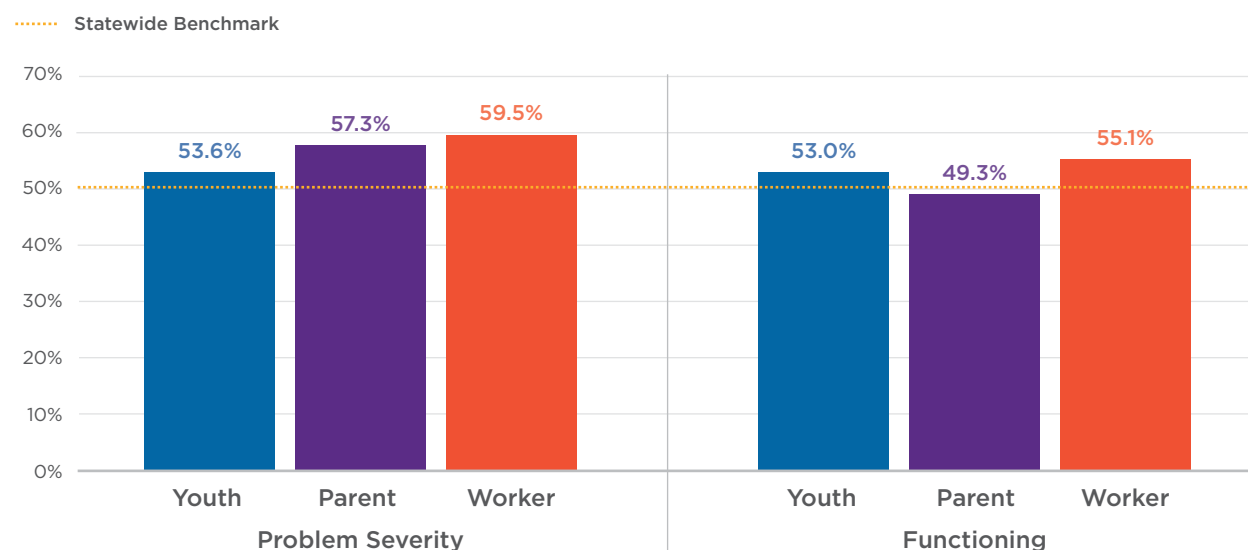
In analyses examining child characteristics (race/ethnicity, sex, age, and DCF status) and receipt of EBTs with best practices as predictors of 5-point change in Problem Severity and Functioning (Tables B9–B11), *the only consistent finding across all three reporters for both Problem Severity and Functioning was a greater rate of improvement for those with a DCF-supported EBTs with best practices.*

Clinical Improvement across Groups on Problem Severity and Functioning.
In addition to documenting the overall rates of symptom reduction, it is important to monitor if any subgroup differences exist. In analyses examining the effect of child characteristics (race/ethnicity, sex, age, and DCF status) and EBT receipt on symptom improvement, the only consistent finding across reporters showed *children who received DCF-supported EBTs (TF-CBT, MATCH-ADTC) had greater improvement in Problem Severity across all reporters.* (Appendix B Tables B12-B14). No other finding consistently predicted changes in Problem Severity or Functioning. Intake and discharge scores for Problem Severity and Functioning by race/ethnicity can be found in Appendix C.

In FY23, a total of 27,497 children received outpatient mental health services. Service use now exceeds the number of youth served prior to the pandemic by 11% even as difficulty hiring and retaining staff continued. OPCC staff reported an increase in staff burnout and a decrease in perceived workplace supports in FY23, suggesting that the increased volume is not sustainable for staff retention. Not only did the number of youth served increase, but youth received 7% more treatment sessions than in the previous year. As the youth mental health crisis continues and demand for services increases, the youth behavioral health system increasingly relies on OPCC providers to serve the bulk of children and families in need of services. Solutions to invest in OPCC providers including workforce support are essential to meet these increasing needs.

OPCC providers maintained a high level of access to services for Connecticut youth and families despite increased demand and a need

for improvements for black, Indigenous and people of color (BIPOC) youth. The proportion of youth who had data exemptions due to discontinuing treatment after less than four sessions decreased in FY23 (12.8%) compared to FY22 (14.4%) but these youth were more likely to be BIPOC. Though there was a high level of provider variability and results should be interpreted with caution, Black, Hispanic Another Race and Hispanic youth were more likely to have telehealth only treatment than White youth. Because youth receiving hybrid or telehealth only were less likely to have fewer than four sessions compared to in-person only, telehealth may be an important format that sustains access to care for youth of color. Further investment in EBTs that are briefer, in addition to the currently available EBTs, would benefit the OPCC system including BIPOC children by increasing engagement and improvement for youth who receive fewer sessions.

The number of youth who received EBTs also increased this year (n=4,224); however, EBT receipt did not keep pace with the overall increase in youth served, resulting in a lower proportion of youth receiving EBTs (47.1%) compared to FY22 (n=3,576, 48.4%). This suggests EBT capacity remained steady but less available with increased service demands. Moreover, given that youth receiving EBTs were more likely to meet treatment goals and experience symptom improvement, further investment in expanding EBT capacity by training and retaining clinical staff in the OPCC network is vital for providing high quality care for the increasing number of youth served.

The increase in children presenting with anxiety symptoms continued in FY23. White children were more likely to have anxiety and less likely to have trauma as their primary presenting problem compared to other youth. Black youth were more

likely to present with disruptive behavior than all other youth. These disparities warrant attention since research suggests youth of color are underdiagnosed for anxiety-related symptoms[11] and experience decreased access to appropriate services for anxiety. The differences in trauma-related presenting problems highlights the importance of expanding the availability and use of trauma-focused treatments to meet the higher needs for such treatment among BIPOC youth.

Collecting consistent and accurate demographic and treatment data is essential for ensuring quality and evaluating outcomes in services. While the rates of missing/declined race and ethnicity decreased in FY23 (19.2%) compared to FY22 (27.4%), it remains concerningly high. For treatment data, Ohio data collection rates across all reporters (youth, caregiver, and worker) fell below statewide benchmarks. Though data availability was higher for White children than for any other racial or ethnic groups, firm conclusions about equity in outcome data collection cannot be made, given the high rates of missing race data and greater likelihood that a child missing race data was also missing outcome data. Combined, these two findings suggest a) further efforts are needed to improve data collection for race and ethnicity, in order to accurately assess potential disparities, and b) further efforts are needed to identify and support providers who are not meeting the statewide benchmarks for outcome data collection.

While the statewide benchmark for Met Treatment goals was just under the benchmark in FY23, the rates of 5-point improvement in Problem Severity and Functioning surpassed the benchmark for 5 out of 6 outcomes. **Importantly, these outcomes were consistent across race and sex, apart from youth of Another Racial Group (primarily those missing race/ethnicity), suggesting that children similarly benefitted from treatment.** As in previous years and in line with research findings[12], EBT interventions achieved better outcomes than treatment as usual. **Receipt of DCF-supported EBTs predicted higher rates of meeting treatment goals, and higher rates of improvement in Ohio scales for all reports.** Outpatient care remains a vital service that will continue to evolve to meet the needs of the growing and changing population of youth and families.

11. Vanderminden, J. & Esala J. J. (2019). Beyond symptoms: Race and gender predict anxiety disorder diagnosis. *Society and Mental Health*, 9(1), 111-125. doi:10.1177/2156869318811435
12. Lang, J. M., Lee, P., Connell, C. M., Marshal, T., & Vanderploeg, J. J. (2022). Outcomes, evidence-based treatments, and disparities in a statewide outpatient children's behavioral health system. *Children and Youth Services Review, 120.* https://doi.org/10.1016/j.childyouth.2020.105729

OPCC Data Collection & Analysis:

- Examine predictors of EBT receipt among eligible youth to identify barriers, better understand discrepancies by race and sex, and develop solutions for overcoming those barriers.

- Analyze equity in access (including session format), quality, and outcomes while accounting for provider effects to determine whether differences or biases occur within agencies, or whether differences between agencies are driving disparities.

- Further improve race and activity data collection rates by 50% to improve the quality of these data, to better understand trends, and make recommendations to improve equitable access and outcomes. Monitor the impact of telehealth on OPCC service access, quality, outcomes, and equity.

- With the increase in CGI data collection, compare CGI to current validated measures to help determine if CGI may replace longer assessments and help reduce data collection burden.

- Monitor the impact of telehealth on OPCC service access, quality, outcomes, and equity.

OPCC Service Improvement:

- Integrate missing race data and EBT penetration rates into QI reports for consultation and include SMARTIE (Specific, Measurable, Attainable, Relevant, Time-Bound, Inclusive, & Equitable) goal-setting to promote equitable implementation at a site-level.

- Increase access to EBT's that address anxiety as the presenting problem, including MATCH-ADTC, as well as briefer interventions appropriate anxiety (e.g. Single-Session Consultation).

- Given higher rates of discontinuation for youth of color, promote use of briefer (e.g., ARC) and single-session trauma-informed interventions (e.g. T-SBIRT) and flexible formats (e.g. telehealth) to improve access to trauma treatment in a shorter amount of time.

- Provide training on EBP adaptations and common disparities in diagnoses for diverse youth to increase clinician comfort providing equitable and tailored care.

State Investment in Outpatient Services:

- Due to increases in OPCC youth served, increase funds and resources that support workforce hiring, development, and retention strategies including funding for non-clinical professionals to support clinicians and clients.

- Update race categories in the PIE data system to align with other state agencies and federal guidelines to improve ease of race reporting for providers and improve rates of race data collection.

X. APPENDIX A: RATES OF DATA AVAILABILITY
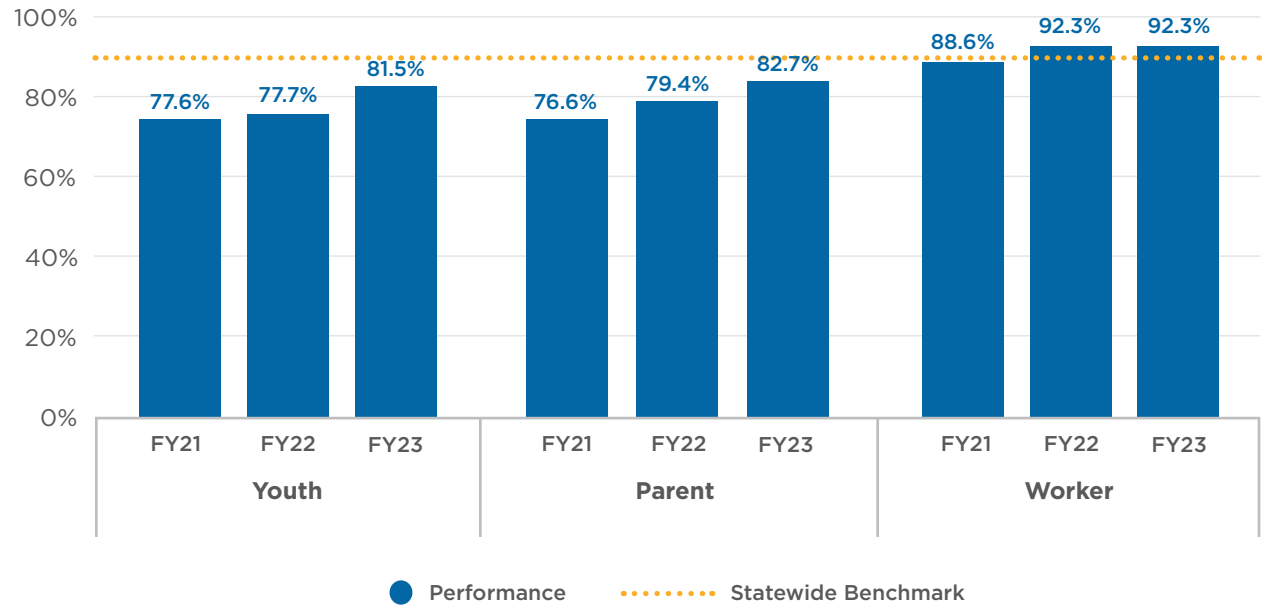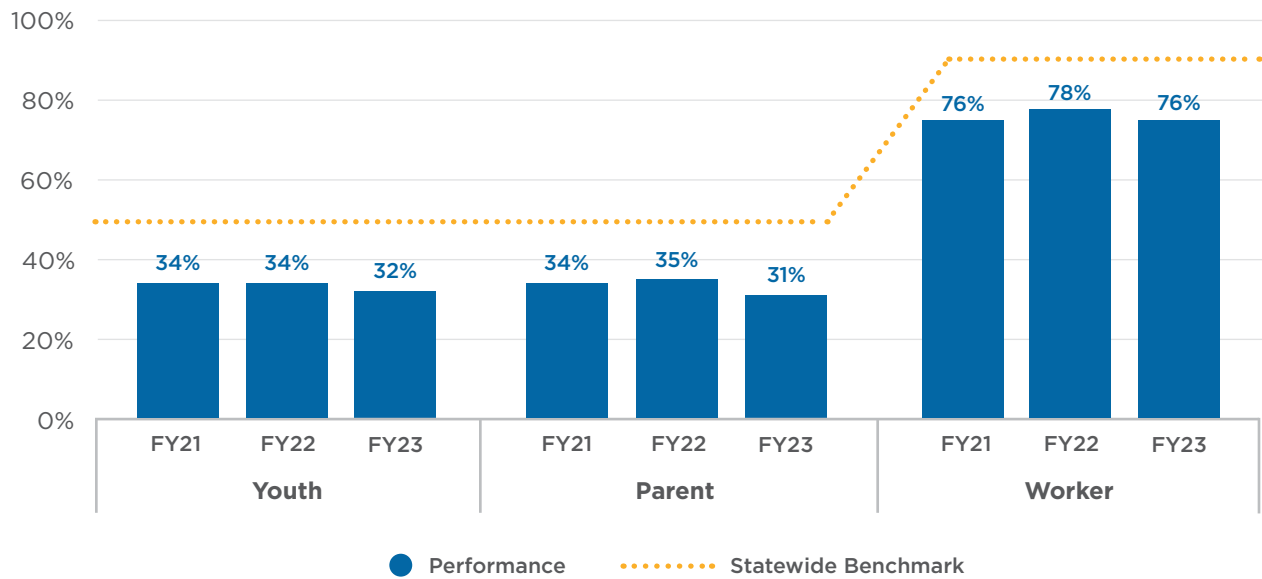
Figure A1. Baseline Data

	Youth			Parent			Worker		
	FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23
Performance	77.6%	77.7%	81.5%	76.6%	79.4%	82.7%	88.6%	92.3%	92.3%

● Performance ⋯⋯ Statewide Benchmark

Figure A2. Outcome Data

	Youth			Parent			Worker		
	FY21	FY22	FY23	FY21	FY22	FY23	FY21	FY22	FY23
Performance	34%	34%	32%	34%	35%	31%	76%	78%	76%

● Performance ⋯⋯ Statewide Benchmark

XI. APPENDIX B: REGRESSION TABLES

Table B1. Multiple Regression on Total Number of Treatment Sessions (Log Transformed)				
Predictors	**β**	**SE**	**95%CI**	**Effect Size (Partial eta squared)**
Intercept	2.673	0.058	(2.559,2.787)	.245
Black Non-Hispanic	-0.091	0.047	(-0.184,0.001)	Negligible (.001)
Hispanic	-0.106*	0.033	(-0.172,-0.041)	Negligible (.002)
Another Race Non-Hispanic	-0.065	0.034	(-0.132,0.002)	Negligible (.001)
Child Age at Intake	-0.015**	0.004	(-0.022,-0.008)	Negligible (.003)
Sex Male	-0.134**	0.027	(-0.187,-0.082)	Negligible (.004)
DCF Status "No"	0.222**	0.038	(0.146,0.297)	Very Small (.005)
R²	0.012			

*p<.05   As compared to White Non-Hispanic Females with DCF Involvement. For treatment sessions, extreme outliers (above 94 sessions) were
**p<.001   winsorized and the variable was log transformed to address violations of model assumptions.

Effect sizes can be interpreted as .01 = small, .06 = medium, .14 = large

Table B2. Logistic Regression for Receiving an EBT Intervention					
Predictors	**N**	**β**	**SE**	**Wald**	**eᴮ(95% CI)**
Black Non-Hispanic	936	-.288	.153	3.548	0.750 (0.555,1.012)
Hispanic	2783	-.004	.099	0.002	0.996 (0.820,1.209)
Another Race Non-Hispanic	2358	-.094	.106	0.788	0.910 (0.740,1.120)
Sex Male	4311	-.254*	.083	9.432	0.776 (0.659,1.912)
Child Age at Intake	8964	.029*	.011	6.745	1.029 (1.007,1.052)
DCF Involved "No"	7744	-.520*	.103	25.669	0.595 (0.486,0.727)
Constant		-2.234	0.171	171.187	0.107

*p<.05   As compared to White Non-Hispanic Females.
**p<.001

Table B3. Logistic Regression Early Discontinuation Data Exemptions					
Variable	**N**	**β**	**SE**	**Wald**	**eᴮ(95% CI)**
Black Non-Hispanic	1266	.883**	.093	89.434	2.419 (2.015,2.905)
Hispanic	3559	.545**	.076	50.863	1.725 (1.485,2.004)
Another Race Non-Hispanic	2981	.369**	.082	20.456	1.446 (1.233,1.697)
Sex Male	5499	-.011	.058	0.039	0.989 (0.882,1.107)
Child Age at Intake	11217	-.015*	.008	4.063	0.985 (0.970,1.000)
DCF Involved "No"	9672	.186*	.086	4.702	1.204 (1.018,1.425)
Constant		-2.304	0.131	310.419	0.100

*p<.05   As compared to White Non-Hispanic Females.
**p<.001

Table B4. Logistic Regression Any Early Discontinuation

Variable	N	β	SE	Wald	e^B(95% CI)
Black Non-Hispanic	1266	.633**	.081	61.506	1.883 (1.608,2.206)
Hispanic	3559	.424**	.063	45.385	1.529 (1.351,1.729)
Another Race Non-Hispanic	2981	.376**	.066	32.458	1.456 (1.280,1.657)
Sex Male	5499	.059	.049	1.494	1.061 (0.965,1.167)
Child Age at Intake	11217	-.007	.006	1.074	0.993 (0.981,1.006)
DCF Involved "No"	9672	-.044	.068	0.414	0.957 (0.837,1.094)
Constant		-1.646**	0.107	237.806	0.193

*p<.05   As compared to White Non-Hispanic Females.
**p<.001   "Any Early Discontinuation" includes any episode with fewer than four treatment sessions, including those with Early Discontinuation Data Exemptions.

Table B5. Logistic Regression for Youth Ohio Available

Variable	N	β	SE	β /SE	e^B(95% CI)
Black Non-Hispanic	469	-.319	.118	-1.317	0.727 (0.452,1.169)
Hispanic	1455	-.128	.079	-0.812	0.880 (0.646,1.199)
Another Race Non-Hispanic	1262	-.344	.084	-1.434	0.709 (0.443,1.135)
Sex Female	2806	.091	.065	1.392	1.096 (0.963,1.246)
Child Age at Intake	4648	-.036	.019	-1.629	0.965 (0.924,1.007)
DCF Involved "Yes"	556	-.276*	.103	-3.149	0.759 (0.639,0.901)
Threshold		0.672*	.257	2.613	

*p<.05   As compared to White Non-Hispanic Females.
**p<.001   Excludes episodes where Ohios were duplicated item-for-item. 17.7% of the variance in youth data availability could be attributed to the interdependency of cases within each provider, so the model was fit using a sandwich estimator (TYPE=COMPLEX in *Mplus 8*) to address clustered data.

Table B6. Logistic Regression for Parent Ohio Available

Variable	N	β	SE	β /SE	e^B(95% CI)
Black Non-Hispanic	898	-.382	.088	-1.470	0.682 (0.410,1.136)
Hispanic	2684	-.199	.059	-1.019	0.819 (0.559,1.202)
Another Race Non-Hispanic	2281	-.246	.062	-0.809	0.782 (0.431,1.419)
Sex Female	4529	.015	.049	0.178	1.015 (0.864,1.192)
Child Age at Intake	8648	-.066**	.007	-8.007	0.936 (0.921,0.951)
DCF Involved "Yes"	1165	-.057	.070	-0.881	0.944 (0.832,1.073)
Threshold		0.734**	.207	3.548	

*p<.05   As compared to White Non-Hispanic Females.

**p<.001   Excludes episodes where Ohios were duplicated item-for-item. 17.7% of the variance in youth data availability could be attributed to the interdependency of cases within each provider, so the model was fit using a sandwich estimator (TYPE=COMPLEX in *Mplus 8*) to address clustered data.

Table B7. Logistic Regression for Worker Ohio Available

Variable	N	β	SE	β /SE	e^B(95% CI)
Black Non-Hispanic	898	-.219	.161	-1.361	0.803 (0.586,1.101)
Hispanic	2684	-.155	.150	-1.028	0.857 (0.638,1.150)
Another Race Non-Hispanic	2281	-.461*	.196	-2.350	0.631 (0.429,0.926)
Sex Female	4589	-.017	.068	-0.251	0.983 (0.861,1.123)
Child Age at Intake	8648	-.031*	.011	-2.781	0.969 (0.948,0.991)
DCF Involved "Yes"	1165	-.017	.097	-0.176	0.983 (0.814,1.188)
Threshold		-1.189**	0.292	-4.075	

*p<.05   As compared to White Non-Hispanic Females.

**p<.001   Excludes episodes where Ohios were duplicated item-for-item. 17.7% of the variance in youth data availability could be attributed to the interdependency of cases within each provider, so the model was fit using a sandwich estimator (TYPE=COMPLEX in *Mplus 8*) to address clustered data.

Table B8. Logistic Regression for Met Treatment Goals

Variable	N	β	SE	β /SE	e^B(95% CI)
Black Non-Hispanic	936	-.150	.193	-1.778	0.861 (0.589,1.256)
Hispanic	2783	-.188	.103	-1.829	0.829 (0.678,1.014)
Another Race Non-Hispanic	2358	-.308*	.099	-3.114	0.735 (0.605,0.892)
Sex Female	4653	.112	.087	-1.290	1.119 (0.943,1.327)
Child Age at Intake	8965	-.339	.076	-3.449	0.712 (0.614,0.827)
DCF Involved	1220	-.013**	.009	-0.375	0.987 (0.969,1.005)
Received a DCF EBT	675	.643**	.140	-6.595	1.903 (1.446,2.503)
Threshold		-0.565	0.139	-5.055	

*p<.05   As compared to White Non-Hispanic Females.

**p<.001   EBTs = TF-CBT, MATCH-ADTC
              10.8% of the variance in likelihood of youth meeting treatment goals could be attributed to the interdependency of cases within each provider, so the model was fit using a sandwich estimator (TYPE=COMPLEX in *Mplus 8*) to address clustered data.

Table B9. Binary Logistic Regression on Ohio Scales 5 Point Change - Youth

Predictors	Problem Severity					Functioning				
	N	β	SE	Wald	e^B(95% CI)	N	β	SE	Wald	e^B(95% CI)
Black Non-Hispanic	129	.152	.200	0.578	1.164 (0.787,1.724)	126	-.229	.201	1.301	0.795 (0.536,1.179)
Hispanic	468	.049	.130	0.140	1.050 (0.814,1.355)	463	-.076	.130	0.343	0.926 (0.717,1.196)
Another Race Non-Hispanic	358	.206	.141	2.153	1.229 (0.933,1.620)	351	-.007	.141	0.003	0.993 (0.753,1.309)
Child Age at Intake	1458	.091*	.028	10.535	1.095 (1.037,1.157)	1435	.092*	.028	10.742	1.096 (1.038,1.158)
Sex Male	561	-.266*	.109	5.964	0.766 (0.619,0.949)	553	-.013	.110	0.015	0.987 (0.796,1.223)
DCF Involved "No"	1305	.196	.174	1.268	1.217 (0.865,1.712)	1289	-.096	.178	0.291	0.909 (0.641,1.287)
Had EBT "No"	1302	-.587*	.179	10.753	0.556 (0.391,0.790)	1278	-.385*	.174	4.880	0.680 (0.484,0.958)
Constant		-0.788	0.454	3.011	0.455		-0.716	0.453	2.501	0.489

*p<.05   As compared to White Non-Hispanic Females.
**p<.001   EBTs = TF-CBT and MATCH-ADTC.

Table B10. Binary Logistic Regression on Ohio Scales 5 Point Change - Parent

Predictors	Problem Severity					Functioning				
	N	β	SE	Wald	e^B(95% CI)	N	β	SE	Wald	e^B(95% CI)
Black Non-Hispanic	214	-.336*	.154	4.772	0.715 (0.529,0.966)	217	-.158	.152	1.081	0.854 (0.633,1.150)
Hispanic	757	-.057	.101	0.316	0.945 (0.775,1.152)	758	-.118	.099	1.429	0.888 (0.732,1.079)
Another Race Non-Hispanic	620	-.299*	.106	7.947	0.742 (0.603,0.913)	608	-.091	.105	0.748	0.913 (0.742,1.122)
Child Age at Intake	2493	-.013	.012	1.203	0.987 (0.965,1.010)	2486	.000	.012	0.001	1.000 (0.978,1.023)
Sex Male	1229	.119	.083	2.084	1.127 (0.958,1.325)	1230	.217*	.082	7.057	1.243 (1.059,1.459)
DCF Involved "No"	2170	.386*	.121	10.091	1.471 (1.159,1.866)	2160	.234	.121	3.744	1.264 (0.997,1.602)
Had EBT "No"	2249	-.408*	.142	8.227	0.665 (0.503,0.879)	2244	-.341*	.137	6.164	0.711 (0.544,0.931)
Constant		0.524*	0.216	5.884	1.689		.036	0.212	0.028	1.036

*p<.05   As compared to White Non-Hispanic Females.
**p<.001   EBTs = TF-CBT and MATCH-ADTC.

Table B11. Binary Logistic Regression on Ohio Scales 5 Point Change - Worker

Predictors	Problem Severity					Functioning				
	N	β	SE	Wald	eᴮ(95% CI)	N	β	SE	Wald	eᴮ(95% CI)
Black Non-Hispanic	646	-.270*	.091	8.811	0.763 (0.638,0.912)	641	-.266*	.091	8.601	0.766 (0.641,0.915)
Hispanic	1971	-.094	.064	2.159	0.910 (0.803,1.032)	1946	-.132*	.063	4.329	0.876 (0.774,0.992)
Another Race Non-Hispanic	1528	-.168*	.069	6.044	0.845 (0.739,0.966)	1514	-.131	.068	3.730	0.877 (0.768,1.002)
Child Age at Intake	6290	-.003	.007	0.172	0.997 (0.983,1.011)	6225	.014*	.007	3.952	1.014 (1.000,1.029)
Sex Male	3025	-.043	.053	0.656	0.958 (0.864,1.062)	3003	-.027	.052	0.260	0.974 (0.879,1.079)
DCF Involved "No"	5443	.315**	.075	17.662	1.371 (1.183,1.588)	5380	.313**	.075	17.500	1.367 (1.181,1.583)
Had EBT "No"	5793	-.454**	.101	20.285	0.635 (0.521,0.774)	5734	-.303*	.097	9.720	0.739 (0.611,0.894)
Constant		0.683**	0.146	21.737	1.980		0.165	0.143	1.319	1.179

*p<.05   As compared to White Non-Hispanic Females.
**p<.001   EBTs = TF-CBT and MATCH-ADTC.

Table B12. Multiple Regression on Ohio Scales Outcomes – Youth Report

Predictors	Problem Severity				Functioning			
	β	SE	95%CI	Effect Size	β	SE	95%CI	Effect Size
Constant	-5.876**	1.520	(-8.859,-2.894)		4.549*	1.520	(1.567,7.532)	
Hispanic	0.327	0.999	(-1.632,2.287)	0.010	0.052	0.999	(-1.908,2.012)	0.002
Another Race Non-Hispanic	-0.964	1.044	(-3.012,1.085)	-0.028	0.946	1.044	(-1.102,2.994)	0.028
Black Non-Hispanic	-2.125	1.416	(-4.904,0.655)	-0.046	0.963	1.416	(-1.816,3.743)	0.021
Sex Male	1.295	0.810	(-0.295,2.884)	0.049	-0.158	0.810	(-1.748,1.431)	-0.006
Child Age at Intake	-0.189	0.107	(-0.400,0.022)	-0.054	0.242*	0.107	(0.032,0.453)	0.071
DCF Involved	2.045	1.164	(-0.239,4.330)	0.054	-1.767	1.164	(-4.051,0.517)	-0.048
Had any EBT	-5.801**	1.508	(-8.762,-2.841)	-0.118	2.064	1.508	(-0.896,5.024)	0.043
R²	.027				.011			
F	4.114**				1.626			

*p<.05   As compared to White Non-Hispanic Females. EBTs = TF-CBT and MATCH-ADTC.
**p<.001   Outliers were identified using the 1.5*QI rule and were winsorized for Youth PS (n = 70) and FX (n = 94).
Effect size uses the Part correlation, which represents the correlation (Pearson r) between the predictor and outcome variables controlling for the other predictors. It can be interpreted as small=.02, med=.13, large=.26

Table B13. Multiple Regression on Ohio Scales Outcomes – Parent Report								
Predictors	**Problem Severity**				**Functioning**			
	β	*SE*	*95%CI*	**Effect Size**	β	*SE*	*95%CI*	**Effect Size**
Constant	-7.904**	1.022	(-9.908,-5.899)		4.549*	1.52	(1.567,7.532)	
Hispanic	-0.621	0.672	(-1.938,0.696)	-0.020	0.052	0.999	(-1.908,2.012)	0.002
Another Race Non-Hispanic	-0.292	0.702	(-1.669,1.084)	-0.009	0.946	1.044	(-1.102,2.994)	0.028
Black Non-Hispanic	-0.763	0.952	(-2.631,1.105)	-0.018	0.963	1.416	(-1.816,3.743)	0.021
Sex Male	-1.180*	0.545	(-2.248,-0.112)	-0.048	-0.158	0.81	(-1.748,1.431)	-0.006
Child Age at Intake	0.065	0.072	(-0.077,0.206)	0.020	0.242*	0.107	(0.032,0.453)	0.071
DCF Involved	2.215*	0.783	(0.680,3.750)	0.063	-1.767	1.164	(-4.051,0.517)	-0.048
Had any EBT	-2.347*	1.014	(-4.336,-0.357)	-0.051	2.064	1.508	(-0.896,5.024)	0.043
R²	.010				.011			
F	2.794*				1.626			

*p<.05   As compared to White Non-Hispanic Females. EBTs = TF-CBT and MATCH-ADTC.
**p<.001   Outliers were identified using the 1.5*QI rule and were winsorized for Parent PS (n=91) and FX (n=152).
Effect size uses the Part correlation, which represents the correlation (Pearson r) between the predictor and outcome variables controlling for the other predictors. It can be interpreted as small=.02, med=.13, large=.26

Table B14. Multiple Regression on Ohio Scales Outcomes – Worker Report

Predictors	Problem Severity				Functioning			
	β	SE	95%CI	Effect Size	β	SE	95%CI	Effect Size
Constant	-9.105	0.596	(-10.273,-7.937)		6.476	0.598	(5.303,7.649)	
Hispanic	0.471	0.392	(-0.297,1.238)	0.016	-0.654	0.393	(-1.425,0.117)	-0.022
Another Race Non-Hispanic	0.269	0.409	(-0.533,1.071)	0.009	-0.312	0.411	(-1.117,0.493)	-0.010
Black Non-Hispanic	1.309*	0.555	(0.220,2.398)	0.032	-1.493*	0.558	(-2.586,-0.400)	-0.036
Sex Male	0.277	0.318	(-0.346,0.899)	0.012	-0.210	0.319	(-0.835,0.415)	-0.009
Child Age at Intake	0.055	0.042	(-0.027,0.138)	0.018	0.053	0.042	(-0.030,0.136)	0.017
DCF Involved	2.394*	0.456	(1.499,3.289)	0.071	-2.533**	0.458	(-3.432,-1.635)	-0.075
Had any EBT	-2.383*	0.591	(-3.543,-1.224)	-0.054	1.845*	0.594	(0.681,3.009)	0.042
R²	.009				.010			
F	7.238**				7.507**			

 *p<.05   As compared to White Non-Hispanic Females. EBTs = TF-CBT and MATCH-ADTC.
**p<.001   Outliers were identified using the 1.5*QI rule and were winsorized for Worker PS (n=154) and FX (n=151).
Effect size uses the Part correlation, which represents the correlation (Pearson r) between the predictor and outcome variables controlling for the other predictors. It can be interpreted as small=.02, med=.13, large=.26

XII. APPENDIX C: OHIO SCORES AT INTAKE AND DISCHARGE BY RACE/ETHNICITY

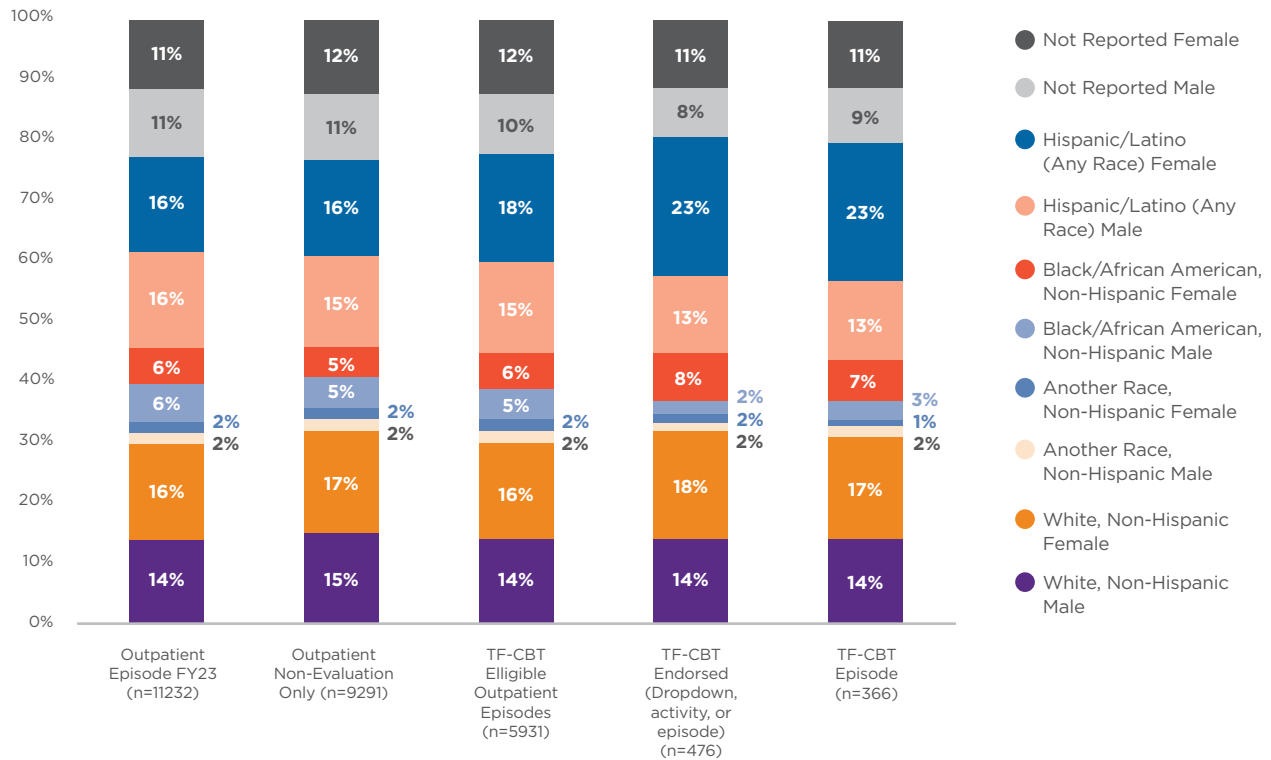**Table C1.** Mean Pre and Post Ohio Scales Problem Severity Scores

	Youth			Parent			Worker		
	N	First Mean (S.D.)	Last Mean (S.D.)	N	First Mean (S.D.)	Last Mean (S.D.)	N	First Mean (S.D.)	Last Mean (S.D.)
Overall	1401	24.10 (15.19)	16.45 (14.29)	2466	22.93 (14.30)	14.88 (13.20)	6196	23.88 (11.83)	16.21 (11.77)
Black	125	24.53 (16.78)	15.67 (15.97)	212	21.00 (14.87)	13.33 (13.37)	635	22.78 (12.16)	16.46 (12.20)
Hispanic	449	23.45 (15.61)	16.19 (14.51)	750	22.91 (14.94)	14.43 (13.17)	1951	24.06 (12.03)	16.37 (11.80)
White	493	24.66 (15.13)	17.29 (14.26)	893	23.18 (13.32)	14.89 (12.22)	2105	24.23 (11.09)	16.09 (11.24)
Another Racial Group	334	23.98 (14.10)	15.84 (13.34)	611	23.27 (14.65)	15.95 (14.47)	1505	23.61 (12.36)	16.08 (12.28)

Table C2. Mean Pre and Post Ohio Scales Functioning Scores

	Youth			Parent			Worker		
	N	First Mean (S.D.)	Last Mean (S.D.)	N	First Mean (S.D.)	Last Mean (S.D.)	N	First Mean (S.D.)	Last Mean (S.D.)
Overall	1378	52.54 (13.39)	57.90 (16.08)	2458	51.31 (14.28)	56.09 (16.65)	6130	48.60 (11.07)	54.71 (12.78)
Black	122	52.30 (15.03)	56.64 (19.82)	215	51.85 (14.81)	57.08 (16.83)	629	48.30 (11.11)	53.24 (13.30)
Hispanic	444	52.70 (12.81)	57.70 (16.08)	750	50.91 (13.87)	56.12 (15.30)	1925	47.89 (10.76)	53.81 (12.50)
White	485	52.44 (13.32)	58.41 (15.10)	894	51.30 (14.49)	56.00 (16.96)	2086	48.89 (10.99)	55.53 (12.64)
Another Racial Group	327	52.56 (13.68)	57.90 (15.98)	599	51.54 (14.30)	55.83 (17.73)	1490	49.23 (11.49)	55.34 (13.00)

Outpatient Mental Health EBT Service Disproportionality – TF-CBT Access SFY2023

Legend:
- Not Reported Female
- Not Reported Male
- Hispanic/Latino (Any Race) Female
- Hispanic/Latino (Any Race) Male
- Black/African American, Non-Hispanic Female
- Black/African American, Non-Hispanic Male
- Another Race, Non-Hispanic Female
- Another Race, Non-Hispanic Male
- White, Non-Hispanic Female
- White, Non-Hispanic Male

OPCC System Disproportionality Rates for TF-CBT SFY23				
	Outpatient Non-Eval Only (n=9291)	TF-CBT Eligible (n=5931)	TF-CBT Endorsed (n=476)	TF-CBT Episode* (n=366)
White, Non-Hispanic Male	1.07	0.93	1.00	1.00
White, Non-Hispanic Female	1.06	0.94	1.13	1.06
Another Race, Non-Hispanic Male	1.00	1.00	0.75	1.00
Another Race, Non-Hispanic Female	1.00	1.00	0.75	0.50
Black/African American, Non-Hispanic Male	0.83	1.00	0.40	0.60
Black/African American, Non-Hispanic Female	0.83	1.20	1.33	1.17
Hispanic/Latino (Any Race) Male	0.94	1.00	0.87	0.87
Hispanic/Latino (Any Race) Female	1.00	1.13	1.28	1.28
Not Reported Male	1.00	0.91	0.80	0.90
Not Reported Female	1.09	1.00	0.92	0.92

*Compared to TF-CBT eligible

Male Disparity Rates in TF-CBT Access Across Racial/Ethnic Groups FY23

|	Any Endorsement	TF-CBT Episode
White, Non-Hispanic	0.89	0.94
Another Race, Non-Hispanic	1.00	2.00
Black/African American Non-Hispanic	0.30	0.51
Hispanic/Latino (Any Race)	0.68	0.68
Not Reported (Non-Hispanic)	0.87	0.98

Disparity rates calculated by dividing male disproportionality rate by female rate within racial/ethnic groups.

Disparity Rates in TF-CBT Access by Sex and Race/Ethnicity FY23

	Females		Males	
	Any Endorsement	TF-CBT Episode	Any Endorsement	TF-CBT Episode
Another Race, Non-Hispanic	0.67	0.47	0.75	1.00
Black/African American Non-Hispanic	1.19	1.10	0.40	0.60
Hispanic/Latino (Any Race)	1.14	1.20	0.87	0.87
Not Reported (Non-Hispanic)	0.81	0.86	0.80	0.90

Disparity rates calculated using White Non-Hispanic children as the comparison group

Outpatient Mental Health EBT Service Disproportionality – MATCH-ADTC Access SFY2023
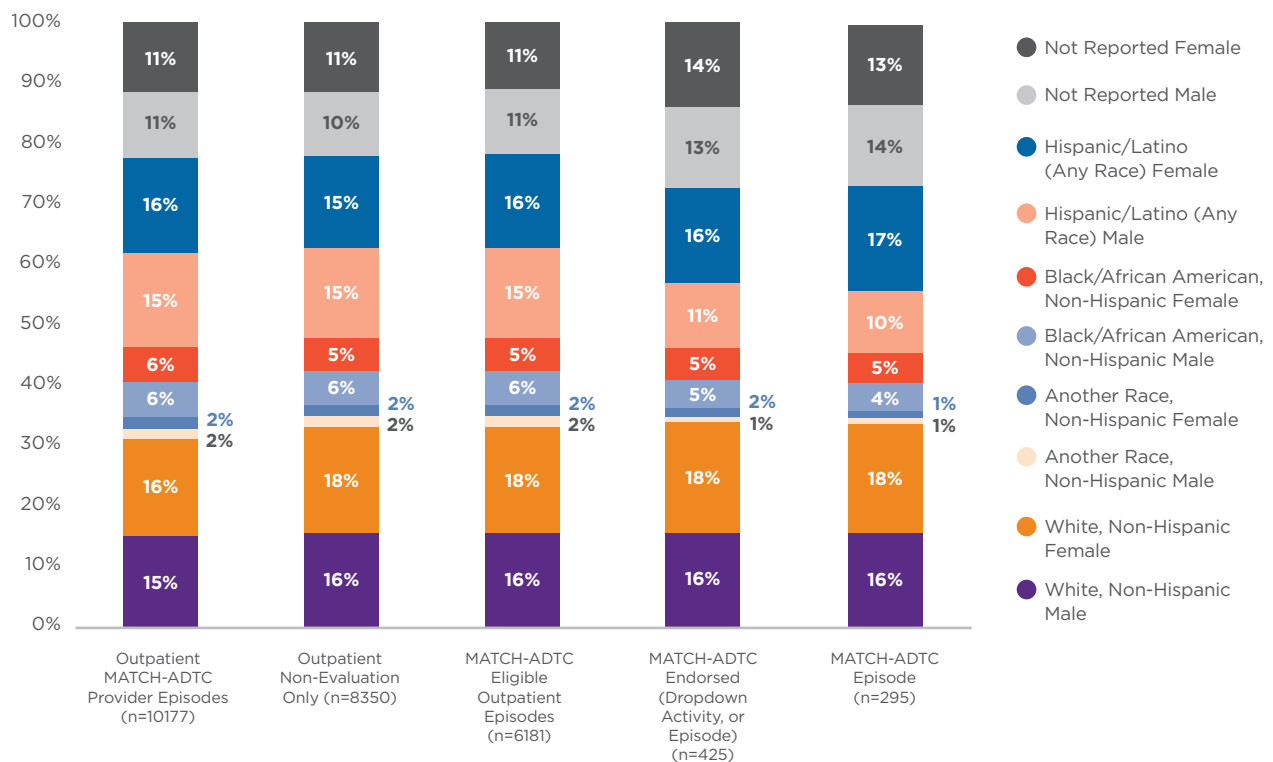
OPCC System Disproportionality Rates for MATCH-ADTC FY23				
	Outpatient Non-Eval Only (N=8350)	MATCH-ADTC Eligible Outpatient Episodes (N=6181)	MATCH-ADTC Endorsed (Dropdown, Activity, Or Episode) (N=425)	MATCH-ADTC Episode (N=295)
White, Non-Hispanic Male	1.05	0.99	0.99	1.00
White, Non-Hispanic Female	1.10	1.00	1.03	1.04
Another Race, Non-Hispanic Male	1.00	1.11	0.45	0.50
Another Race, Non-Hispanic Female	1.00	0.94	0.94	0.82
Black/African American, Non-Hispanic Male	0.93	1.02	0.80	0.79
Black/African American, Non-Hispanic Female	0.92	1.00	1.00	0.94
Hispanic/Latino (Any Race) Male	0.97	0.99	0.72	0.68
Hispanic/Latino (Any Race) Female	0.98	1.03	1.00	1.09
Not Reported Male	0.96	1.02	1.26	1.28
Not Reported Female	1.01	0.97	1.28	1.21

*Compared to TF-CBT eligible

Male Disparity Rates in MATCH-ADTC Access FY23		
	Any Endorsement	MATCH-ADTC Episode
White, Non-Hispanic	0.97	0.96
Another Race, Non-Hispanic	0.48	0.61
Black/African American Non-Hispanic	0.80	0.83
Hispanic/Latino (Any Race)	0.72	0.63
Not Reported (Non-Hispanic)	0.99	1.06

Disparity rates calculated by dividing male disproportionality rate by female rate within racial/ethnic groups.

Disparity Rates in MATCH-ADTC Access by Sex and Race/Ethnicity FY23				
	Females		Males	
	Any Endorsement	MATCH-ADTC Episode	Any Endorsement	MATCH-ADTC Episode
Another Race, Non-Hispanic	0.92	0.79	0.45	0.50
Black/African American Non-Hispanic	0.97	0.91	0.81	0.79
Hispanic/Latino (Any Race)	0.97	1.05	0.73	0.68
Not Reported (Non-Hispanic)	1.24	1.16	1.27	1.28

Disparity rates calculated using White Non-Hispanic children as the comparison group
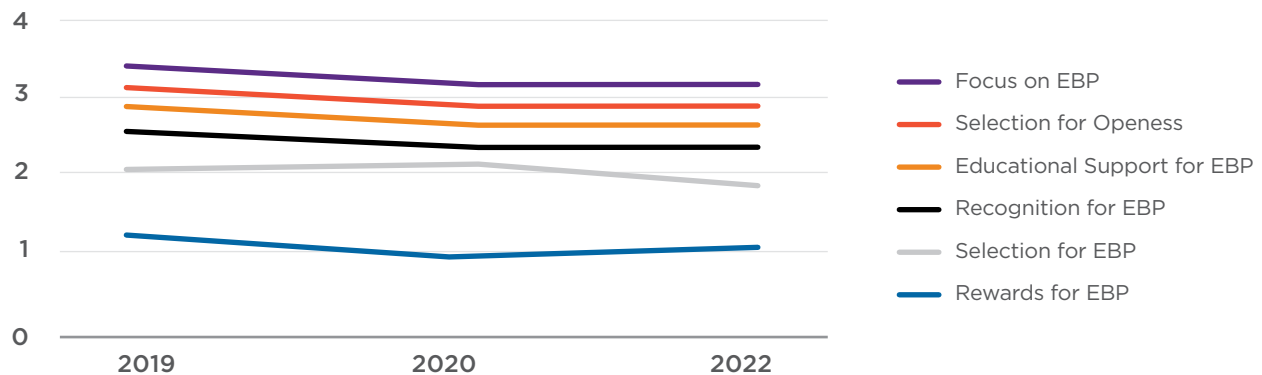
XIV. APPENDIX E CT-PSS STATEWIDE REPORT

Connecticut Provider Support Survey (CT-PSS) OPCC Statewide Providers - 2022 Results

Background on Survey

CHDI administers the CT-PSS to understand what impacts service delivery and how best to improve access, quality, outcomes, and equity in children's outpatient behavioral health. In August-September, 2022, 413 OPCC providers and supervisors participated in the survey. The overall completion rate was 60%. The higher the response rate, the more confident we are that the results represent those within the state.

Perceptions of Workplace Factors that Facilitate the Implementation of EBP

The Implementation Climate Scale (ICS) can be used to evaluate and better understand the current climate as you consider how to improve the likelihood of implementation success.

Legend:
- Focus on EBP
- Selection for Openess
- Educational Support for EBP
- Recognition for EBP
- Selection for EBP
- Rewards for EBP

Perceptions of the Work Environment that Support the Implementation of EBP

The Organizational Climate Measure (OCM) assesses workers' perceptions of their work environment.

Legend:
- Quality
- Welfare
- Pressure to Produce
- Innovation and Flexibility
- Efficiency
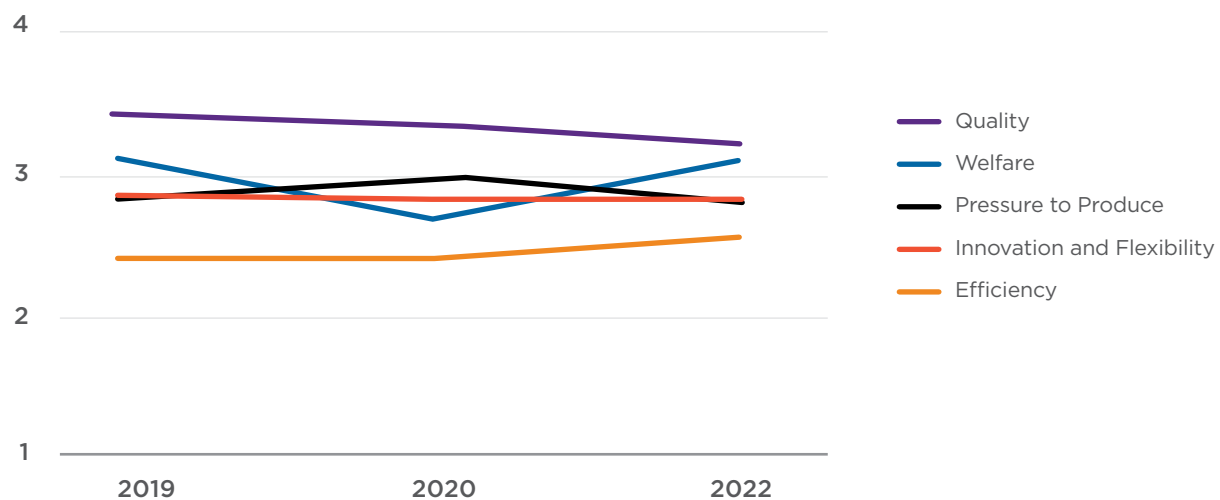
Workforce Development and Wellness

Burnout

The Burnout Scale assesses emotional exhaustion and depersonalization. Since 2019, burnout has increased by 14%.
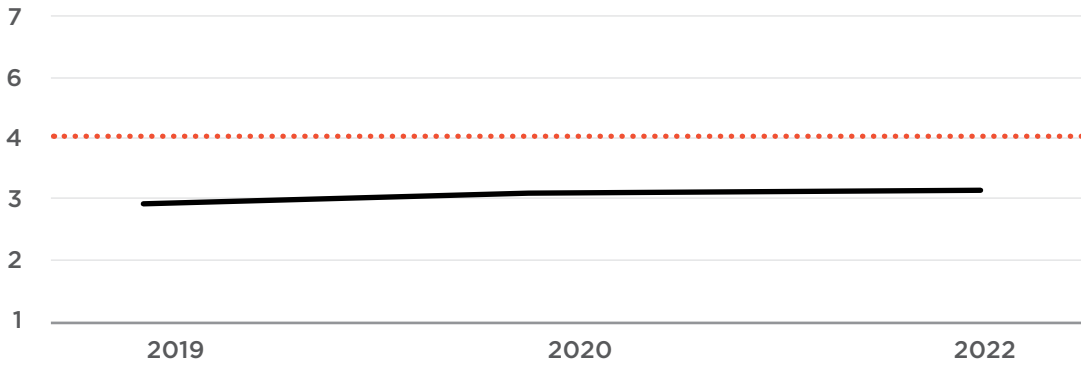
Turnover

The Turnover Intention Scale (TIS-6) assesses employees' intent to stay with their organization. This year, the average score was 2.51, indicating employees had some/neutral intention to leave the organization.

Top Three Strategies to increase retention:
1. Increased Compensation **(63.2%)**
2. Decreased Paperwork **(26.2%)**
3. Loan Forgiveness **(25.9%)**

**Top Three Benefits of Working at an OPCC:**
1. Working with a Group of Peers **(35.4%)**
2. Reliable Salary and Benefits **(31.2%)**
3. Supervision **(20.1%)**

Top Six Training Topics of Interest
1. Vicarious and Secondary Trauma **(30.3%)**
2. Intellectual Developmental Disability, Autism **(21.3%)**
3. Single Session/Briefer EBT Interventions **(18.9%)**
4. First-Episode Psychosis **(18.4%)**
5. Structural Determinants **(16.9%)**
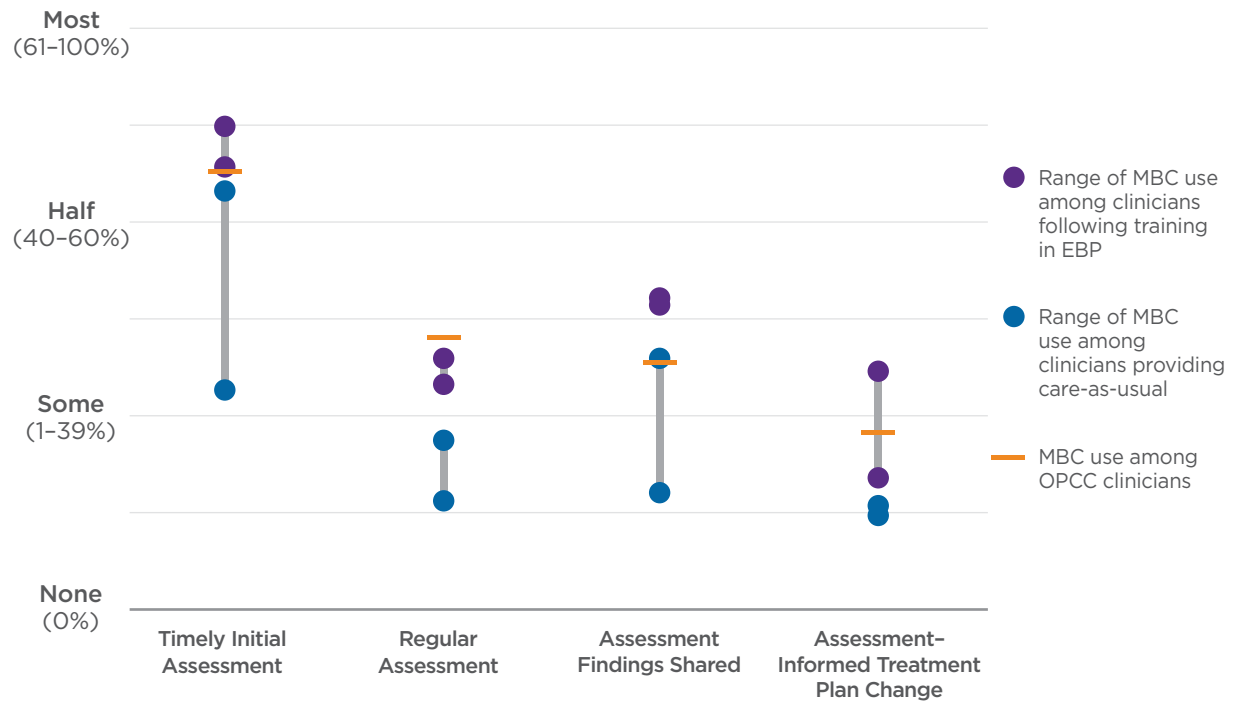6. Cultural Competency **(15.7%)**

Racial Justice and Equity

Questions from the domains below were selected from the full Improving Health Equity Assessment Tool for Health Care Organizations. This tool is designed to assess the level of progress organizations have made in their health equity efforts.
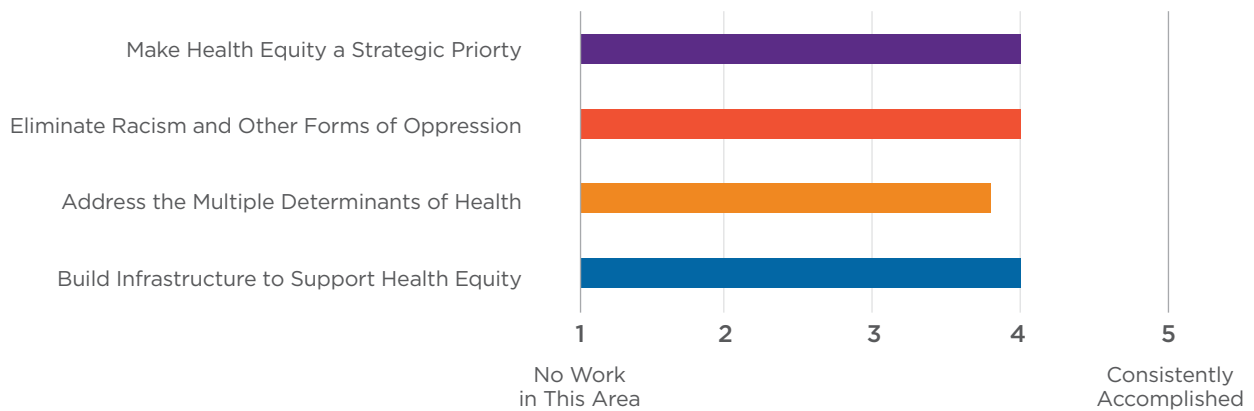
Measurement-Based Care

Questions below were selected from the full Current Assessment Practice Evaluation-Revised (CAPER). This measure is designed to assess measurement-based care (MBC) practices.

Legend:
- Range of MBC use among clinicians following training in EBP
- Range of MBC use among clinicians providing care-as-usual
- MBC use among OPCC clinicians

Y-axis: Most (61–100%), Half (40–60%), Some (1–39%), None (0%)

X-axis: Timely Initial Assessment, Regular Assessment, Assessment Findings Shared, Assessment–Informed Treatment Plan Change

XV. APPENDIX F: ABBREVIATIONS USED IN THIS REPORT

A-SBIRT	Adolescent Screening, Brief Intervention, and Referral to Treatment
ARC	Attachment, Regulation, Competency
BB	Bounce Back
BIPOC	Black, Indigenous and People of Color
CAPER	Current Assessment Practice Evaluation-Revised
CBITS	Cognitive Behavioral Intervention for Trauma in Schools
CGI	Clinical Global Impressions Scale
CGI-I	CGI Improvement Scale
CGI-S	CGI Severity Scale
CHDI	Child Health and Development Institute
CPP	Child Parent Psychotherapy
CT	Connecticut
CT-PSS	Connecticut Provider Support Survey
DCF	Department of Children and Families
EBP	Evidence-Based Practice
EBT	Evidence-Based Treatment
FY	Fiscal Year
ICS	Implementation Climate Scale
MATCH-ADTC	Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct
MBC	Measurement-Based Care
OCM	Organizational Climate Measure
OPCC	Outpatient Psychiatric Clinics for Children
QI	Quality Improvement
SAMHSA	Substance Abuse and Mental Health Services Administration
SMARTER	Specific, Measurable, Attainable, Relevant, Time-Bound, Evaluated & Reviewed
SMARTIE	Specific, Measurable, Attainable, Relevant, Time-Bound, Inclusive, & Equitable
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
TIS-6	Turnover Intention Scale
T-SBIRT	Trauma Screening, Brief Intervention, and Referral to Treatment

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