

# Cognitive Behavioral Intervention for Trauma in Schools

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CONNECTICUT'S EVIDENCE-BASED  
TREATMENT COORDINATING CENTER



## **Connecticut CBITS/BB Coordinating Center**

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*The authors retain full responsibility for all opinions and content.*

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# 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) 2025 (July 1, 2024 through June 30, 2025).

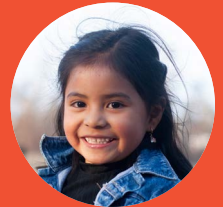
## KEY FINDINGS OF FY25:



**1,575**

students were screened for trauma exposure and associated symptoms, a decrease from 2,120 the previous year.

There was High satisfaction with CBITS/BB treatment among children **(85%)** and caregivers **(95%)**.



**47** new clinicians were trained in CBITS and **35** new clinicians in BB.

**652**

students received CBITS or BB across **87 CBITS** and **76 BB** groups.

Most youth receiving CBITS and BB experienced reliable PTSD symptom reduction (**59.4%** and **68.6%** of children, respectively)



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.

**78.4%** of children receiving CBITS and **86.6%** of children receiving BB successfully completed treatment.



**100** schools and **12** other community-based organizations offered CBITS and/or BB.

For both CBITS and BB, older youth experienced greater improvement in trauma symptoms, and for CBITS, Hispanic youth experienced greater improvement.



### KEY RECOMMENDATIONS:

- Identify and implement strategies to engage more CBITS-age youth, with particular attention to increasing the number of male children served in CBITS. This will include collaborating with the CBITS network to identify successful interventions and disseminating targeted resources to support clinicians engaging and serving CBITS male youth.
- Increase the number of children screened (1,575) in CBITS and Bounce Back by 5% (1,654) through targeted goal setting with teams to increase the overall number of children served in CBITS and Bounce Back. Strategies include enhancing engagement by ensuring dedicated time to discuss CBITS and Bounce Back with youth and families. Additionally, improve data collection by modifying the CBITS and Bounce Back survey tool to improve usability and be less time-intensive for clinicians.
- Examine the teams involved and the reasons contributing to a higher percentage of children in CBITS who did not successfully complete treatment. Collaborate with teams to identify and implement practices that enhance client engagement and treatment completion, while addressing barriers that disrupt care, with the goal of reaching a greater portion of youth successfully completing CBITS.

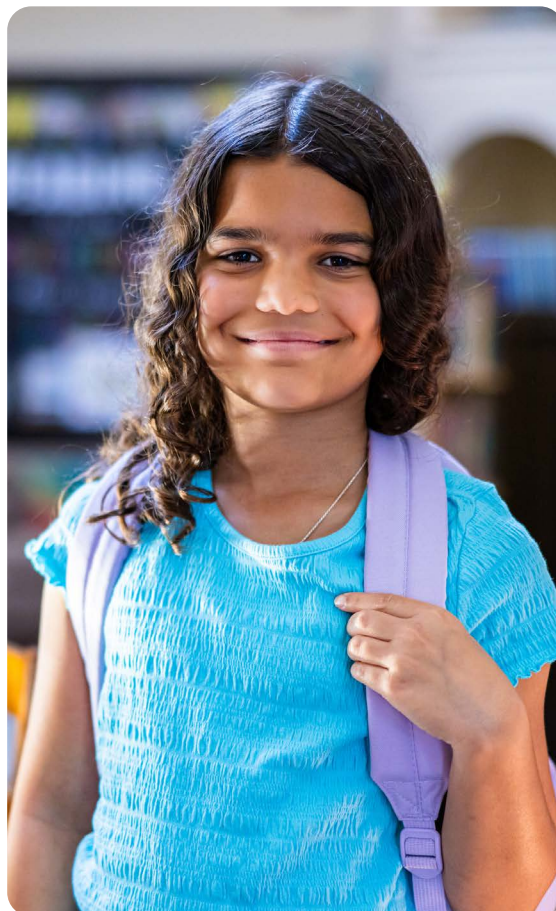


## II. INTRODUCTION

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS)<sup>1</sup> 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<sup>2</sup> in kindergarten through grade 5. Recognizing the need to provide schools 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 FY25, the network consisted of 39 providers. The figure below illustrates the goals and primary activities of the Coordinating Center<sup>3</sup>. This FY25 report is framed across access, quality, outcome, and equity goals. Summary, conclusions, and recommendations are shared to guide future work.

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

- Investigating racial and ethnic disparities between the children being screened for CBITS/BB, those deemed eligible, and those served, by improving data collection methods and implementing an enhanced survey across the CBITS/BB network in FY25.
- Examining reasons why a higher percentage of children that were screened eligible for CBITS/BB were referred to another service, such as individual treatment or out-of-school services instead of being treated with CBITS/BB.
  - › Lack of caregiver consent and the child's comfort with the group format were found to be concerns among children not receiving CBITS/BB that were discussed with CBITS/BB providers.
  - › In FY25, of the 1,575 children who were screened, the percentage referred to other services, such as individual treatment or out-of-school treatment significantly decreased from 24% to 8%.



1. Jaycox, L.H., Langley, A.K., Hoover, S.A. (2018). Cognitive Behavioral Intervention for Trauma in Schools, second edition (revised). San 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 FY25 can be found in Appendix A

- › This fiscal year there will be an emphasis in support on how to talk about trauma within the group format with different types of audiences.
- › Implementing a bilingual stipend through sustainability funding for CBITS/BB teams with active bilingual clinicians providing CBITS/BB treatment. Throughout the year, 14 CBITS/BB teams received a total of \$9,000 for having active bilingual clinicians on their teams.

## 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?**

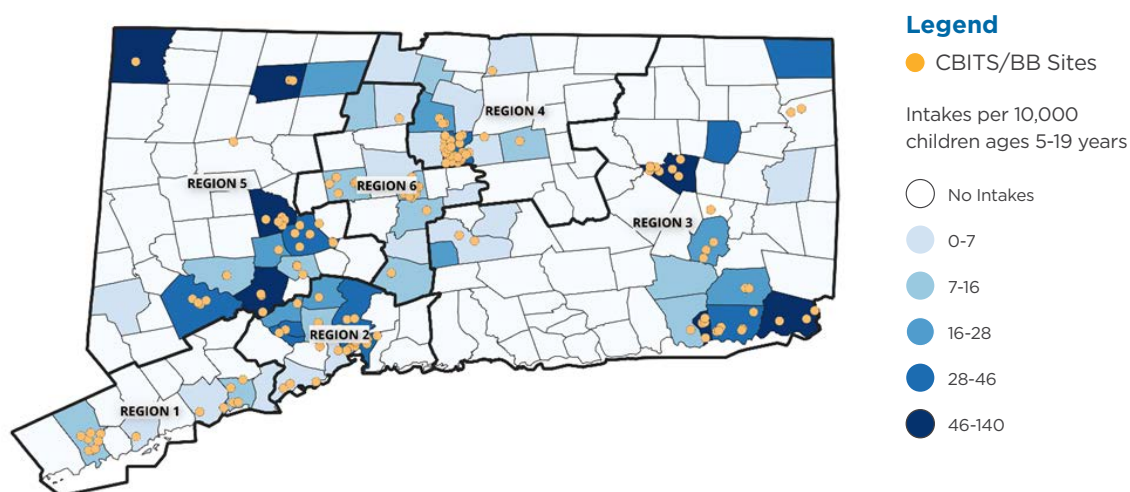
### III. ACCESS TO CBITS/BB IN CONNECTICUT

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 FY25, CBITS was available at 56 schools and 6 community-based settings across 27 different providers; BB was available at 50 schools and 6 community-based settings across 24 different providers. A total of 87 CBITS and 76 BB groups were held in FY25.

**Figure 1.** Map of CBITS/BB Sites and Children Served in FY25 by DCF Region



This year, providers trained 47 CBITS and 35 BB clinicians, which remains consistent with the number of clinicians trained last year. Providers faced challenges regarding personnel, especially due to budget reductions, which led to a more selective approach in the training of staff. 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, 33 CBITS and 16 BB clinicians attended booster training and 13 CBITS and 3 BB clinicians achieved certification. There continues to be clinicians certified in CBITS and BB, showing a continued commitment to the models by the CBITS/BB initiative members. Tables 1 and 2 show details about CBITS and BB teams.





**Table 1. FY25 CBITS and BB Teams**

|                                   | CBITS        | BB           |
|-----------------------------------|--------------|--------------|
| # of clinicians on team           | 139          | 108          |
| # of active clinicians            | 63           | 55           |
| Average team size-school district | 4.0 (R 1-12) | 3.8 (R 1-10) |
| Average team size-community based | 3.9 (R 1-12) | 2.8 (R 1-12) |

**Table 2. Trends in CBITS/BB Provider Network**

|                                | FY 2022 | FY 2023 | FY 2024 | FY 2025 | Cumulative Since 2015 |
|--------------------------------|---------|---------|---------|---------|-----------------------|
| Schools                        |         |         |         |         |                       |
| CBITS                          | 58      | 62      | 70      | 56      | 276*                  |
| BB                             | 47      | 55      | 52      | 50      |                       |
| School Districts               |         |         |         |         |                       |
| CBITS                          | 26      | 26      | 29      | 28      | 50*                   |
| BB                             | 20      | 21      | 21      | 26      |                       |
| Community-Based Settings**     |         |         |         |         |                       |
| CBITS                          | 10      | 2       | 4       | 6       | 22*                   |
| BB                             | 5       | 2       | 5       | 6       |                       |
| Newly Trained Clinicians       |         |         |         |         |                       |
| CBITS                          | 57      | 61      | 47      | 47      | 793*                  |
| BB                             | 39      | 42      | 34      | 35      |                       |
| # Newly Certified              |         |         |         |         |                       |
| CBITS                          | 6       | 11      | 21      | 13      | 105*                  |
| BB                             | 4       | 10      | 10      | 3       |                       |
| Clinicians Providing Treatment |         |         |         |         |                       |
| CBITS                          | 69      | 80      | 76      | 63      | 559*                  |
| BB                             | 56      | 62      | 54      | 55      |                       |

\*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 139 clinicians on a CBITS team and 108 clinicians on a BB team this year are presented in Table 3. CBITS and BB clinicians were primarily female and mostly White; 20% of CBITS clinicians and 19% 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 continues to be provided to teams. Clinicians from CBITS/BB were also invited to participate in bilingual/bicultural meetings to support staff in implementing interventions in Spanish and/or Portuguese. New materials in Spanish were also distributed to providers to support Spanish speaking youth and families in treatment. There has also been an increase in conversations around who has access to the level of education required to be eligible for CBITS or BB training, and how to support staff working towards the advancement of practices such as CBITS and BB.



**Table 3. Demographics of CBITS/BB Staff**

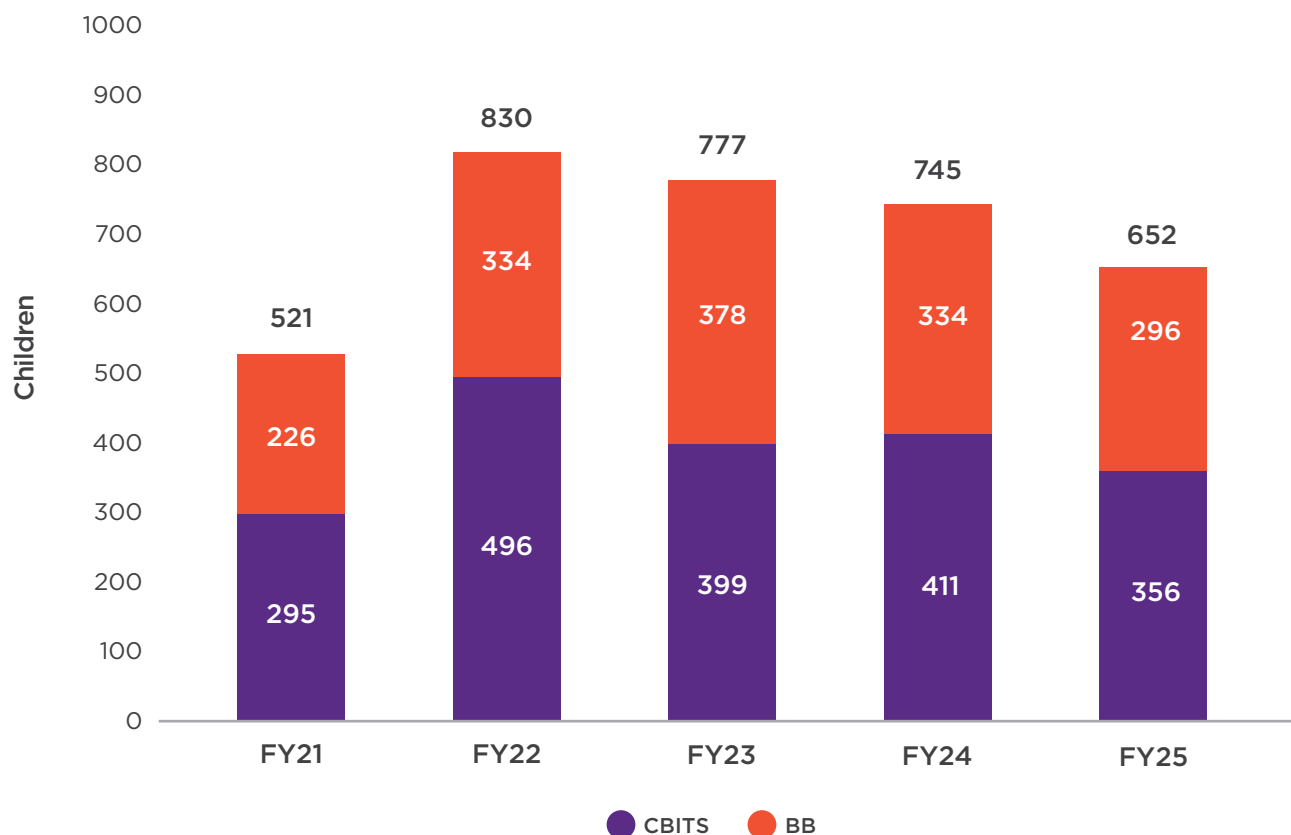
|                                         | CBITS % (n=139) | BB % (n=108) |
|-----------------------------------------|-----------------|--------------|
| <b>Sex (Male)</b>                       | 10.1            | 8.2          |
| <b>Race</b>                             |                 |              |
| Black or African American               | 14.4            | 9.3          |
| Hispanic, Latino, or Spanish (any race) | 18.1            | 16.4         |
| White                                   | 59.7            | 74.1         |
| Other Race/Ethnicity                    | 5.0             | 2.8          |
| Missing                                 | 0.7             | 0            |
| <b>Languages Spoken</b>                 |                 |              |
| Spanish                                 | 20.1            | 19.4         |
| Other                                   | 5.0             | 2.7          |

## Children who Received CBITS/BB

In FY25, 1,575 children were screened for trauma exposure and traumatic stress and 771 (49%) were eligible to participate in a group. Of the children screened that were found eligible, 85% (652 of 771 children) participated in treatment. This is an increase from FY24, where 79% of children received treatment. Of the 1,575 children who were screened, the percentage referred to other services, such as individual treatment or out-of-school interventions decreased from 24% to 8% and the number of youth that declined services also decreased from 4% to 2%. The Supporting Transition Resilience of Newcomer Groups (STRONG) model was offered to education providers to enhance their ability to assist newcomer youth who do not qualify for CBITS/BB treatment. This initiative saw significant participation aimed at supporting newcomer youth, especially during a period marked by new immigration actions impacting youth and their families.

During the year, 356 children received CBITS, and 296 children received BB. The average number of youth in a CBITS group was 4.0, which was the same as the previous year. The average number of children in BB groups decreased from 4.16 in the previous year to 3.83. The number of children receiving CBITS who were referred to higher levels of care this fiscal year was 1.1%, which was the same as the previous year. Children reported an average of 7.9 (CBITS) and 5.6 (BB) of 18 types of traumatic exposures. Figure 2 shows the number of children who have received CBITS and BB since FY21.

**Figure 2.** Children served since FY21



## Child Demographics

Table 4 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. The average age of youth receiving CBITS was 14.1 (SD=2.91) which was slightly higher than the previous year (13.5) and the average age for those receiving BB was 8.7 (SD=1.84) which was about the same as the previous year (8.4). 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. This is consistent with previous years.

| <b>Table 4. Characteristics of children receiving CBITS (n=356) and BB (n=296) with comparisons</b> |       |      |     |      |                         |                      |
|-----------------------------------------------------------------------------------------------------|-------|------|-----|------|-------------------------|----------------------|
|                                                                                                     | CBITS |      | BB  |      | CT Schools <sup>i</sup> | CT Pop <sup>ii</sup> |
|                                                                                                     | N     | %    | N   | %    | %                       | %                    |
| <b>Sex (Male)</b>                                                                                   | 113   | 31.7 | 150 | 50.7 | 51.5                    | 51.2                 |
| <b>Race</b>                                                                                         |       |      |     |      |                         |                      |
| American Indian or Alaska Native                                                                    | 12    | 3.4  | 0   | 0.0  | 0.2                     | 0.4                  |
| Asian                                                                                               | 1     | 0.3  | 0   | 0.0  | 5.2                     | 5.1                  |
| Black or African American                                                                           | 108   | 30.3 | 54  | 18.2 | 12.4                    | 12.2                 |
| Native Hawaiian or Pacific Islander                                                                 | 5     | 1.4  | 0   | 0.0  | 0.1                     | 0.1                  |
| White                                                                                               | 176   | 49.4 | 189 | 63.9 | 45.1                    | 53.2                 |
| Another Racial Group (includes multiracial/ethnic)                                                  | 41    | 11.5 | 48  | 16.2 | 4.8                     | 29.0                 |
| Not Disclosed/Missing                                                                               | 13    | 3.7  | 5   | 1.7  | N/A                     | N/A                  |
| <b>Hispanic, Latino, or Spanish (Any Race)</b>                                                      | 169   | 47.5 | 133 | 44.9 | 32.1                    | 28.0                 |
| <b>Age (Years)</b>                                                                                  |       |      |     |      |                         |                      |
| Under 6 years                                                                                       | 0     | 0.0  | 16  | 5.4  | N/A                     | 30.2                 |
| 6–11 years                                                                                          | 58    | 16.3 | 268 | 90.5 | N/A                     | 32.6                 |
| 12–17 years                                                                                         | 281   | 78.9 | 12  | 4.1  | N/A                     | 37.2                 |
| 18 and older                                                                                        | 17    | 4.8  | 0   | 0.0  | N/A                     | N/A                  |
| <b>Grade</b>                                                                                        |       |      |     |      |                         |                      |
| Elementary                                                                                          | 24    | 6.7  | 266 | 89.9 | 43.3                    | N/A                  |
| Middle                                                                                              | 144   | 40.4 | 26  | 8.8  | 23.2                    | N/A                  |
| High                                                                                                | 188   | 52.8 | 0   | 0.0  | 33.5                    | N/A                  |

**Table 4. Characteristics of children receiving CBITS (n=356) and BB (n=296) with comparisons**

|                                                      | CBITS |      | BB |      | CT Schools <sup>i</sup> | CT Pop <sup>ii</sup> |
|------------------------------------------------------|-------|------|----|------|-------------------------|----------------------|
|                                                      | N     | %    | N  | %    | %                       | %                    |
| <b>Child Welfare Involvement During Treatment</b>    | 43    | 12.1 | 44 | 14.9 | N/A                     | 2.3 <sup>iii</sup>   |
| <b>Juvenile Justice Involvement During Treatment</b> | 8     | 2.2  | 4  | 1.4  | N/A                     | N/A                  |
| <b>Child Primary Language</b>                        |       |      |    |      |                         |                      |
| Spanish                                              | 16    | 4.5  | 14 | 4.7  | N/A                     | 14.3                 |
| Neither Spanish nor English                          | 1     | 0.3  | 1  | 0.3  | N/A                     | 8.5                  |
| <b>Caregiver Speaks English (No)</b>                 | 32    | 9.0  | 38 | 12.8 | N/A                     | N/A                  |

<sup>i</sup>Data obtained from CT Dept. of Education: [edsight.ct.gov](https://edsight.ct.gov) for 2024-25 school year. Age and language spoken not available

<sup>ii</sup>American Community Survey 2023 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.

<sup>iii</sup>Based on 2023 National Child Abuse and Neglect Data System (NCANDS) data for children subject of an investigated report alleging child maltreatment.



## ACCESS / EQUITY:

**356** children received CBITS and **296** children received BB.

Child welfare involvement was **12%** for **CBITS** and **15%** for **BB**, and **2%** 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**.

**31.7%** of children served in CBITS were male, a decrease from **37.7%** last year.



## IV. QUALITY: CLINICAL IMPLEMENTATION AND IMPROVEMENT

### Treatment Dose and Duration

A total of 76 BB and 87 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 8.7 (SD=2.5) group and 1.3 (SD=1.0) individual sessions over an average of 2.6 months. Youth receiving BB completed an average of 9.1 (SD=1.9) group and 2.0 (SD=1.3) individual sessions over an average of 2.9 months.

### Quality Improvement Indicators

Once children begin a CBITS/BB episode, it is important they receive high-quality care that adheres to best practices and is associated with improved outcomes. The Coordinating Center monitors and reports on quality indicators that are used in site-based consultation with providers and to inform technical assistance efforts (see Appendix D). Below are state-level results for key indicators of quality. They are calculated on the 637 children that had a CBITS/BB episode that ended this year and who also had at least four treatment sessions. For this report, each indicator was analyzed for differences between racial/ethnic groups, and no differences were found.

#### Did children/families engage in treatment?

Engagement is defined as attending four or more sessions. Treatment completion literature identifies a need to distinguish between children who end treatment early (1-2 sessions) and those who end treatment before full completion, but after 3-4 or more sessions.<sup>4,5,6</sup> The latter group tends to have positive outcomes in treatment even if they end treatment early, compared to the early termination group. In FY25, 95% of children who started CBITS/BB engaged in treatment. This is above the benchmark of 85%.

#### Was CBITS/BB delivered with high quality?

Of the children who were engaged in treatment, nearly all children (99%) receiving CBITS/BB in the fiscal year had a measure of baseline symptoms, and 87% had data at two timepoints. This is above the benchmark of 70%.

#### Did children have improved outcomes?

Of the children who engaged in treatment that had both a baseline and follow-up measure completed, 80% showed improvement on any measure of child symptoms, which is above the benchmark of 75%. Additionally, 91% of children engaged in treatment completed 8 or more group sessions, which is above the benchmark of 30%.

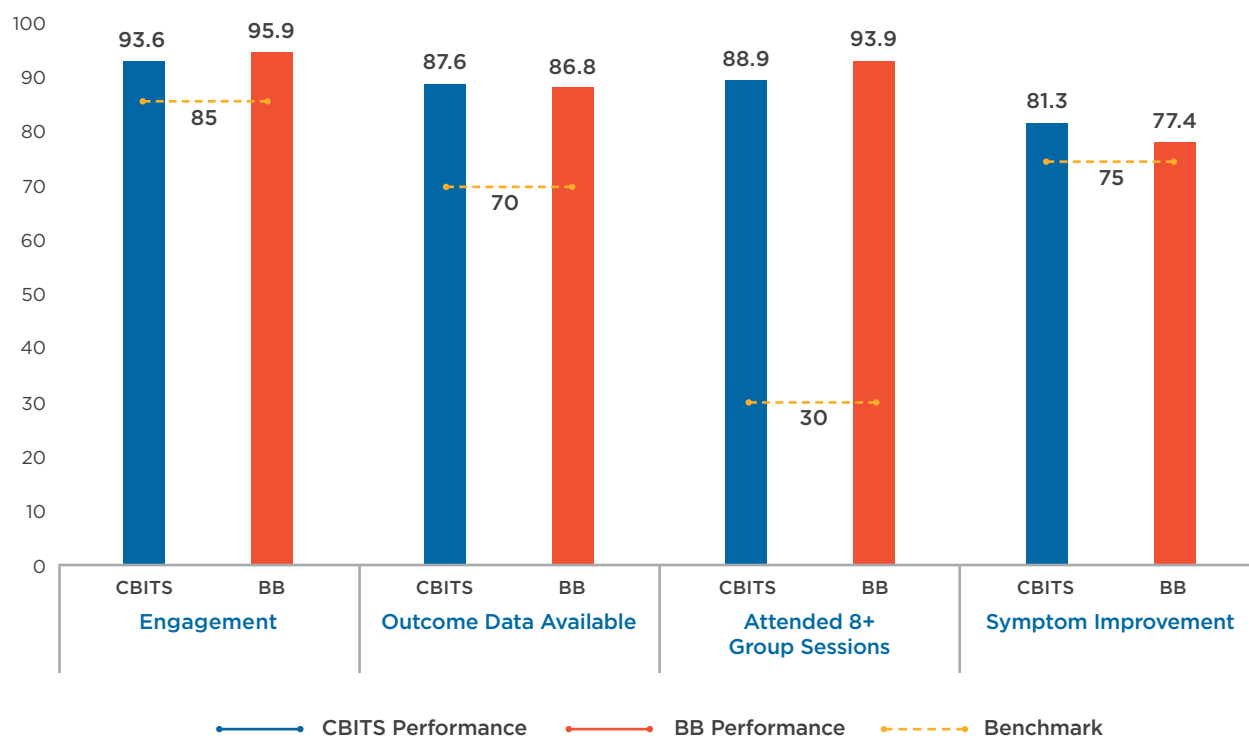
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4. Pekarik, G. (1986). The use of termination status and treatment duration patterns as an indicator of clinical improvement. *Evaluation and Program Planning*, (9), 25-30. Doi: 10.1016/0149-7189(86)90004-2

5. De Haan, A. M. et al. (2013). A meta-analytic review of treatment dropout in child and adolescent outpatient mental health care. Doi: 10.1016/j.j.cpr.2013.04.005

6. Wierzbicki, M. & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology, Research, and Practice*. Doi: 10.1037/0735-7028.24.2.190

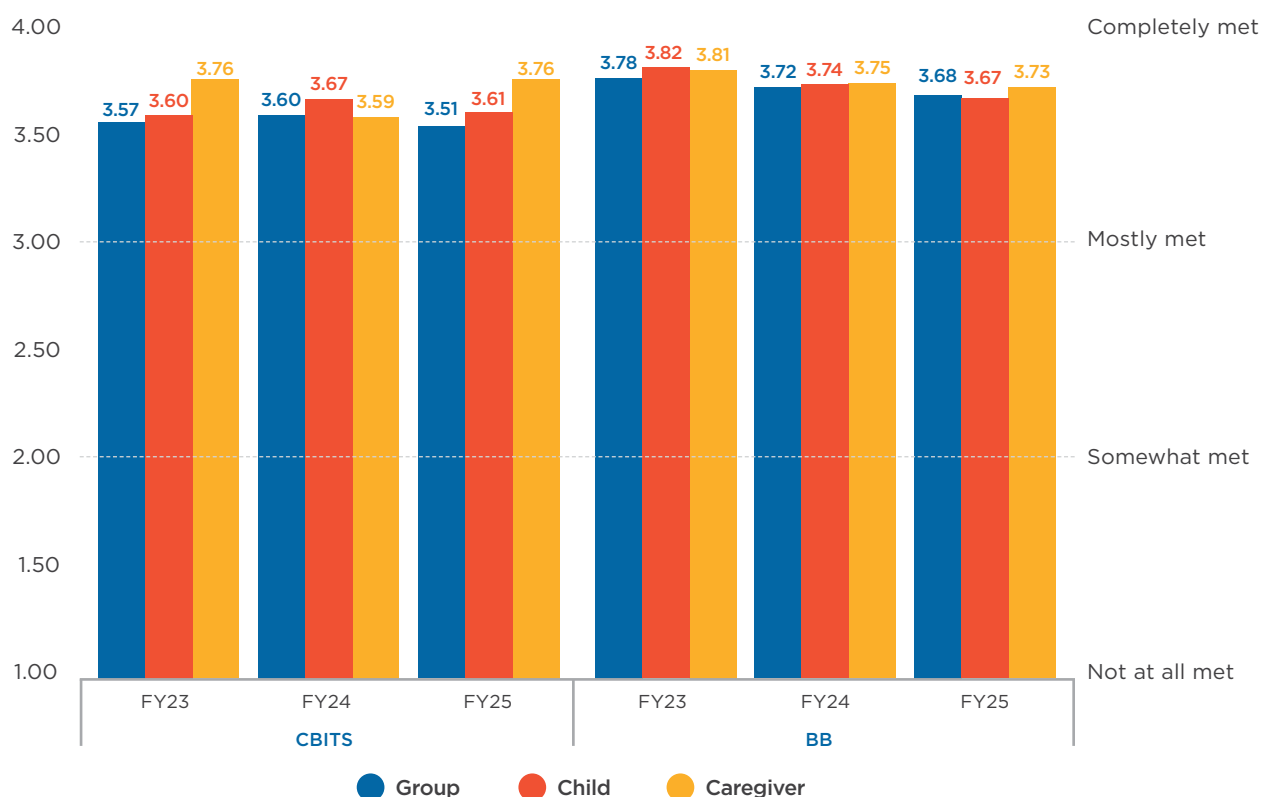
**Figure 3. FY25 QI Indicators**



## Session Ratings by Clinicians

Clinicians rate session objective completion for group, child, and caregiver sessions 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



## Satisfaction

### QUALITY AND EQUITY:

**85% of children and 95% of caregivers** reported being moderately or extremely satisfied with treatment.



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

In FY25, 102 children and 21 caregivers completed Ohio Satisfaction assessments about their CBITS/BB group. 85% of children and 95% of caregivers reported being moderately or extremely satisfied with treatment.





## V. OUTCOMES: IMPROVEMENT FOR CHILDREN RECEIVING CBITS/BB



### Discharge Reason

A total of 362 youth in CBITS and 297 youth in BB completed their treatment episode in FY25. Successful completion was the most common discharge reason for both treatment models (78.4% CBITS, 86.6% BB). This is a decrease for CBITS from FY24, when 82.7% of children successfully completed treatment.

Other common discharge reasons for CBITS included “other” (4.7%), and administrative discharge (CHDI-level discharge) (9.7%). Family discontinued was reported as the discharge reason for 2.8% of CBITS episodes, and referral to a higher level of care or other treatment was reported for 3.3% of CBITS episodes.

For BB, administrative discharge was reported for 3.4% of episodes. Family discontinued was reported for 2.7% of BB episodes, and 3.4% of children were referred to a higher level of care or other treatment. To support clinicians with engagement, several workshops were offered at the EBP conference for clinical staff working with children, such as “Creative ways to engage clients and families in EBPs” in an effort to expand the number of children served in EBPs such as CBITS/BB.

**There were no differences in successful completion by race/ethnicity or sex (See Appendix B, Tables B7 and B8).**

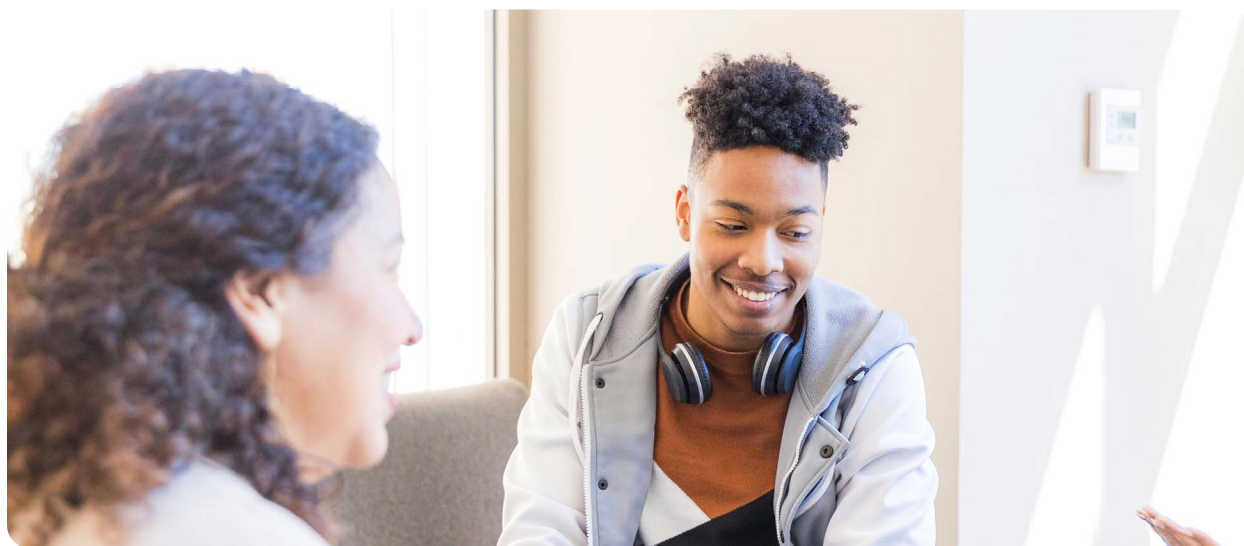
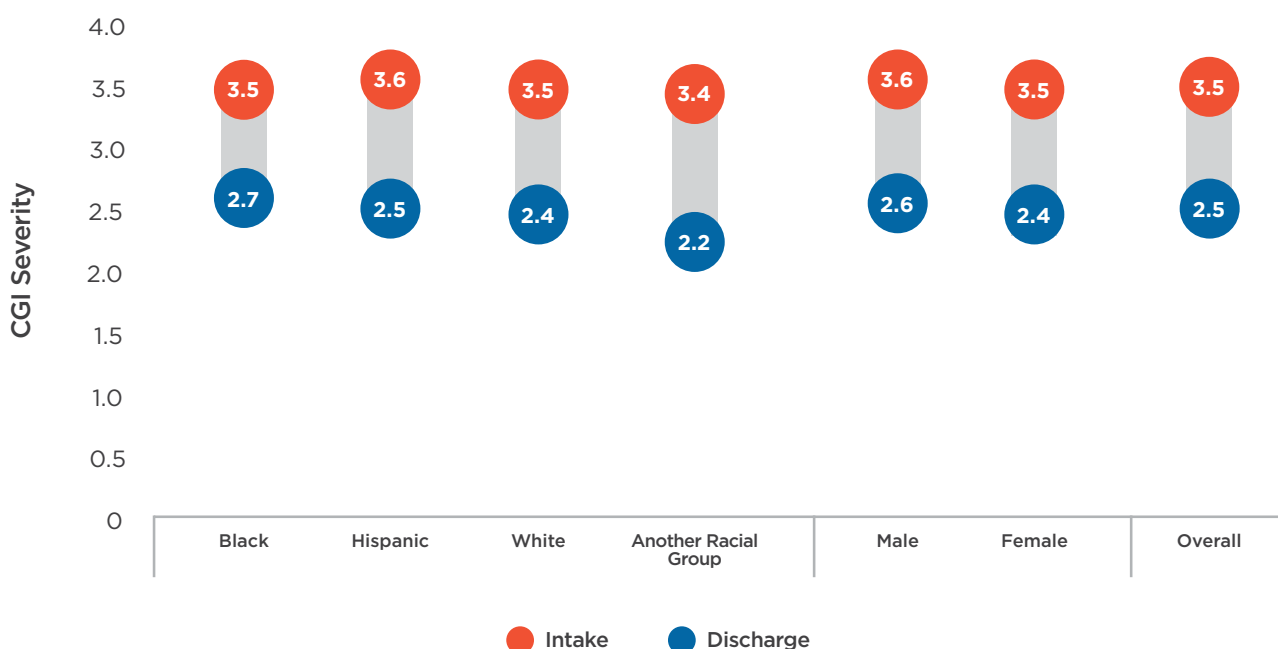


## Clinical Global Impressions (CGI) Scale

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 91.9% of youth receiving CBITS (n=194) and 92.0% of youth receiving BB (n=200). On the CGI-S, 67.0% of youth receiving CBITS (n=182) and 71.1% of children who received BB (n=180) 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 Ratings 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 C.

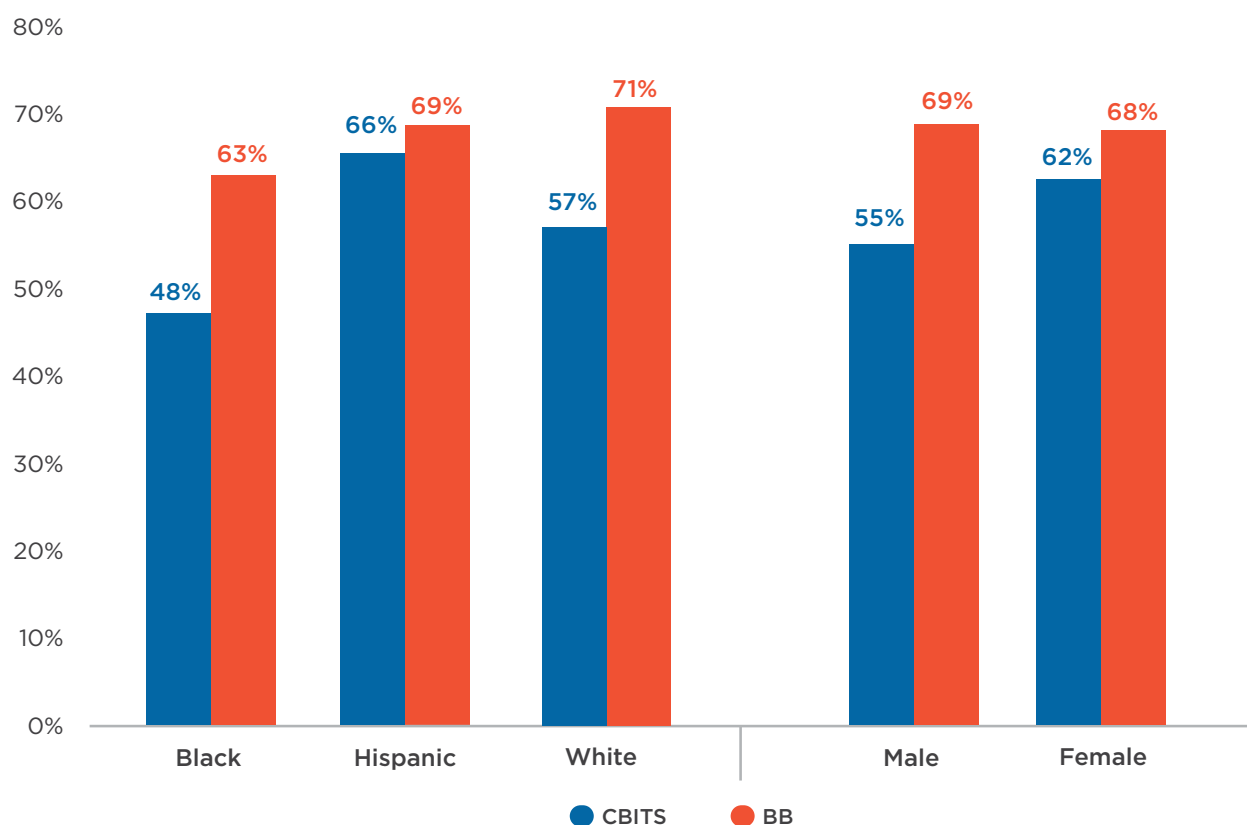
### Overall Clinical Improvements Across Groups

For both CBITS and BB, older youth had higher rates of reliable improvement across any measure, and for CBITS, Hispanic youth had higher rates of reliable improvement. **There were no differences in improvement on any measure by sex (see Appendix B, tables B5 and B6).**

### 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). 59.4% of youth who received CBITS and 68.6% of youth who received BB showed improvement in posttraumatic stress symptoms. This was a decrease for CBITS compared to FY24 (67.4%), and rates of improvement remained the same for BB. Figure 6 shows the rates of improvement by subgroup; **there were no differences in posttraumatic stress symptom improvement by race/ethnicity or sex (see Appendix B, tables B3 and B4).**

**Figure 6.** Percentage of Children that Show Reliable Improvement 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 and Hispanic youth had **higher rates of reliable improvement** across any measure.

For BB, older youth had higher rates of **reliable improvement** across any measure.

There were **no differences in successful completion** by race/ethnicity or sex.

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



There were **no differences in improvement** by sex across any measure or in posttraumatic stress symptoms. There were also no differences in posttraumatic stress symptom improvement by race and ethnicity.



## VI. SUMMARY AND RECOMMENDATIONS





In FY25, network providers screened more than 1,500 youth for trauma exposure and delivered care to 652 youth in CBITS or BB. Despite smaller teams this year, 48% of all trained clinicians provided CBITS/BB treatment services; this was approximately equivalent to the previous fiscal year (49%).

Both CBITS and BB maintained strong outcomes. Youth completed approximately 89% of group sessions in less than three (3) months, and the average session ratings were marked as nearly “Completely met” by clinicians. Across the fiscal year, all the Quality Improvement (QI) indicators met or exceeded benchmarks. Finally, most youth (85%) and nearly all caregivers (95%) reported satisfaction or high satisfaction with services.

Approximately 79% of youth receiving CBITS and 87% of youth receiving BB had completed the group successfully, with 59.4% of CBITS youth and 68.6% of BB youth experiencing clinically meaningful reductions in post-traumatic stress symptoms. According to the CGI, overall improvements by the end of treatment were high for both models (CBITS, 91.9%; BB, 92.0%).

The characteristics of youth, the provision of best practices, and the delivery of quality care to all eligible children are essential factors in assessing 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 and Hispanic youth experienced greater improvements in symptoms across any measure compared to White youth, while for BB, older youth experienced greater improvements in symptoms across any measure. Hispanic youth also showed greater CGI severity change than White youth. Screening for trauma among children decreased this year, with about 545 fewer youth screened than in 2024. In this



year’s trauma screening process, a new form was introduced and piloted. It is expected that more teams will enter this data as more support and familiarity is provided among providers. Among the children eligible for treatment, 85% of children received CBITS/BB, an increase from last year. Improving engagement and retention strategies for eligible CBITS/BB youth will be a priority in service delivery.



## Recommendations

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

- **Identify and implement strategies** to engage more CBITS-age youth, with particular attention to increasing the number of male children served in CBITS. This will include collaborating with the CBITS network to identify successful interventions and disseminating targeted resources to support clinicians engaging and serving CBITS male youth.
- **Increase the number of children screened (1,575) in CBITS and Bounce Back by 5% (1,654)** through targeted goal setting with teams to increase the overall number of children served in CBITS and Bounce Back. Strategies include enhancing engagement by ensuring dedicated time to discuss CBITS and Bounce Back with youth and families. Additionally, improve data collection by modifying the CBITS and Bounce Back survey tool to improve usability and be less time-intensive for clinicians.
- **Examine the teams involved and the reasons contributing to a higher percentage of children in CBITS** who did not successfully complete treatment. Collaborate with teams to identify and implement practices that enhance client engagement and treatment completion, while addressing barriers that disrupt care, with the goal of reaching a greater portion of youth successfully completing CBITS.
- **Continue efforts to diversify and support the workforce** through targeted conversations with team leadership in consultation regarding who is trained in an EBP and inviting bilingual clinicians to bilingual/bicultural meetings to support bilingual clinicians.
- **Increase the amount of screening data collected** to be able to better investigate racial and ethnic disparities between the children in the schools' general population, the children being screened eligible for CBITS/BB and the children served. Approximately, 10% of screened children were missing race and ethnicity data, and the goal is to reduce this to 5%. Strategies to support this effort include discussions in network leadership meetings to address family concerns about treatment and data collection, sharing effective approaches for engaging caregivers in these conversations and treatment.
- **Continue to offer 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.
- **Strengthen resources for clinicians by enhancing and distributing a centralized resource platform**, fostering a connected and supported workforce across the state.
- **Maintain and strengthen** the capacity of the CBITS/BB initiative to deliver CBITS training in Connecticut through the certification of new state-level trainers.



## 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 FY25, 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 46 CBITS and 35 BB staff.
- Coordinated two CBITS Booster trainings and one Bridgeport-specific CBITS Booster trainings for 33 clinical staff and one BB Booster trainings for 16 clinical staff.
- Coordinated one State-Level Trainer Booster for seven clinical staff.
- Coordinated four CBITS clinical consultation call groups with 48 total calls for 57 clinical staff.
- Coordinated three BB clinical consultation call groups with 36 total calls for 36 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 39 clinical staff.
- Convened the 17th annual EBP conference in person consisting of 32 workshops with 17.6% meeting the cultural competency CE requirement. A total of 398 unique participants from community providers, DCF, CSSD, and other partners attended the conference.

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

- Conducted 144 site visits and 76 non-clinical consultation calls (virtual or telephonic).
- Onboarded three new provider teams: Berlin Public Schools, Bloomfield Public Schools, and Oxford 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 EBP Tracker that meets the needs of the increasing number of CBITS/BB providers and the children and families they serve.
- 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](mailto: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=281)                                                         | Post-traumatic stress symptoms                    | 185                   | 39.96                   | 24.69                  | -12.23**     | -14.91  | Large                   | 99/185    |
|                                                                              |                                                   | 65.8%                 | (15.43)                 | (15.86)                |              |         | .89                     | 53.5%     |
| Ohio Problem Severity Child (n=246)                                          | Severity of internalizing/externalizing behaviors | 125                   | 28.16                   | 20.51                  | -7.18**      | -8.98   | Medium                  | 53/125    |
|                                                                              |                                                   | 50.8%                 | (15.44)                 | (13.85)                |              |         | .57                     | 42.4%     |
| Ohio Functioning Child (n=246)                                               | Child's adjustment and functioning                | 73                    | 50.62                   | 56.27                  | 5.56**       | 7.25    | Medium                  | 51/73     |
|                                                                              |                                                   | 29.7%                 | (12.54)                 | (11.60)                |              |         | .46                     | 69.9%     |

\*\*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: Ohio PS child, Ohio Functioning Child

Outliers were found and corrected for the following last scores: 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=220)                                                      | post-traumatic stress symptoms                    | 117                   | 33.2                    | 18.80                  | -14.24**     | -14.38  | Large                   | 90/117    |
|                                                                           |                                                   | 53.1%                 | (12.29)                 | (13.51)                |              |         | 0.97                    | 76.9%     |
| Ohio Problem Severity Child (n=97)                                        | Severity of internalizing/externalizing behaviors | 50                    | 26.72                   | 15.06                  | -11.65**     | -8.66   | Large                   | 36/50     |
|                                                                           |                                                   | 51.5%                 | (13.23)                 | (11.52)                |              |         | 0.88                    | 72.0%     |
| Ohio Problem Severity Caregiver (n=51)                                    | Severity of internalizing/externalizing behaviors | 15                    | 18.0                    | 11.63                  | -6.14**      | -4.62   | Medium                  | 11/15     |
|                                                                           |                                                   | 29.4%                 | (11.31)                 | (10.10)                |              |         | 0.65                    | 73.3%     |
| Ohio Functioning Child (n=97)                                             | Child's adjustment and functioning                | 21                    | 52.89                   | 61.78                  | 8.97**       | 7.02    | Medium                  | 18/21     |
|                                                                           |                                                   | 21.6%                 | (11.45)                 | (9.97)                 |              |         | 0.71                    | 85.7%     |
| Ohio Functioning Caregiver (n=51)                                         | Child's adjustment and functioning                | 10                    | 55.99                   | 59.79                  | 2.31*        | 1.55    | Small                   | 4/10      |
|                                                                           |                                                   | 19.6%                 | (15.50)                 | (15.17)                |              |         | 0.22                    | 40.0%     |

\*\*p < .001, \* p < .01

Effect sizes were derived using Cohen's D as follows: .2 = small, .5 = medium, .8 = large

CPSS 5 Caregiver statistics suppressed due to low n

Outliers were found and corrected for the following first scores: CPSS 5 Child, Ohio PS (caregiver), Ohio Functioning (child and caregiver)

Outliers were found and corrected for the following last scores: CPSS 5 Child, Ohio PS (child), Ohio Functioning (child and caregiver)

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                      | $\beta$        | SE    | 95%CI            |
|-------------------------------|----------------|-------|------------------|
| Constant                      | 0.461          | 5.146 | (-9.670, 10.592) |
| Trauma Exposure-TEC Child     | -0.453         | 0.262 | (-0.968, 0.063)  |
| Child Discharged "Successful" | <b>-4.266*</b> | 2.143 | (-8.486, -0.047) |
| Hispanic                      | -3.398         | 1.983 | (-7.303, 0.506)  |
| Black Non-Hispanic            | 1.474          | 2.330 | (-3.113, 6.060)  |
| Sex(male)                     | 0.980          | 1.781 | (-2.527, 4.487)  |
| Child age                     | -0.341         | 0.281 | (-0.894, 0.212)  |
| R <sup>2</sup>                | 0.053          |       |                  |
| F                             | 2.174          |       |                  |

\*p<.05 As compared to White Females

\*\*p<.01 Outliers were found and corrected for CPSS5 Child change score

\*\*\*p<.001 Another Race Non-Hispanic removed due to low sample size

**Table B4. Multiple regression analyses of selected demographic variables on child CPSS5 change scores (BB)**

| Variable                      | $\beta$        | SE    | 95%CI            |
|-------------------------------|----------------|-------|------------------|
| Constant                      | -3.933         | 5.572 | (-14.916, 7.051) |
| Trauma Exposure-TEC Child     | <b>-0.755*</b> | 0.357 | (-1.459, -0.051) |
| Child Discharged "Successful" | -3.972         | 3.070 | (-10.024, 2.080) |
| Hispanic                      | -0.050         | 2.164 | (-5.908, 6.188)  |
| Black Non-Hispanic            | 0.140          | 3.068 | (-5.908, 6.188)  |
| Sex(male)                     | 2.013          | 1.999 | (-1.927, 5.954)  |
| Child age                     | -0.419         | 0.558 | (-1.519, 0.680)  |
| R <sup>2</sup>                | 0.039          |       |                  |
| F                             | 1.431          |       |                  |

\* p<.05 As compared to White females

\*\*p<.01 Outliers were found and corrected for CPSS5 child change score

\*\*\*p< .001 Another Race Non-Hispanic removed due to low sample size



**Table B5.** Logistic Regression analyses for predicting any child symptom RCI from selected background characteristics (CBITS)

| Predictors                         | N   | $\beta$          | SE    | Wald   | $e^{\beta}$ (95% CI) |
|------------------------------------|-----|------------------|-------|--------|----------------------|
| Hispanic                           | 162 | <b>0.718*</b>    | 0.350 | 4.216  | 2.051 (1.033, 4.072) |
| Black Non-Hispanic                 | 76  | -0.248           | 0.377 | 0.435  | 0.780 (0.373, 1.632) |
| Sex (Male)                         | 105 | -0.037           | 0.312 | 0.014  | 0.963 (0.522, 1.776) |
| Child Age                          | 332 | <b>0.211***</b>  | 0.064 | 10.810 | 1.235 (1.089, 1.401) |
| Trauma Exposure from TEC           | 332 | 0.023            | 0.047 | 0.254  | 1.024 (0.934, 1.122) |
| Child Discharged as "Unsuccessful" | 59  | <b>-3.585***</b> | 0.442 | 65.880 | 0.028 (0.012, 0.066) |
| Constant                           |     | -1.964           | 0.943 | 4.339  | 0.140                |

\* $p < .05$  As compared to White females

\*\* $p < .01$  "Another NonHispanic" removed due to small sample size.

\*\*\* $p < .001$



**Table B6.** Logistic Regression analyses for predicting any child symptom RCI from selected background characteristics (BB)

| Predictors                         | N   | $\beta$          | SE    | Wald   | e <sup>B</sup> (95% CI) |
|------------------------------------|-----|------------------|-------|--------|-------------------------|
| Hispanic                           | 133 | 0.017            | 0.296 | 0.003  | 1.017 (0.570, 1.815)    |
| Black Non-Hispanic                 | 41  | -0.476           | 0.403 | 1.391  | 0.621 (0.282, 1.370)    |
| Sex (Male)                         | 142 | 0.388            | 0.274 | 2.005  | 1.473 (0.862, 2.520)    |
| Child Age                          | 282 | <b>0.169*</b>    | 0.076 | 4.901  | 1.184 (1.020, 1.375)    |
| Trauma Exposure from TEC           | 282 | 0.010            | 0.049 | 0.046  | 1.011 (0.918, 1.112)    |
| Child Discharged as "Unsuccessful" | 34  | <b>-1.950***</b> | 0.430 | 20.534 | 0.142 (0.061, 0.331)    |
| Constant                           |     | -0.743           | 0.673 | 1.218  | 0.476                   |

\*p<.05 As compared to White Females

\*\*p<.01 "Another NonHispanic" removed due to small sample size.

\*\*\*p< .001



**Table B7. Logistic regression analyses for predicting treatment completion from selected background characteristics (CBITS)**

| Variable                  | <i>N</i> | $\beta$ | <i>SE</i> | <i>Wald</i> | <i>e<sup>B</sup></i> (95% <i>CI</i> ) |
|---------------------------|----------|---------|-----------|-------------|---------------------------------------|
| Hispanic                  | 162      | -0.272  | 0.348     | 0.613       | 0.762 (0.385, 1.506)                  |
| Black Non-Hispanic        | 76       | 0.138   | 0.430     | 0.103       | 1.148 (0.494, 2.667)                  |
| Sex (Male)                | 105      | -0.181  | 0.314     | 0.335       | 0.834 (0.451, 1.543)                  |
| Child age                 | 332      | -0.054  | 0.044     | 1.522       | 0.948 (0.87, 1.032)                   |
| Trauma Exposure-TEC Child | 332      | 0.017   | 0.047     | 0.140       | 1.018 (0.928, 1.115)                  |
| Constant                  |          | 2.335   | 0.794     | 8.644       | 10.334                                |

\**p*<.05 As compared to White Females

\*\**p*<.01 Another Race Non-Hispanic was removed due to small sample size

\*\*\**p*< .001

**Table B8. Logistic regression analyses for predicting successful discharge from selected background characteristics (BB)**

| Variable                  | <i>N</i> | $\beta$ | <i>SE</i> | <i>Wald</i> | <i>eB</i> (95% <i>CI</i> ) |
|---------------------------|----------|---------|-----------|-------------|----------------------------|
| Hispanic                  | 133      | 0.762   | 0.430     | 3.141       | 2.142 (0.923, 4.973)       |
| Black Non-Hispanic        | 41       | -0.356  | 0.481     | 0.549       | 0.7 (0.273, 1.797)         |
| Sex (male)                | 142      | -0.317  | 0.378     | 0.700       | 0.729 (0.347, 1.53)        |
| Child age                 | 282      | 0.045   | 0.104     | 0.189       | 1.046 (0.854, 1.282)       |
| Trauma Exposure-TEC Child | 282      | 0.008   | 0.066     | 0.016       | 1.008 (0.886, 1.147)       |
| Constant                  |          | 1.487   | 0.907     | 2.685       | 4.423                      |

\**p*<.05 As compared to White Females

\*\**p*<.01 Another Race Non-Hispanic was removed due to low sample size

\*\*\**p*< .001

## IX. APPENDIX C: RELIABLE CHANGE INDEX

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

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

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

## X. APPENDIX D: QI OVERVIEW

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

| QI Indicators                                                | Benchmark                                                  | QI Description                                                                                                                                                                                                    |
|--------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Engagement</b>                                            | 85% of closed episodes                                     | Percentage of closed episodes with four or more clinical sessions attended. Starting SFY21 the benchmark for this indicator changed from 55% to 85%.                                                              |
| <b>Outcome Data Available/<br/>Measures</b>                  | 70% of closed and engaged episodes                         | Percentage of closed and engaged treatment episodes with at least one measure available at two different time points for any measure of child or caregiver symptoms.                                              |
| <b>Symptom Improvement/<br/>Improved Outcomes</b>            | 75% of closed and engaged episodes with measures available | Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change (symptom improvement only) on any measure. Includes any measure of child or caregiver symptoms. |
| <b>Consistent Care</b>                                       | 65% of closed and engaged episodes                         | Percentage of closed and engaged treatment episodes with an average of two or more treatment episodes per month. Calculated by dividing the LOS by number of visits.                                              |
| <b>All Components/<br/>Model Completion<br/>*TF-CBT Only</b> | 30% of closed and engaged episodes                         | <p>Percentage of closed and engaged treatment episodes that fully complete the model. Model completion definitions are:</p> <ul style="list-style-type: none"> <li>completion of 8 or more sessions</li> </ul>    |





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