# Connecticut's Outpatient Psychiatric Clinics for Children

FISCAL YEAR 2024 ANNUAL REPORT

Child Health and Development Institute

CONNECTICUT Children & Families

## Connecticut's Outpatient Psychiatric Clinics for Children

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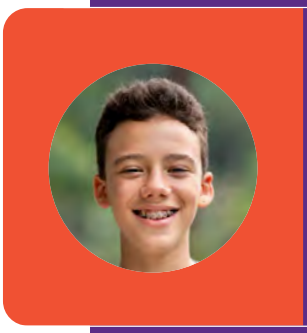
# I. EXECUTIVE SUMMARY

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 behavioral 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 QI 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) 2024** (July 1, 2023 through June 30, 2024). OPCC providers have had to navigate a changing landscape of increasing youth and family needs alongside workforce challenges that impact service delivery. Despite these challenges, **OPCC providers demonstrated strong results in access, quality, and outcomes.**

## KEY FINDINGS FY24:



**27,248** children were served with an average of **22** sessions per treatment episode, maintaining a trend in high utilization and engagement.

Over half of all children served **(50.8%)** received an EBP and **237 OPCC clinicians** were trained in DCF-supported Evidence-based practices (EBPs) or best practices.

Black youth were less likely to receive a DCF-supported EBP compared to White youth.

Increased engagement in treatment was seen with **83.1%** of children completing **4+** sessions, up **14%** from the prior year.

Despite increased engagement across populations, Black, Hispanic, and children of another race were less likely to complete **4+ sessions** than White children.

A majority of children experienced significant symptom improvement **(53-56%)**, exceeding the 50% benchmark.

**The most common primary presenting problems among children served were:**

- Anxiety **(24.3%)**
- Disruptive Behavior **(19.9%)**
- Depressive Disorders **(17.4%)**
  Trauma/PTSD **(11.8%)**

**62.1% of children** met treatment goals overall, with goals met for **76%** of those receiving DCF-supported EBPs.

Receiving an EBP eliminated disparities in meeting treatment goals across race and ethnicity.

## KEY RECOMMENDATIONS:

- Promote the use of briefer EBPs (e.g., MET/CBT)/single-session substance use and trauma-informed interventions (e.g. A-SBIRT, T-SBIRT), to improve access to needed treatment in a shorter amount of time.
- Examine trends in discontinuation by provider to prioritize targeted strategies for improving youth and family engagement, particularly for Black and Hispanic youth and families.
- Provide training on diagnostic bias and engaging diverse youth to increase clinician awareness of providing equitable care.
- Due to the continued higher volume of OPCC youth served, invest in resources that support workforce hiring, training support, and retention strategies including funding for non-clinical professionals to support clinicians and clients.

# II. INTRODUCTION

The Connecticut (CT) Department of Children and Families (DCF) contracts with the Child Health and Development Institute (CHDI) to provide quality improvement (QI) services to 22 Outpatient Psychiatric Clinics for Children (OPCC).

**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 state fiscal year (FY) 2023 (July 1, 2023 through June 30, 2024).

## Background

The OPCC Quality Improvement Center works with a network of 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 behavioral 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 evidence-based practices (EBPs)

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

## Achievements from Previous Fiscal Year

Last year's annual report identified recommendations related to data collection and analysis, service improvement, and state investment in outpatient services. Progress was made on many of these recommendations.

A major focus of recommendations from last year's report was improving equity through enhanced race data quality and addressing inequitable access to evidence-based practices (EBPs). Two key recommendations included improving rates of missing race and ethnicity data by 50%, and updating the race and ethnicity data fields to align with newly mandated statewide requirements. To that end, CHDI integrated missing race data and EBP access rates by race and ethnicity into QI reports for consultation. Consultation also included CHDI staff co-developed individualized Specific, Measurable, Attainable, Relevant, Time-Bound, Inclusive, & Equitable (SMARTIE) goal-setting to promote inclusive and equitable implementation at the site level. **Through these efforts, rates of missing race and ethnicity data decreased from 14% in FY23 to 7.9% for FY24.** DCF updated the race and ethnicity data fields to align with state-mandated changes at the end of the fiscal year, which will ultimately improve race and ethnicity data quality, but technical difficulties with that change led to a larger amount of missingness (12.3% of discharged cases) in the data CHDI received at the end of FY24 that is used in analyses in this report. That data was subsequently corrected, with only 7.9% cases missing, but it was not corrected in time for the analyses in this report, therefore findings related to race and ethnicity should be interpreted with caution.

The integration of race/ethnicity data availability and access rates by race/ethnicity into provider consultation reports sparked productive discussions during site visits and statewide meetings, prompting providers to investigate their own disparities in EBP access. CHDI also completed recommended data analyses on differences in presenting problems by race and ethnicity, and potential child-level and provider-level causes of lower TF-CBT access for Black and Hispanic youth. These analyses were also discussed in statewide meetings, and resulted in plans for training on bias reduction in diagnosis and assessment. CHDI published an issue Brief in September 2023 on Adapting Evidence-Treatments for Children of Diverse Backgrounds which will be summarized during an OPCC provider meeting. OPCC providers were invited to the Annual EBP Conference hosted by CHDI on June 4, 2024, and twenty-one sessions (61.8%) met the NASW CE Cultural Competency requirement, supporting training in care for diverse populations.

Recommendations also called for expanding the array of EBPs to include briefer and more flexible interventions. CHDI worked with DCF in FY24 to pilot **Single-Session Consultation (SSC)** with four providers, primarily for clients on waitlist or in initial therapy sessions. Among youth who completed outcome questions, all indicated that SSC was at least "a little" helpful, and 83% indicated is was "somewhat" or "mostly" helpful. Additionally, the array of trauma-informed EBPs was expanded in FY24 to include **Attachment, Regulation, and Competency (ARC),** providing support for an additional EBP for trauma that can be used for a wide age range and with youth for whom TF-CBT is not a good fit. **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** was also added to provide a brief motivational intervention for youth screening with substance use embedded within their outpatient episode of care.

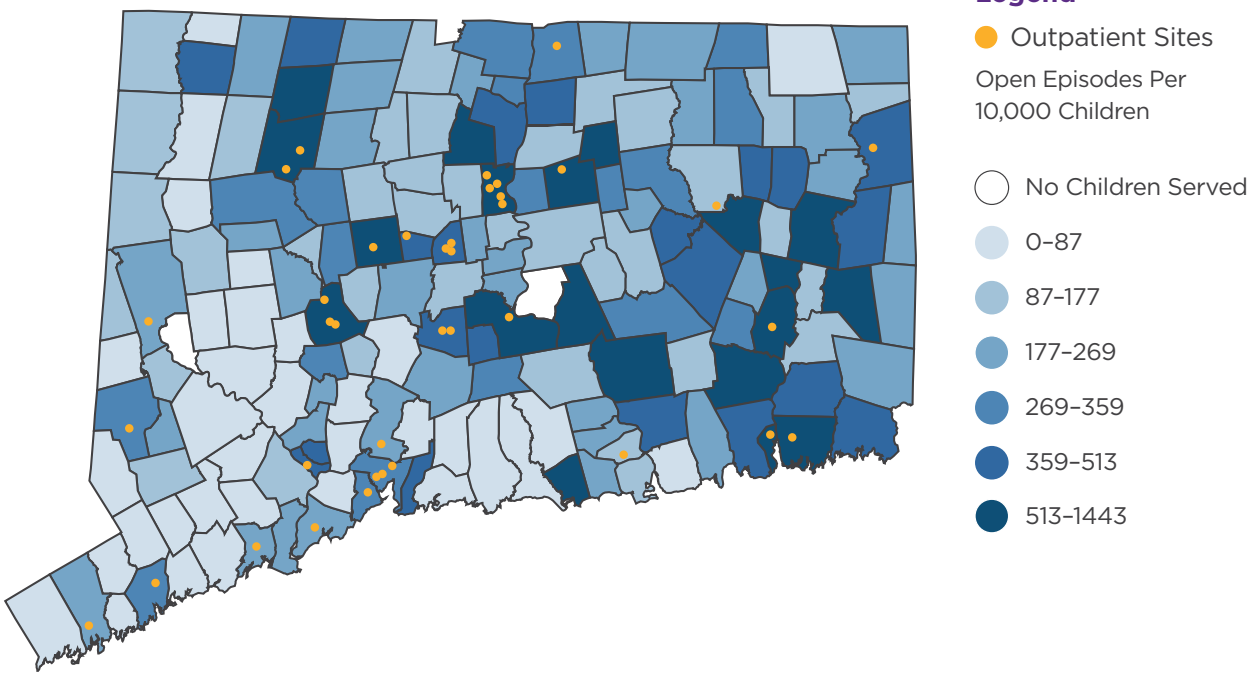
Last year's report further recommended increasing funds and resources to support outpatient workforce hiring, development, and retention, including funding for non-clinical professionals to support clinicians and clients. CHDI staff working with outpatient providers advised on the development of an **online self-paced learning system, Kids Mental Health Training,** making children's behavioral health trainings available to OPCC providers through a separate project with funding from DCF and CHDI. Providers also identified a need to utilize EBP sustainability funds to support the workforce and proposed that CHDI integrate language into performance incentive fund letters in FY25 encouraging the use of sustainability funds for staff retention.

# III. ACCESS TO OPCC SERVICES IN CONNECTICUT

Across the network of 22 OPCC providers, a total of 27,248 children were served in FY24. 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 FY24, relative to each town's child population (episodes per 10,000 children). Table 1 describes characteristics of the children served by OPCCs in FY24 with comparison rates of the general population. Overall, OPCCs primarily served children between ages 6-17 (90%) and children served were most likely to identify as White (50.3%). Compared to the general CT population, youth in OPCC services were more likely to identify as being Black and Hispanic. The number of youth served by OPCC providers has remained high, maintaining a 14% increase since a decline during the first year of the Covid-19 pandemic, and exceeds the number served prior to the pandemic by 10%, even with two fewer providers (Figure 2). Children served included 12,190 who initiated treatment during FY24, and 15,058 whose treatment episodes began prior to the fiscal year.

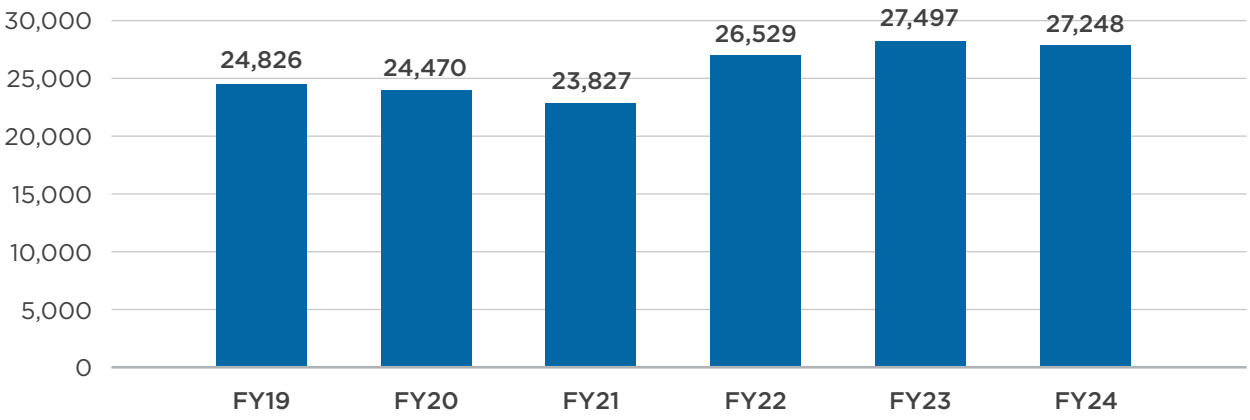
**Figure 1.** Map of OPCC Sites and Children Served

### OPCC Open Episodes per 10,000 Children SFY 2024



| Table 1. Characteristics of children receiving OPCC services, with comparisons (n= 27,248) | | | |
|---|---|---|---|
| | OPCC | | CT pop[2] |
| | N | % | % |
| **Sex** | | | |
| Male | 13346 | 49.0 | 51.2 |
| Female | 13902 | 51.0 | 48.8 |
| **Race** | | | |
| American Indian or Alaska Native | 124 | 0.5 | 0.3 |
| Asian | 315 | 1.2 | 4.8 |
| Black or African American | 4477 | 16.4 | 11.9 |
| Native Hawaiian or Pacific Islander | 54 | 0.2 | 0.1 |
| White | 13850 | 50.8 | 53.4 |
| Other Race/Ethnicity (includes multiracial/ethnic) | 826 | 3.0 | 29.6 |
| **Missing/Declined** | **7602** | **27.9** | **-** |
| **Hispanic, Latino, or Spanish (any race)** | **9479** | **34.8** | **27.5** |
| **Age[3] (years)** | | | |
| Under 6 years | 2714 | 10.0 | 29.9 |
| 6–11 years | 12048 | 44.4 | 32.9 |
| 12–17 years | 12402 | 45.7 | 37.2 |
| **Child Primary Language** | | | |
| English | 21675 | 79.5 | 77.8 |
| Spanish | 2716 | 10.0 | 13.4 |
| Neither English nor Spanish | 470 | 1.7 | 8.7 |
| Nonverbal | 310 | 1.1 | – |
| Missing | 2077 | 7.6 | – |
| **Child Welfare Involvement During Treatment** | **3642** | **13.4** | **3.4[4]** |
| **JJ Involvement During Treatment** | **300** | **1.1** | **N/A** |

**Figure 2.** Youth Served in OPCC FY19–FY24




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 FY22 CT Data for total number of CPS reports and 2020 U.S. Census estimates for 0–19 year olds.

## OPCC Youth Discharged in FY24

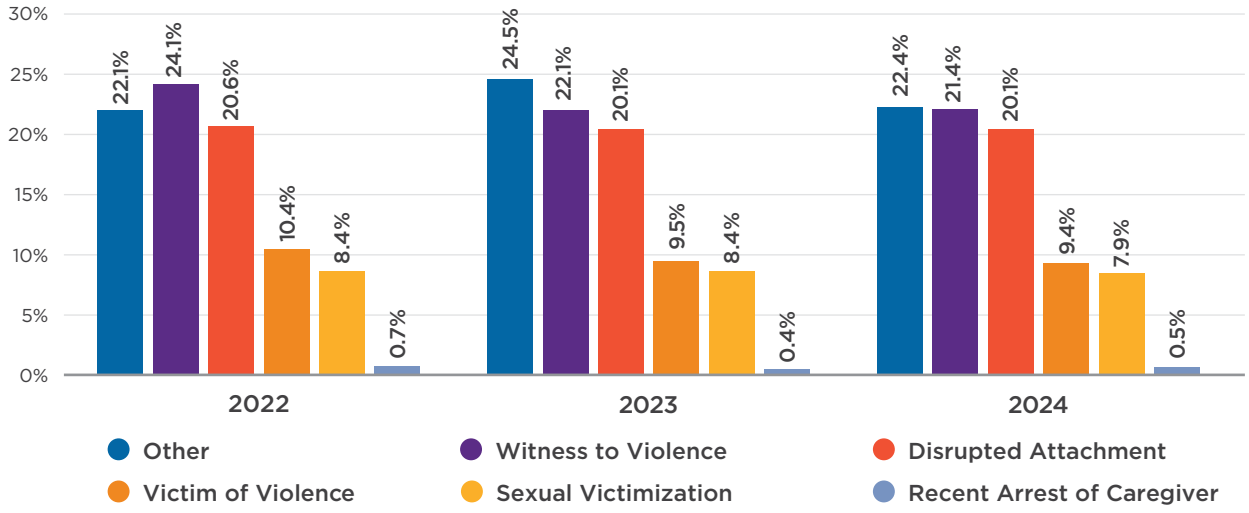
A total of 11,217 children ages 0-18 were discharged in FY24. Children who were referred for an evaluation only, or who a clinician indicated withdrew from treatment after less than four sessions and did not respond to attempts to re-engage made up 16.1% of children discharged. These episodes are considered "evaluation only," excluding them from most data collection requirements. Of the children discharged, 83.9% 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 A1 in Appendix A 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 9,182 youth discharged from OPCC services with data collection required (see Appendix A, Figure A1).

### *Trauma Exposure*

At intake, clinicians report on trauma exposure across six different trauma types (see Figure 3). Of those discharged in FY24, over half (55.3%) of youth experienced at least one type of trauma and some youth experienced multiple types of trauma (average number was 0.8). 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 (56.1%), Hispanic (57.1%), and White youth (54.5%) were more likely to report having any trauma exposure than youth of Another Race or Ethnicity (52.8%). Female youth reported experiencing trauma exposure at higher rates (57.9%) than males (52.5%).

**Figure 3.** Types of Trauma Exposure at Intake



## *Substance Use*

Information on substance use is collected at intake using several methods, including an item on the Ohio Scales Problem Severity Scale indicating how often alcohol or drug use has been a problem for the youth in the last month. Parents and workers complete this item for children ages 5 and older, and youth ages 12 and up complete a self-report. Among youth ages twelve and over who were discharged in FY24, rates of reporting any drug or alcohol use in the previous month ranged from 15.3%–17.9% across reporters. This represents a continuous increase over FY22 (12.2%-14.4%) and FY23 (13.8%-16.5%).

## *Presenting Problem*

Among children discharged in FY24, the most common presenting problem categories were Anxiety (24.3%) followed by Disruptive Behavior (19.9%), Depressive Disorders (17.4%), and Trauma (11.8%). Anxiety continued its post-pandemic trend as the most common presenting problem, with disruptive behavior being the second most common. Trauma-related presenting problems continued a trend of increasing over the last four years. (see Figure 4). Figure 5 shows the breakdown of primary presenting problem by race/ethnicity.[5]

**Figure 4.** OPCC Primary Presenting Problem at Intake

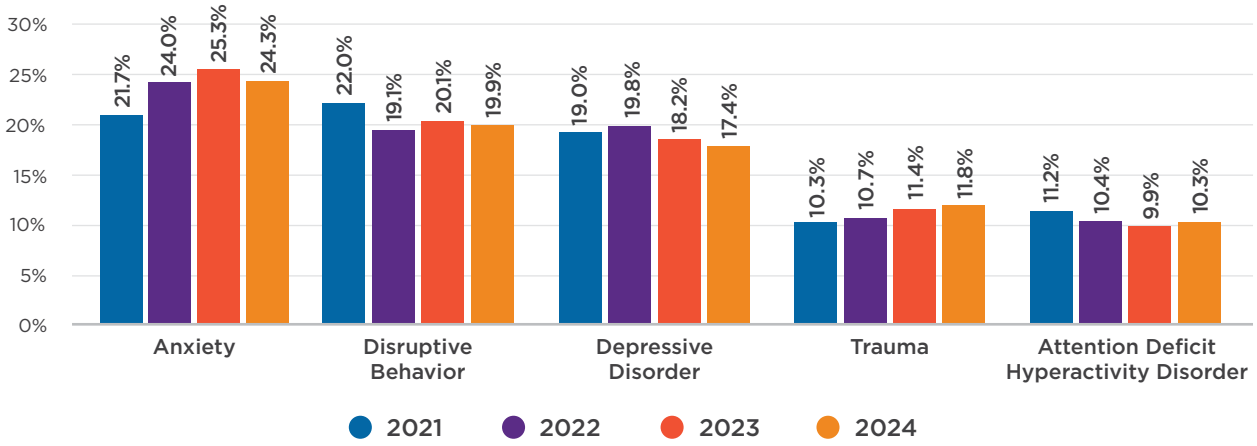
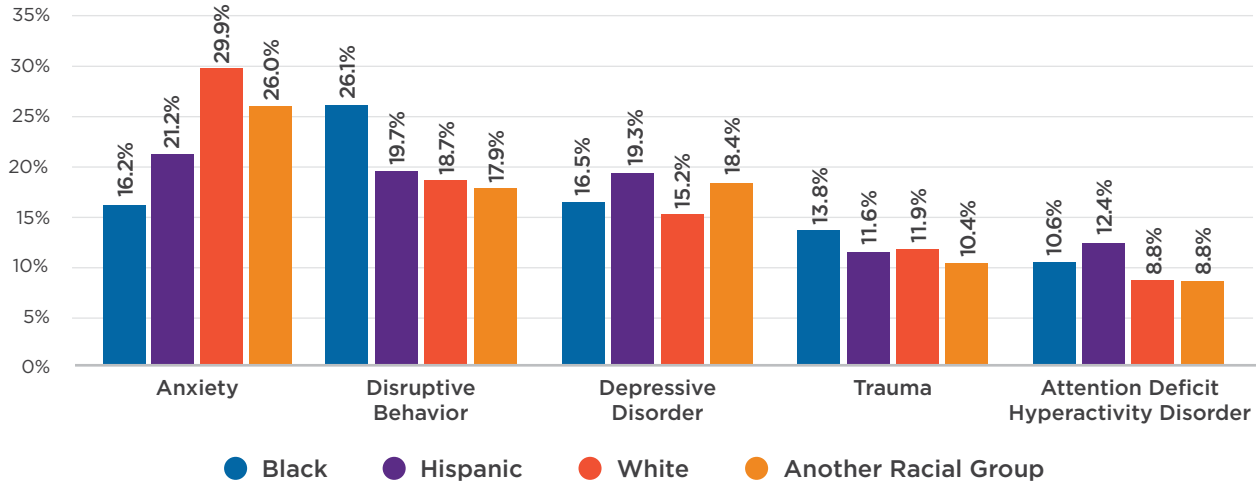



**Figure 5.** Racial/Ethnic Differences in Primary Presenting Problem




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 (77.6%), Multiracial (14%) and Asian (6.7%)

## DIFFERENCES IN PRIMARY PRESENTING PROBLEM BY RACE/ETHNICITY:

**Anxiety**
Highest rates for White youth, but all groups differed.

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

**Depression and ADHD**
Hispanic youth had higher % than White or Another Race.

**Trauma**
Higher % for Black youth than Another Race.

# IV. QUALITY OF OPCC SERVICES IN CONNECTICUT

## Treatment Information

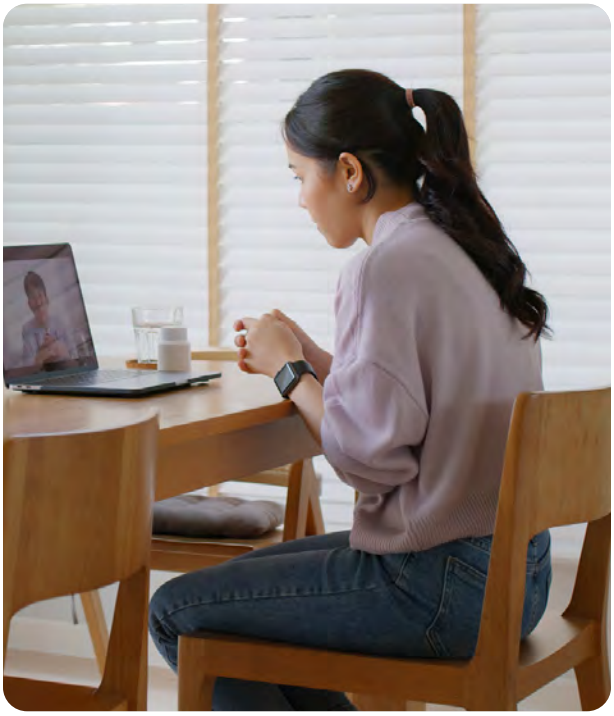
Activity data is date-based, session-level information entered during the episode or at discharge about the type of treatment provided. Of the 9,182 discharged and receiving treatment with data requirements, 6,612 (72.0%) had at least one activity data record corresponding to a treatment session.[6]

## Number of Sessions

The overall number of treatment sessions quantifies the dose of treatment received by a child. Of the children discharged in FY24, the mean number of sessions was 22.0 (SD= 22.5) and the median (50th percentile) was 14 sessions.[7] This represented a continued increase in the typical number of sessions over FY22 and FY23, which could suggest children and families are engaged for longer.

## Format of Sessions

Of all activity data reported for FY24, 22.3% were indicated as telehealth sessions, a substantial decrease from FY23 (32.5%) and FY22 (38.5%). While over half (61.8%) of youth discharged had only in-person treatment sessions, 33.6% had a hybrid of in-person and telehealth sessions, and 4.6% had telehealth sessions only, representing an increase in in-person only treatment compared to FY23 (52.9%). Youth receiving telehealth only were slightly older (12.4 years) compared to in-person only (11.1 years) and hybrid (11.1) youth. Youth receiving hybrid episodes were less likely to have fewer than four sessions (including intake) compared to in-person or telehealth only. White (37.1%) and Another Race (42.0%) youth received hybrid telehealth/in-person treatment at higher rates than Black (27.9%) and Hispanic youth (27.7%), who were more likely to have in-person only.



## Use of EBPs

OPCC providers may identify whether any EBP 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 EBPs, 50.8% (n=4,663) of children received an EBP during their treatment, 10% increase over FY23 (n=4,224). Of these, 3,695 (79.2%) received Cognitive Behavioral Therapy, 655 (14%) received Motivational Interviewing, 531 (11.4%) received Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and 510 (10.9%) received Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct (MATCH-ADTC). Children may have received more than one EBP during their treatment

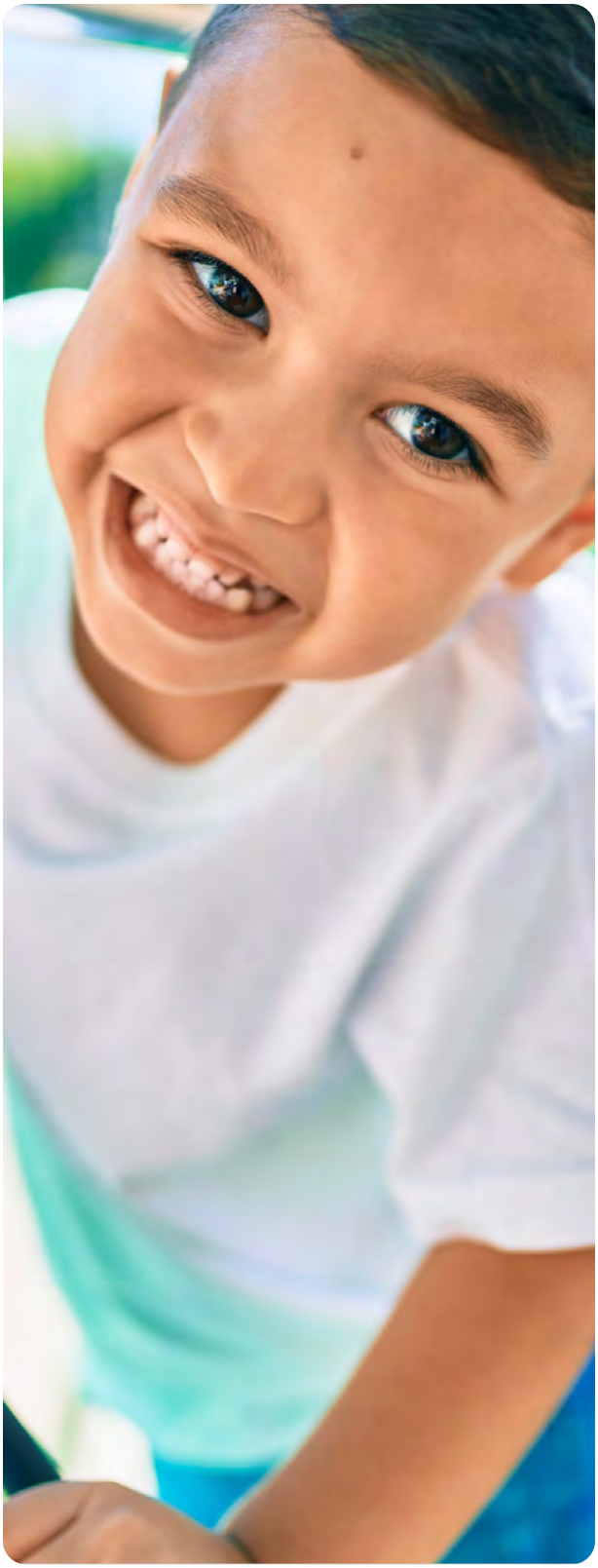
6. Excludes cases with activity for an intake only with no subsequent treatment sessions.
7. Number of sessions was winsorized to address 144 cases that were extreme outliers (based on 3*Interquartile Range above the 75th percentile) with 99–81 sessions.

episode. No other EBP was used 5% or more of the time. One of the DCF-supported outpatient EBPs (MATCH or TF-CBT) was provided according to best practice guidelines in 7.7% of OPCC episodes, with the rates ranging from 0% – 17.6% across providers.

In analyses accounting for age, sex, and DCF involvement, DCF-involved, older youth, and female youth were more likely to receive a DCF-supported EBP (MATCH-ADTC, TF-CBT) according to best-practice guidelines, and Black youth were less likely to receive them (Appendix B, Table B1). This suggests that, when DCF involvement, age, and sex are the same, Black youth are less likely to access these treatments. Rates of TF-CBT and MATCH service access by race are monitored in CHDI's Disproportionality Report, which is conducted annually.

## Early Discontinuation

In FY24, a total of 11,217 children were discharged from outpatient treatment, and 16.1% (n=1,809) of all children were classified as evaluation only by their agency, which exempts the episode from many of the data collection requirements. 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, including intake. There were 1,311 cases marked as evaluation only due to early discontinuation (11.7% of all discharged cases) and an additional 593 treatment episodes had less than four sessions and were not designated by the clinician as evaluation only. Overall, 1,904 (16.9%) discharged cases discontinued treatment with less than four sessions, representing a decrease compared to FY23 (19.7%). White youth (14.7%) were less likely to have fewer than four treatment sessions than Black (20.5%), Hispanic (18.1%) and youth of Another Race (17.9%), even when controlling for other demographic factors (Appendix B, Table B2).



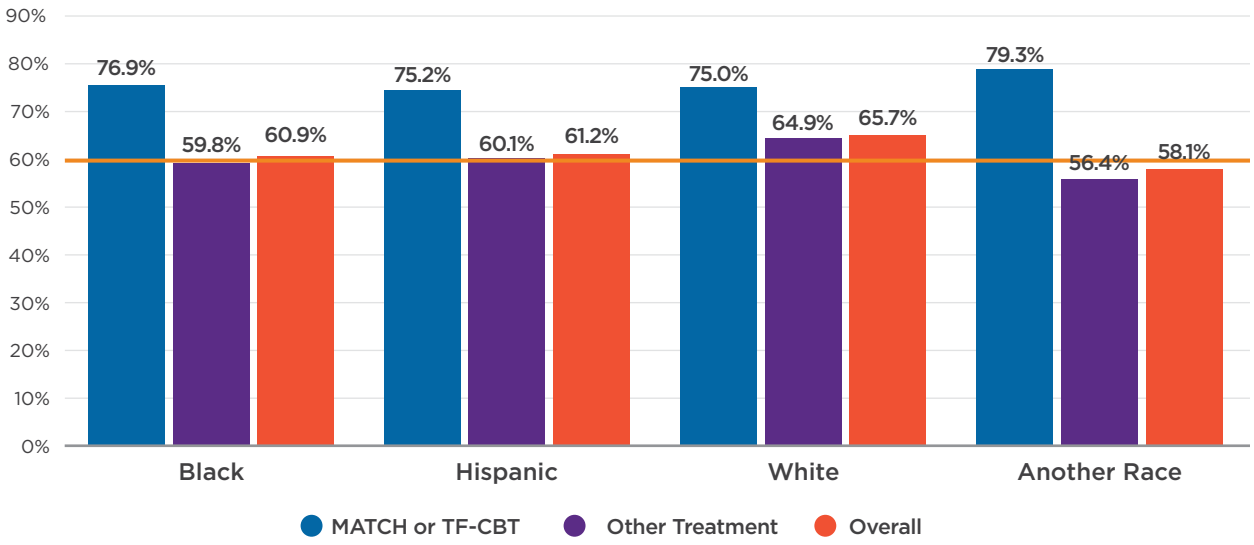
# V. OUTCOMES OF CHILDREN RECEIVING OPCC SERVICES

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 Clinical Global Impressions (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[8] are administered at intake, 90 days after intake, and discharge to measure treatment progress. Outcomes across these categories are presented below; including overall outcomes and relevant breakdowns by subgroup.

## Treatment Goals

DCF's benchmark for met treatment goals for each individual agency in FY24 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, 62.1% of children met treatment goals; 12 of 22 (55%) agencies met the benchmark. Episodes of care in which a DCF-supported EBP with fidelity was used met treatment goals 76.0% of the time compared to only 60.9% for episodes with treatment as usual or another EBP. Figure 6 shows racial group percentages that met treatment goals. **Youth receiving a DCF-supported EBP met treatment goals at equivalent rates across race and ethnicity, whereas among youth receiving other treatments White youth met treatment goals at higher rates than other youth, as seen in Figure 6.**

**Figure 6.** Met Treatment Goal by Race/Ethnicity and EBP Receipt




8. 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.

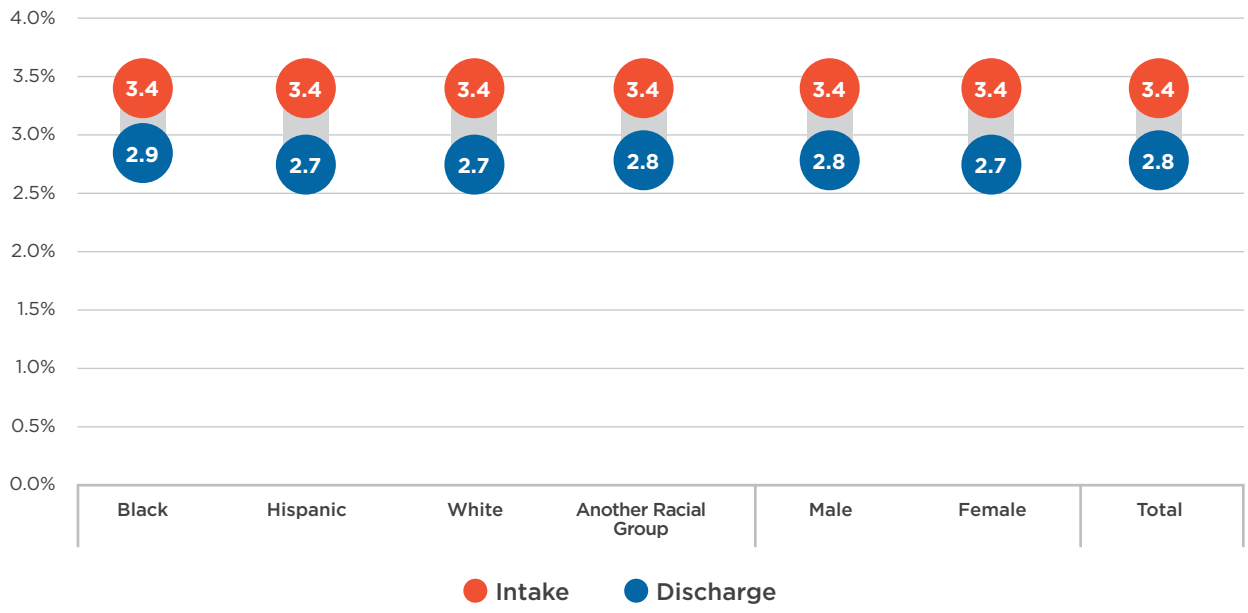
Regression analysis found ***children who received a DCF-supported EBP with best practices (TF-CBT, MATCH) had over twice the odds of meeting treatment goals than those who had any other treatment.*** DCF-involved children were less likely to have met treatment goals than those without DCF involvement (see Appendix B, Table B3). ***White youth were more likely to meet treatment goals than youth of any other race or ethnicity.*** (see Appendix B, Table B3).

## 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 7,649 cases where CGI-I was completed, clinicians reported that improvement was made in 70.6% of discharged episodes.

Of the 6,578 cases with CGI-S at intake and discharge, 49.1% changed from a "more severe" to a "less severe" category from intake to discharge. An additional 34.9% showed no change on the CGI-S. There were no differences in change in the CGI-S by race, and males showed less improvement on CGI-S than females, as seen in Figure 7. Clinicians reported symptom improvement for 69.1% of youth using the CGI-I. Information on CGI data availability can be found in Appendix A.

**Figure 7.** Change in CGI Severity from Intake to Discharge by Subgroup



## Ohio Scales

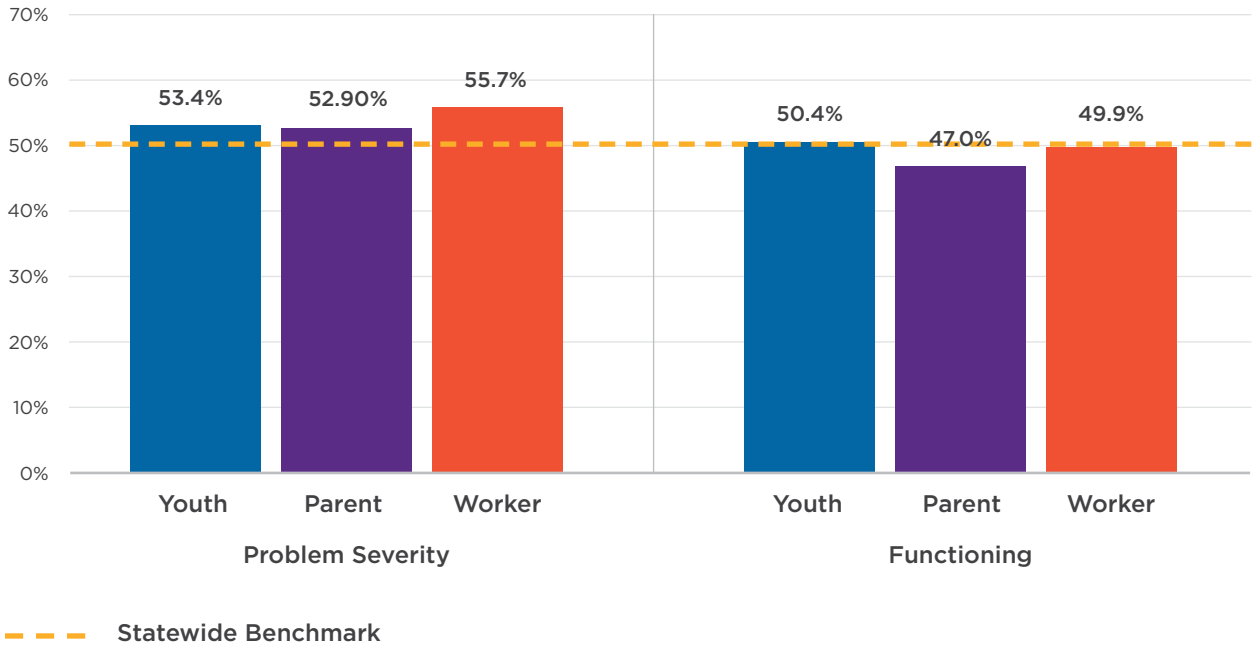
The Ohio Scales include 40 items that measure the degree of problems a child is currently experiencing (Problem Severity) and the degree to which a child's problems affect their day-to-day activities (Functioning). There are three versions: Youth-report, Parent-report, and Worker-report completed by the clinician. Scales are administered at intake, 90 days after intake, and discharge. The use of three reporters adds confirmatory value, as if all three reporters agree then a trend is unlikely to be a fluke. The availability rate in FY24 was 34.4% for Youth report, 29.8% for Parent report, and 72% for Worker report, with no consistent differences by race, ethnicity, or sex across reporters when controlling for other child factors (Appendix B, Table B4). Further information on data availability can be found in Appendix A.

***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 better for hybrid format per worker and parent report.

***5-point Improvement.*** 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.

In FY24, rate of improvement for all reporters exceeded the 50% benchmark for Problem Severity, but only youth reports exceeded the benchmark for Functioning. Statewide results on these indicators are shared in Figure 8 below.

**Figure 8.** Rates of Improvement on Ohio Problem Severity and Functioning



***Clinical Improvement across Groups on Problem Severity and Functioning.***[9] 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 EBP receipt on symptom improvement, the only consistent findings across reporters showed ***children who received DCF-supported EBPs (TF-CBT, MATCH) had greater improvement in Functioning across all reporters, and DCF-involved youth had less improvement in Problem Severity and Functioning.*** (Appendix B Tables B5–B7). No other finding consistently predicted changes in Problem Severity or Functioning across reporters. Intake and discharge scores for Problem Severity and Functioning by race/ethnicity can be found in Appendix C.

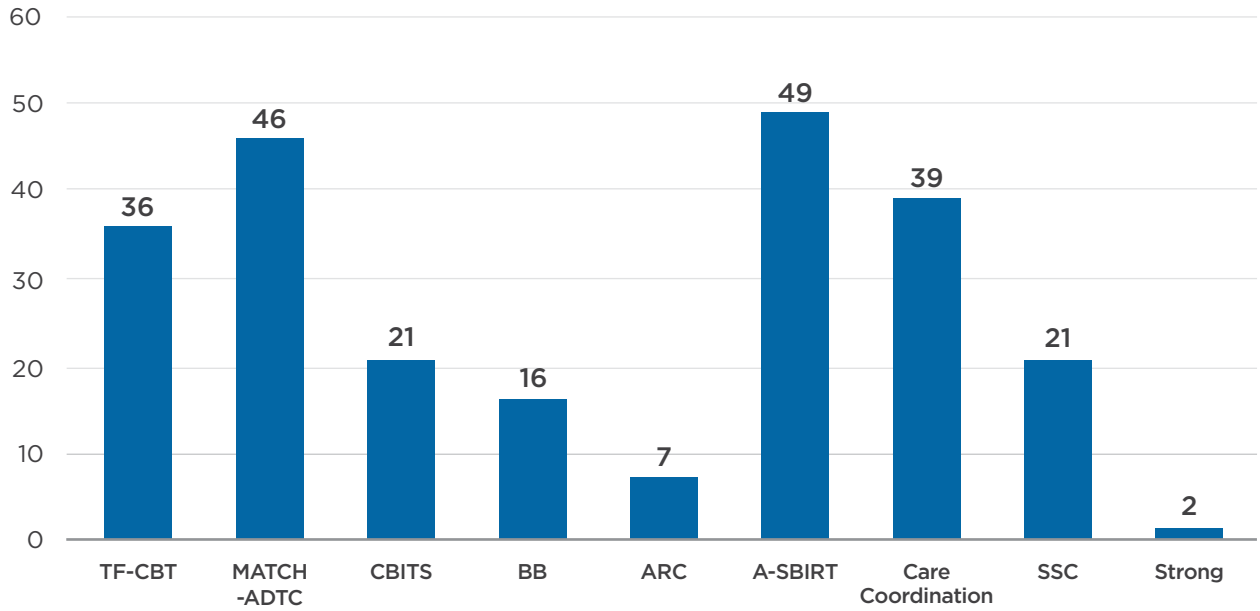
9. A substantial portion of Ohio scale data showed identical responses to all items at both timepoints, suggesting an intake Ohio was duplicated for the discharge Ohio. For Problem Severity there were 100 Youth, 208 Parent, and 463 Worker, and for Functioning there were 104 Youth, 197 Parent, and 477 Worker exact duplicates for all items. These cases were excluded from this analysis of change in Ohio scores from intake to discharge to prevent biased test results.

# VI. TRAINING AND WORKFORCE DEVELOPMENT

In collaboration with DCF, CHDI aims to expand the use of EBPs (some of which are funded through separate contracts) and to improve the quality of outpatient care. The EBPs of particular focus include Bounce Back (BB); Cognitive Behavioral Intervention for Trauma in Schools (CBITS); Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, and Conduct (MATCH-ADTC); and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). In addition to these EBPs, CHDI provides support for OPCC providers in the Attachment, Self-Regulation, and Competency (ARC) model and Child Parent Psychotherapy (CPP), which were established through a SAMHSA grant, and Screening, Brief Intervention, and Referral to Treatment (SBIRT, which includes the adolescent adaptation, A-SBIRT), and Wraparound Care Coordination though Connecticut's 1115(a) Demonstration Waiver. CHDI, in collaboration with DCF, also piloted Single-Session Consultation (SSC) and Supporting Transition Resilience of Newcomer Groups (STRONG) this fiscal year. **In FY24, 126 OPCC clinicians were trained in one or more of these EBPs and an additional 111 were trained in other best practices** (Figure 9).

In addition to these EBPs, CHDI hosted the 2024 Evidence-Based Practice Conference, which provided 228 OPCC staff training from state and national experts to enhance their trauma-informed skills and best practice knowledge.

**Figure 9.** OPCC Clinicians Trained in EBTs and Best Practices in FY24



# VII. OUTPATIENT COORDINATING CENTER IMPLEMENTATION SUPPORT ACTIVITIES

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 FY24, CHDI co-chaired and coordinated 10 meetings. The first in-person meeting since pre-Covid was held and will continue at least once per year. Consistent themes throughout the year were workforce needs (e.g., staff retention/compensation, significant training for new staff), client engagement, statewide policy and budget advocacy efforts, equitable care, and interest in new programs and EBPs (e.g., UCC, SSC, SBIRT, Urban Trauma). At providers' request, CHDI and DCF began offering an optional Data Meeting every other month, commencing in May, 2024. This meeting provides an opportunity to discuss technical details related to data system updates and providers' data questions, and to facilitate peer-to-peer collaboration and support among providers related to data systems.

## 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-developed individualized Specific, Measurable, Attainable, Relevant, Time-Bound, Inclusive, & Equitable (SMARTIE) goals with OPCC agencies that target areas of growth or concern and encouraged agencies to include goal setting that integrates inclusivity and equity specifically. In FY24, agencies invested a high amount of effort to ensure strong data collection and quality care with a focus on race data collection and equitable 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 SMARTIE goals and support OPCC providers to meet benchmarks. During FY24, MATCH-ADTC and TF-CBT access rates by race and ethnicity were added to agency dashboards in order to facilitate improvements in equity in access to these EBPs.

## Connecticut Provider Support Survey (CT-PSS)

CHDI conducted the annual CT-PSS in August-October, 2023. Respondents included clinicians, supervisors, and administrators within the OPCC network, as well as those who provide DCF-supported Evidence-based practices (EBPs). There were 309 OPCC respondents who fully completed the survey and 16 who completed the vast majority of the survey, representing a 54.4% response rate. Topics covered within the survey fell into four main categories: (1) General Background Information, (2) EBPs, (3) Service Delivery, and (4) Organizational and Staff Wellness. Results from the survey can be found in the statewide report (Appendix D). Broadly, results showed that:

- Since 2022, there has been a slight decrease in perceived workplace supports for implementing EBPs, positive perceptions of the work environment, and measurement-based care practices.
- Since 2022, there has been a slight decrease in average burnout scores, with the top two contributors to burnout being "Administrative burden, including paperwork and data entry" and "Too large of a caseload".
- The top training topics of interest were (1) vicarious and secondary trauma, (2) intellectual developmental disability/autism, (3) substance abuse, (4) self-care strategies, (5) first-episode psychosis, (6) structural/social determinants, and (7) single session/briefer EBP interventions.
- Racial justice and equity remain a strong priority across the OPCC network.

Results of the survey have been used to inform a number of initiatives, including what training topics to prioritize data and reporting needs. Data from the survey were also used in a blog post published by CHDI that highlighted a trend of an increasing proportion of OPCC clinicians who were new to the field (33%), and a simultaneous increase in the proportion of supervisors reporting significant burnout (36%).

## 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 SMARTIE goals for improvement. In FY24, 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
- Duplicate activity data
- Completion of activity data and CGI data
- Updating and maintaining the OPCC Data Quality Guidelines document

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 and rates of missing CGI scores improved substantially over the course of FY24. The optional OPCC Provider Data Meeting every other month serves as an additional space to support improved provider data quality. Providers agreed to name their Electronic Health Record (EHR) systems to CHDI to facilitate meaningful collaboration between providers with the same EHR to improve the quality of data entry.

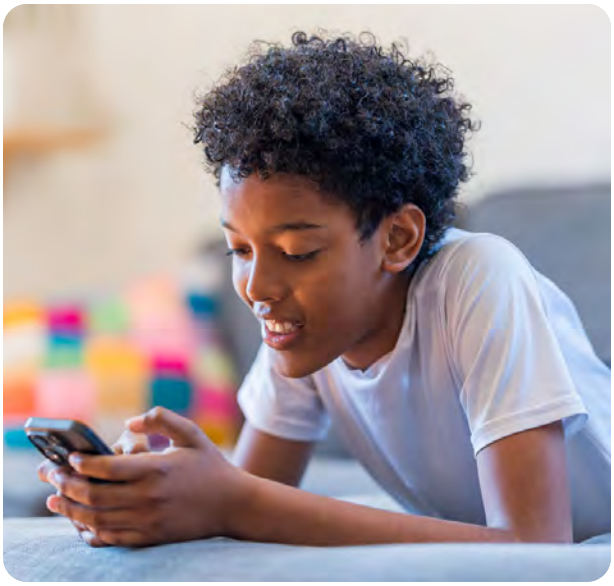
# VIII. SUMMARY AND CONCLUSIONS

Amidst a challenging landscape of youth and family needs and workforce challenges, the number of children who received outpatient mental health services remained high in FY24 at 27,248, a 0.9% decrease from FY23, but consistent with the high volume of service utilization seen in the prior two years. The number of intakes in FY24 increased by 3% compared to the FY23, suggesting the trend of increasing need for services continues. With the increasing proportion of newer clinicians in recent years, a greener workforce is tasked with serving an increasing number of youth following the departure of many experienced clinicians in FY23. Supporting newer staff is taking a toll on supervisors, who experienced burnout at higher rates than in previous years. Providers have also expressed concerns about the increasing complexity of OPCC youth and family needs. Additional workforce supports for OPCC providers, such as more centralized trainings and greater ability to utilize peer supports are critical to allow providers to meet the increasing demands on the system.

OPCC providers maintained a high level of access to services for Connecticut youth and families, serving a similarly elevated number of youth with more in-person sessions compared to previous years and an increase in the average number of sessions from 21.3 to 22.0. Youth engagement improved in FY24, with 16.9% of treatment episodes ending before four treatment sessions compared to 19.7% in FY23. However, Black and Hispanic youth continued to experience higher rates of early discontinuation (17.9 – 20.5%) compared to White youth (14.7%). CHDI, DCF, and OPCC providers discussed this gap in engagement in network meetings and site visits to better understand potential causes. CHDI also explored bias in identifying the primary presenting problem as a possible cause of disparities in engagement and treatment sustainment and has begun planning a training on reducing bias in assessment and diagnosis. Training relating to cultural competency was emphasized in the FY24 Annual EBP conference hosted by CHDI, with 61.8% of sessions meeting NASW CE Cultural Competency requirement. Future trainings focused on building rapport and engagement for new clinicians, particularly with Black and Hispanic families, could increase clinician awareness of providing equitable care to address disparities with engagement and

improve newer clinician self-efficacy. Beyond training needs, further investment in briefer or more flexible EBPs could improve treatment sustainment for Black and Hispanic youth and families.
To that end, CHDI and DCF piloted Single-Session Consultation from February to August 2024 to improve motivation and engagement of youth and families initiating treatment, with positive feedback from clinicians and youth. In the coming year, CHDI will continue looking for training opportunities, ways to use data to understand causes of engagement disparities, and opportunities expand briefer evidence-based practices targeted at engagement and motivation, such as T-SBIRT.

The number of youth who received EBPs also increased this year (n=4,663) such that more than half (50.8%) of all youth discharged from OPCC received at least one EBP session. Some of that increase can be attributed to efforts to train a larger number of clinicians in MATCH-ADTC and TF-CBT in FY23, as well as training in Motivational Interviewing (MI) that many clinicians received in their A-SBIRT training. Though overall EBP access improved in FY24, Black youth were less likely to access DCF supported EBPs (MATCH-ADTC and TF-CBT) compared to White youth. To address this disparity, CHDI integrated EBP access rates by race/ethnicity into provider consultation reports, leading to productive discussions in site visits and statewide meetings. Providers set goals to understand and address EBP access disparities. Understanding how EBPs are working across demographic groups could inform needed EBP investments to better serve diverse youth and families. To address EBP access disparities, ARC, a model effective for young children and complex trauma, was integrated into the EBP array in the second half of FY24. Providers using ARC are serving a higher proportion of Black youth and families compared to TF-CBT and MATCH. CHDI will monitor how TF-CBT, MATCH, and ARC are being used across race, ethnicity, age, and gender in the coming fiscal year to determine how these models may complement each other.



Outcomes for children discharged from OPCC were good, meeting statewide benchmarks for Met Treatment Goals, and for 5-point improvement in 4/6 Ohio Scale outcomes.
A subgroup of DCF-involved youth were less likely to meet treatment goals, which could suggest that cross-system collaboration is needed to support the success of these youth.
As in previous years and in line with research findings,[10] EBP interventions achieved better outcomes than treatment as usual**. Receipt of DCF-supported EBPs predicted higher rates of meeting treatment goals and higher levels of improvement in Ohio functioning for all reports.** White youth met treatment goals at higher rates than other youth, but **youth receiving MATCH-ADTC or TF-CBT met treatment goals at equivalent rates across race and ethnicity, suggesting use of these EBPs may eliminate outcome disparities**, and highlighting the value of investing in EBPs to further health equity in outpatient care. As Connecticut continues to adapt to the evolving behavioral health needs of its youth, ongoing investments in workforce training and development, engagement strategies, and access to evidence-based practices will be essential in promoting long-term success and equity in outpatient care.

10. Lang, J. M., Lee, P., Connell, C. M., Marshal, T., & Vanderploeg, J. J. (2022). Outcomes, Evidence-based practices, 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

# IX. RECOMMENDATIONS

## OPCC Data Collection & Analysis:

- Increase transparency and engagement in outpatient Quality Improvement efforts by making interactive OPCC data reports publicly available.
- Examine early discontinuation rates and early discontinuation levels by race and ethnicity across OPCC providers to prioritize targeted strategies for improving youth and family engagement, particularly for Black and Hispanic youth and families.
- Given expressed concerns from providers about the increasing complexity of OPCC youth and family needs alongside a higher average number of treatment sessions for discharged youth, examine unmet health-related social needs data variables among OPCC youth served and support improved data quality during FY25.

## OPCC Service Improvement:

- Given higher rates of discontinuation for youth of color, promote the use of more flexible EBPs (e.g., ARC, MET/CBT) and single-session substance use and trauma-informed interventions (e.g., A-SBIRT, T-SBIRT) to improve accurate identification of trauma symptoms across youth of all races and access to trauma treatment in a shorter amount of time.
- Encourage increased collaboration between local DCF offices and OPCC providers to support increased engagement of DCF-involved youth in OPCC care to improve outcomes and develop/utilize a report that shows services by DCF region.
- Provide training on bias in diagnosis and rapport building and engagement with diverse youth to increase clinician awareness of and comfort providing equitable care.
- Collect input from OPCC providers regarding training needs and use of peer supports alongside clinical care and share with existing initiatives to improve these efforts to promote clinical workforce retention.
- Integrate language into provider performance incentive fund letters in FY25 encouraging the use of sustainability funds for staff retention.

## State Investment in Outpatient Services:

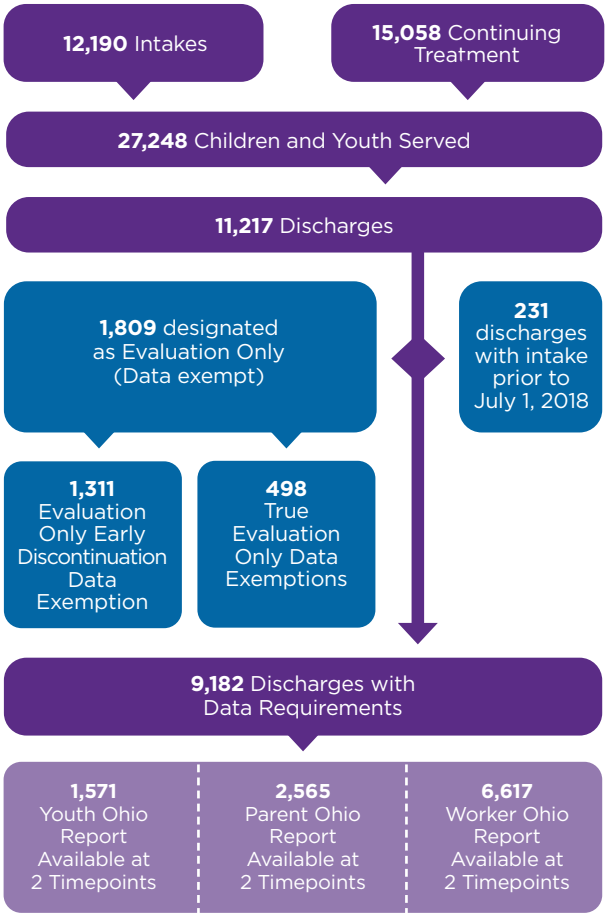
- Due to continued historically high volume of youth served in OPCC, the newer workforce, and increasing burnout for supervisors, invest in resources that support workforce hiring, training, and retention strategies including funding for non-clinical professionals to support clinicians and clients.

# X. APPENDIX A: DATA AVAILABILITY

OPCC providers use several clinical scales to track client progress and outcomes for discharged episodes. As described on page 10, these measures are required for episodes with intakes after July 1, 2018 who are not designated as "Evaluation Only." In FY24 there were 9,182 youth discharged from OPCC services with data collection required.

Figure A1 shows a flowchart of youth served in OPCC, their pathway to discharge, and their outcomes data availability.

**Figure A1.** Flowchart of Youth Served in OPCC



## Ohio Scales

Completion of the Ohio Scales for baseline and outcome data is monitored, and performance across years on relevant benchmarks can be found in Figures A2 and A3. 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.

Any data available, either Problem Severity or Functioning, is examined below. The availability rate was 33.4% for Youth report, 28.9% for Parent report, and 71.3% for Worker report.

**Figure A2.** Baseline Data

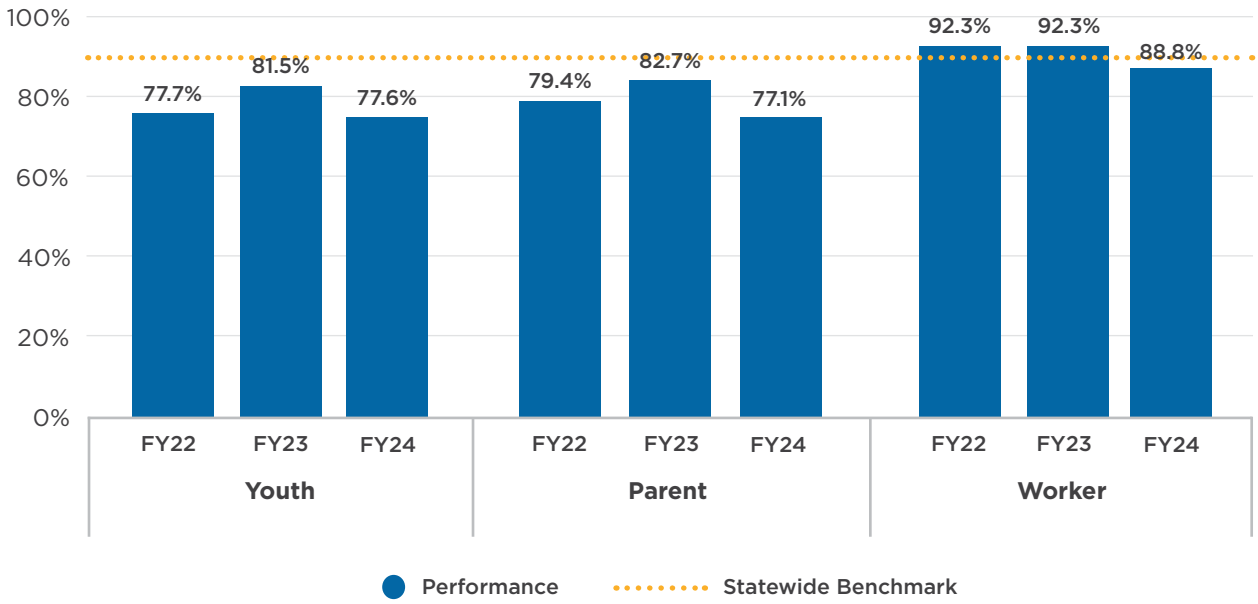



**Figure A3.** Outcome Data

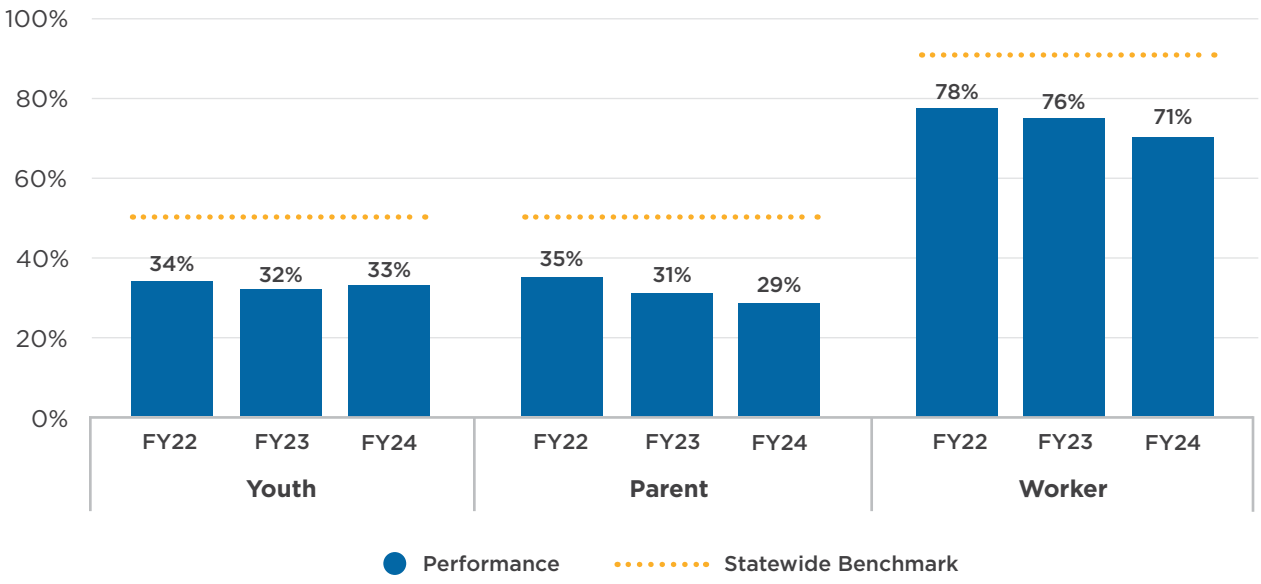
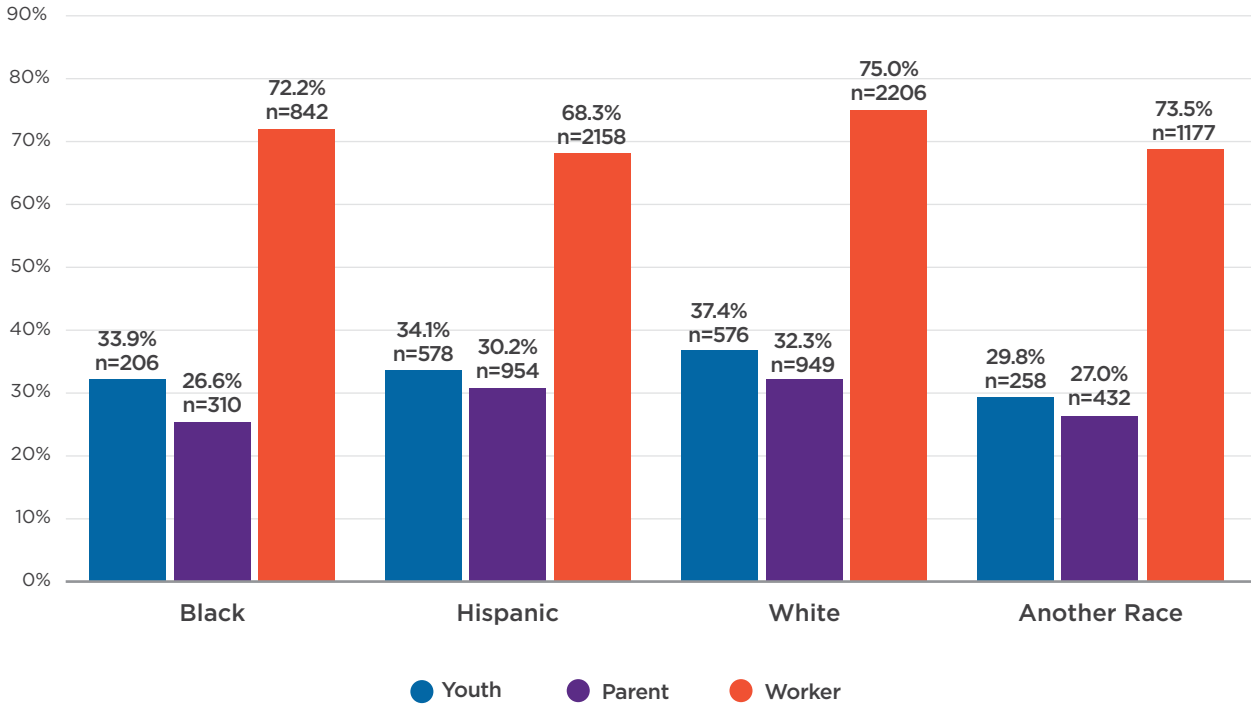


Figure A4 shows the percentage of youth with outcome data available for each of the three reporters by racial group. Availability of outcome data was lower for Black, Hispanic, and Another Race youth than for White youth across reporters (Figure A4), but there were no consistent differences by race and ethnicity across reporters when controlling for other child characteristics, suggesting factors other than race are the primary drivers of these differences (Appendix B, Table B4). 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.

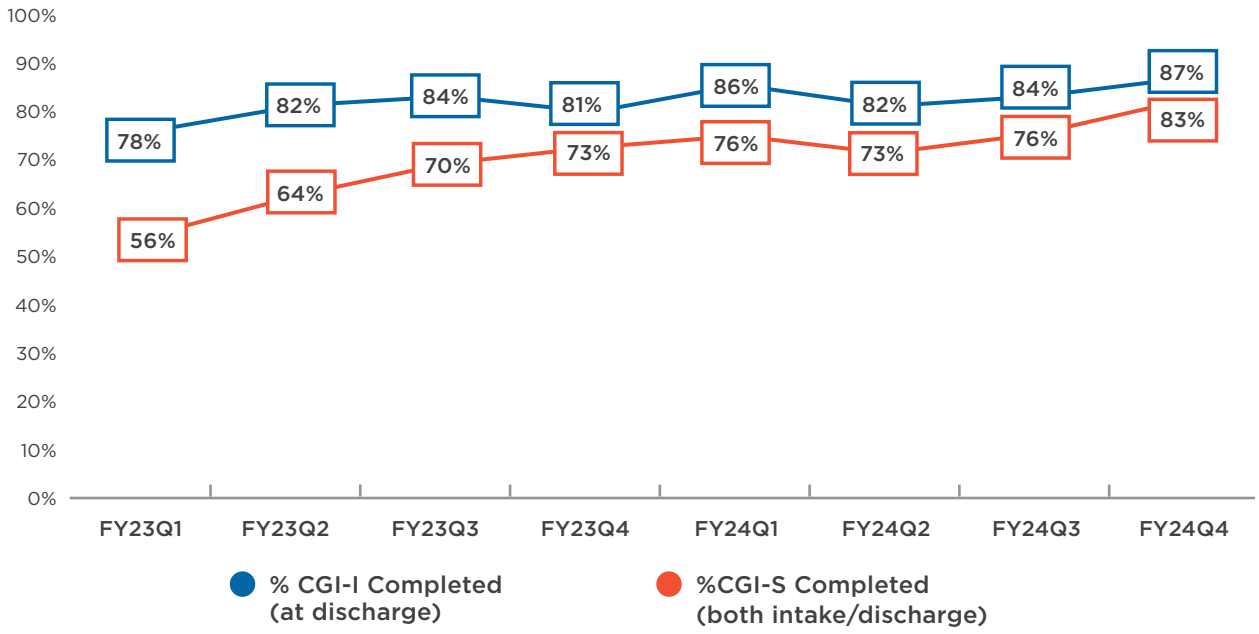
**Figure A4.** Data Availability by Race and Ethnicity




## 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; 84.1% of episodes discharged in FY24 had the CGI-I scale completed, and 76.4% had the CGI-S completed. Trends in CGI data completion can be found in Figure A5.

**Figure A5.** Percent of Discharges with CGI Completed (Intake 3/1/21/ or Later)




CGI-S is for those who completed at both intake and discharge

# XI. APPENDIX B. REGRESSION TABLES

**Table B1.** Logistic Regression for Receiving an EBP Intervention

| Predictors | *N* | β | *SE* | *Wald* | $e^B$*(95% CI)* |
|---|---|---|---|---|---|
| **Black Non-Hispanic** | 1213 | -0.299* | 0.135 | 4.95 | 0.741 (0.569,0.965) |
| **Hispanic** | 3267 | -0.103 | 0.093 | 1.239 | 0.902 (0.752,1.082) |
| **Another Race Non-Hispanic** | 1662 | -0.169 | 0.115 | 2.145 | 0.845 (0.674,1.059) |
| **Sex Male** | 4395 | -0.502** | 0.083 | 36.679 | 0.689 (0.563,0.844) |
| **Child Age at Intake** | 9182 | 0.031* | 0.011 | 8.473 | 0.605 (0.515,0.712) |
| **DCF Involved "No"** | 7913 | -0.372** | 0.103 | 12.998 | 1.032 (1.010,1.054) |
| **Constant** | | -2.213 | 0.169 | 172.456 | 0.109 |

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

**Table B2.** Logistic Regression Any Early Discontinuation

| Variable | *N* | β | *SE* | *Wald* | $e^B$*(95% CI)* |
|---|---|---|---|---|---|
| **Black Non-Hispanic** | 1524 | 0.387** | .079 | 23.734 | 1.473 (1.26,1.721) |
| **Hispanic** | 3923 | 0.236** | .063 | 13.894 | 1.266 (1.118,1.433) |
| **Another Race Non-Hispanic** | 2000 | 0.241* | .075 | 10.265 | 1.273 (1.098,1.475) |
| **Sex Male** | 5337 | 0.181** | .052 | 12.316 | 1.198 (1.083,1.326) |
| **Child Age at Intake** | 10986 | 0.002 | .007 | 0.061 | 1.002 (0.989,1.015) |
| **DCF Involved "No"** | 9392 | -0.339** | .067 | 25.497 | 0.713 (0.625,0.813) |
| **Constant** | | -1.577** | .109 | 209.836 | 0.207 |

*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 B3.** Logistic Regression for Met Treatment Goals

| Variable | *N* | β | *SE* | β*/SE* | $e^B$*(95% CI)* |
|---|---|---|---|---|---|
| **Black Non-Hispanic** | 1213 | -0.185* | 0.071 | 6.884 | 0.831 (0.724,0.954) |
| **Hispanic** | 3267 | -0.181** | 0.053 | 11.721 | 0.835 (0.753,0.926) |
| **Another Race Non-Hispanic** | 1662 | -0.323** | 0.063 | 26.255 | 0.724 (0.640,0.819) |
| **Child Age at Intake** | 9182 | -0.014* | 0.006 | 6.018 | 0.986 (0.975,0.997) |
| **Sex Male** | 4395 | -0.049 | 0.044 | 1.244 | 0.952 (0.873,1.038) |
| **DCF Involved "No"** | 7913 | 0.262** | 0.062 | 17.838 | 1.299 (1.151,1.467) |
| **Did NOT Receive a DCF EBP** | 8473 | -0.720** | 0.091 | 62.155 | 0.487 (0.407,0.582) |
| **Threshold** | | 1.272** | 0.127 | 99.935 | 3.568 |

*p<.05 As compared to White Non-Hispanic Males.
**p<.001 EBPs = TF-CBT, MATCH-ADTC

**Table B4.** Logistic Regression for Any Ohio Data Availability

| Variable | Youth | | Parent | | Worker | |
|---|---|---|---|---|---|---|
| | *N* | *$e^B$(95% CI)* | *N* | *$e^B$(95% CI)* | *N* | *$e^B$(95% CI)* |
| **Black Non-Hispanic** | 607 | 0.875 (0.715,1.070) | 1167 | 0.751** (0.642,0.878) | 1167 | 0.914 (0.790,1.058) |
| **Hispanic** | 1697 | 0.891 (0.770,1.033) | 3159 | 0.898 (0.803,1.004) | 3159 | 0.731** (0.657,0.813) |
| **Another Race Non-Hispanic** | 866 | 0.743* (0.620,0.892) | 1602 | 0.795* (0.692,0.913) | 1602 | 0.947 (0.830,1.081) |
| **Sex Male** | 1823 | 0.833* (0.734,0.946) | 4207 | 0.940 (0.854,1.035) | 4207 | 0.935 (0.854,1.023) |
| **Child Age at Intake** | 4710 | 1.007 (0.971,1.046) | 8869 | 0.944** (0.931,0.956) | 8869 | 0.979* (0.967,0.992) |
| **DCF Involved "No"** | 4125 | 1.206 (0.996,1.462) | 7651 | 1.155* (1.005,1.328) | 7651 | 1.192* (1.050,1.353) |
| **Threshold** | | 0.426* | | 0.743* | | 2.605** |

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

**p<.001 Data considered "available" if either Ohio Problem Severity or Functioning data were available at two timepoints and were not exact item-for-item duplicates.

**Table B5.** 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** | -9.580** | 1.327 | (-12.182,-6.978) | | 6.406** | 1.283 | (3.89,8.922) | |
| **Hispanic** | -0.868 | 0.843 | (-2.522,0.785) | -0.027 | 1.714* | 0.815 | (0.115,3.313) | 0.055 |
| **Another Race Non-Hispanic** | -0.817 | 1.020 | (-2.818,1.184) | -0.021 | 0.716 | 0.986 | (-1.218,2.65) | 0.019 |
| **Black Non-Hispanic** | 1.058 | 1.136 | (-1.17,3.287) | 0.024 | -0.674 | 1.099 | (-2.828,1.481) | -0.016 |
| **Sex Male** | 0.346 | 0.713 | (-1.053,1.745) | 0.013 | 0.404 | 0.690 | (-0.949,1.757) | 0.015 |
| **Child Age at Intake** | 0.114 | 0.094 | (-0.07,0.298) | 0.032 | -0.024 | 0.091 | (-0.202,0.154) | -0.007 |
| **DCF Involved** | 3.286* | 1.015 | (1.295,5.276) | 0.084 | -2.189* | 0.981 | (-4.114,-0.265) | -0.058 |
| **Had any EBP** | -1.223 | 1.312 | (-3.796,1.351) | -0.024 | 2.960* | 1.268 | (0.471,5.448) | 0.061 |
| **$R^2$** | .011 | | | | .011 | | | |
| ***F*** | 2.274* | | | | 2.422* | | | |

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

**p<.001 Outliers were identified using the 1.5*QI rule and were winsorized for Youth PS (n = 62) and FX (n = 50).

Exact item-level duplicates were removed before analysis.

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 B6.** 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** | -8.349** | 0.985 | (-10.28,-6.419) | | 3.954** | 1.042 | (1.912,5.997) | |
| **Hispanic** | -0.673 | 0.626 | (-1.901,0.554) | -0.022 | 0.581 | 0.662 | (-0.717,1.879) | 0.018 |
| **Another Race Non-Hispanic** | 0.830 | 0.757 | (-0.654,2.315) | 0.022 | -1.038 | 0.801 | (-2.609,0.532) | -0.027 |
| **Black Non-Hispanic** | 0.619 | 0.843 | (-1.035,2.272) | 0.015 | -1.772* | 0.892 | (-3.521,-0.022) | -0.041 |
| **Sex Male** | 0.228 | 0.529 | (-0.81,1.267) | 0.009 | 0.474 | 0.560 | (-0.624,1.572) | 0.017 |
| **Child Age at Intake** | 0.018 | 0.070 | (-0.118,0.155) | 0.005 | 0.179* | 0.074 | (0.034,0.323) | 0.050 |
| **DCF Involved** | 0.891 | 0.753 | (-0.586,2.368) | 0.024 | -1.341 | 0.797 | (-2.904,0.221) | -0.034 |
| **Had any EBP** | -0.623 | 0.974 | (-2.532,1.287) | -0.013 | 2.249* | 1.030 | (0.229,4.269) | 0.045 |
| **$R^2$** | .003 | | | | .010 | | | |
| ***F*** | 0.978 | | | | 3.341* | | | |

*p<.05 As compared to White Non-Hispanic Females. EBPs = TF-CBT and MATCH-ADTC.
**p<.001 Outliers were identified using the 1.5*QI rule and were winsorized for Parent PS (n=93) and FX (n=86).
Exact item-level duplicates were removed before analysis.
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 B7.** 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** | -6.463** | 0.563 | (-7.566,-5.361) | | 4.709** | 0.570 | (3.591,5.828) | |
| **Hispanic** | -0.926* | 0.358 | (-1.627,-0.225) | -.034 | 0.317 | 0.363 | (-0.393,1.028) | 0.011 |
| **Another Race Non-Hispanic** | 0.338 | 0.433 | (-0.51,1.185) | .010 | -0.264 | 0.439 | (-1.124,0.596) | -0.008 |
| **Black Non-Hispanic** | 1.315* | 0.482 | (0.371,2.260) | .035 | -1.682** | 0.489 | (-2.639,-0.724) | -0.045 |
| **Sex Male** | 0.262 | 0.302 | (-0.331,0.855) | .011 | -0.158 | 0.307 | (-0.759,0.443) | -0.007 |
| **Child Age at Intake** | -0.082* | 0.040 | (-0.160,-0.004) | -.027 | 0.146** | 0.040 | (0.067,0.226) | 0.047 |
| **DCF Involved** | 1.307* | 0.430 | (0.464,2.151) | .039 | -1.451** | 0.436 | (-2.307,-0.596) | -0.043 |
| **Had any EBP** | -2.453** | 0.556 | (-3.544,-1.363) | -.057 | 1.379* | 0.564 | (0.273,2.485) | 0.032 |
| **$R^2$** | .010 | | | | .009 | | | |
| ***F*** | 8.715** | | | | 7.406** | | | |

*p<.05 As compared to White Non-Hispanic Females. EBPs = TF-CBT and MATCH-ADTC.
**p<.001 Outliers were identified using the 1.5*QI rule and were winsorized for Worker PS (n=217) and FX (n=162).
Exact item-level duplicates were removed before analysis.
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** | 1566 | 25.32 (15.12) | 17.62 (13.74) | 2616 | 23.67 (14.58) | 16.18 (13.25) | 6318 | 23.65 (11.69) | 16.81 (11.71) |
| **Black** | 195 | 22.40 (13.07) | 16.29 (13.66) | 302 | 22.87 (15.05) | 16.38 (13.95) | 839 | 22.68 (11.31) | 17.16 (11.79) |
| **Hispanic** | 559 | 24.66 (15.62) | 16.44 (13.37) | 917 | 23.56 (15.31) | 15.37 (13.55) | 2136 | 24.11 (11.96) | 16.53 (11.91) |
| **White** | 560 | 26.25 (15.12) | 18.81 (13.60) | 946 | 24.52 (14.03) | 17.05 (12.88) | 2186 | 24.11 (11.72) | 17.25 (11.59) |
| **Another Racial Group** | 252 | 26.96 (15.16) | 18.60 (14.64) | 418 | 22.62 (13.74) | 15.88 (12.76) | 1175 | 22.66 (11.30) | 16.22 (11.46) |

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

| | Youth | | Parent | | | Worker | | |
|---|---|---|---|---|---|---|---|---|
| | N | First Mean (S.D.) | N | First Mean (S.D.) | Last Mean (S.D.) | N | First Mean (S.D.) | Last Mean (S.D.) |
| **Overall** | 1559 | 51.32 (13.90) | 2596 | 50.04 (14.41) | 55.61 (14.83) | 6289 | 48.49 (10.95) | 54.05 (12.58) |
| **Black** | 196 | 53.62 (12.14) | 300 | 51.57 (14.74) | 55.43 (15.19) | 823 | 48.89 (11.13) | 52.96 (12.16) |
| **Hispanic** | 556 | 50.68 (14.99) | 918 | 49.90 (14.41) | 56.25 (14.26) | 2133 | 48.01 (10.81) | 53.98 (12.74) |
| **White** | 558 | 51.80 (13.43) | 925 | 49.34 (14.50) | 55.10 (14.99) | 2174 | 48.64 (11.09) | 54.40 (12.82) |
| **Another Racial Group** | 249 | 49.86 (13.48) | 407 | 50.80 (13.89) | 55.43 (15.46) | 1159 | 48.80 (10.79) | 54.31 (12.09) |

# XIII. APPENDIX D. CT-PSS STATEWIDE REPORT

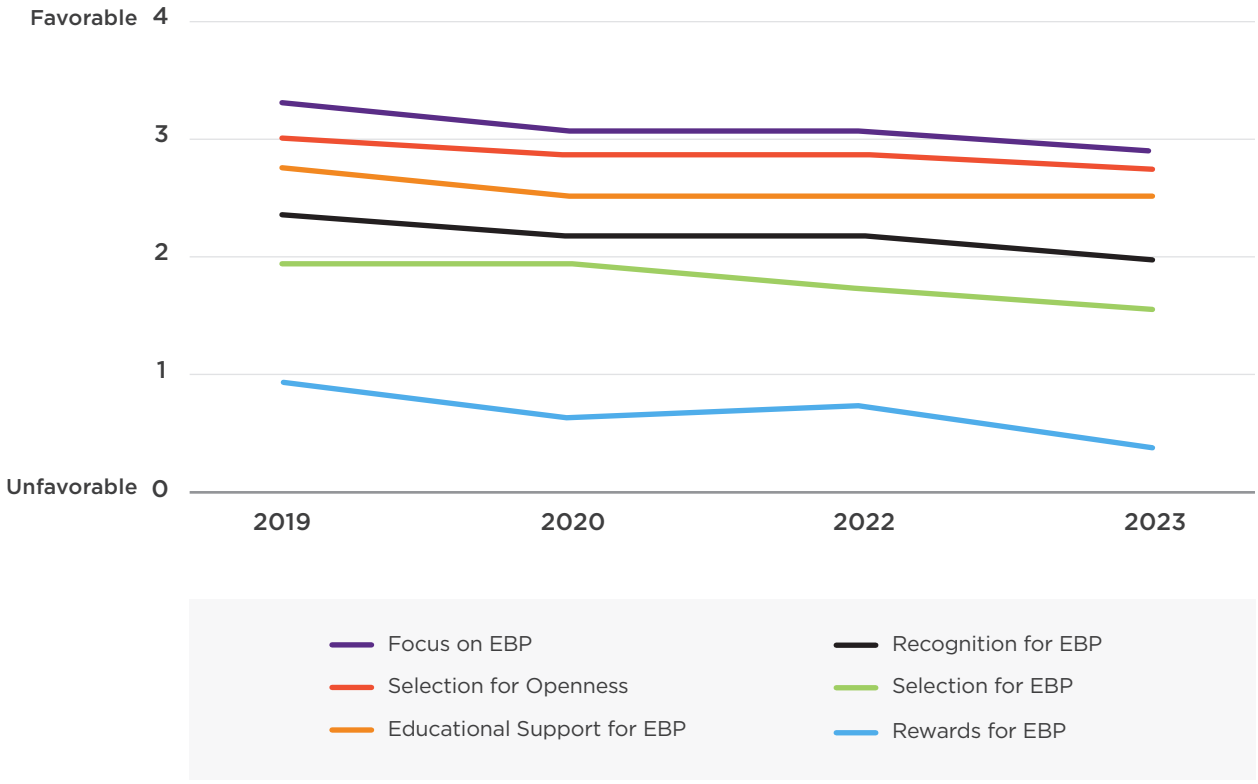
## Connecticut Provider Support Survey (CT-PSS) OPCC Agency Statewide - 2023 Results

### 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.** This report includes data from 309 individuals at OPCC agencies who fully completed the survey and from 16 individuals at OPCC agencies who completed the vast majority of the survey, representing a 54.4% response rate. The higher the response rate, the more confident we are that the results represent those within the state.

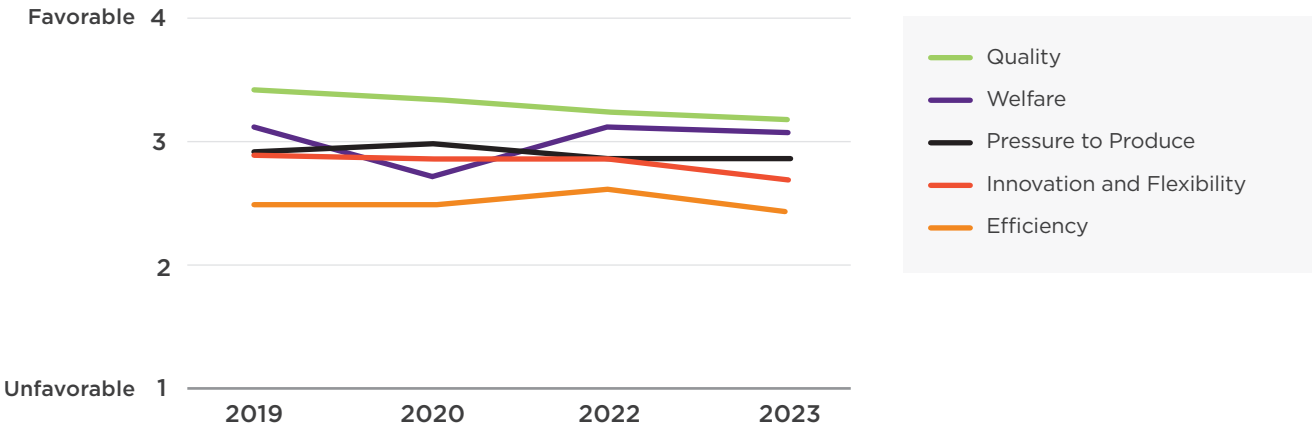
### Perceptions of Workplace Factors that Facilitate the Implementation of EBP

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.



## Perceptions of the Work Environment that Support the Implementation of EBP

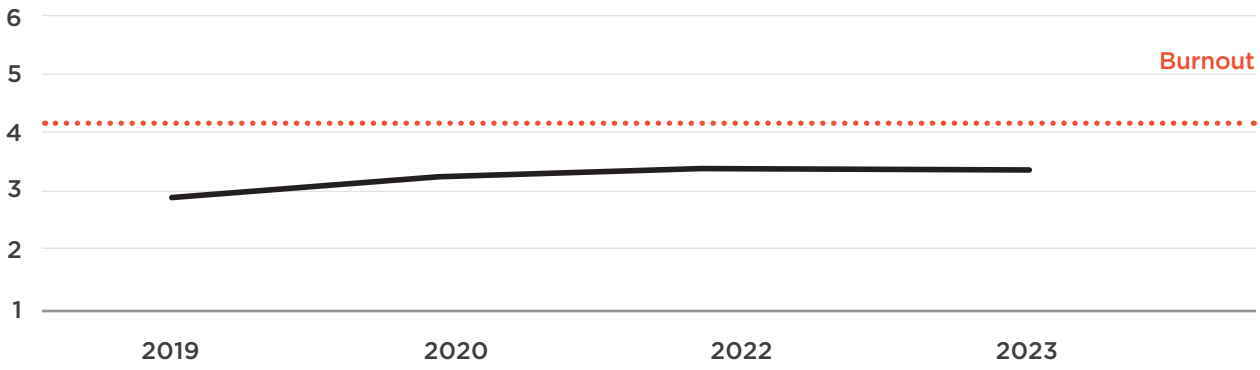
The Organizational Climate Measure (OCM) assesses workers' perceptions of their work environment.




## Workforce Wellness

### Burnout

The Burnout Scale assesses emotional exhaustion and depersonalization. Since 2019, burnout has increased by 11%, though there was a 2.5% decrease in burnout between 2022 and 2023. The top two contributors to burnout listed by staff were "Administrative burden, including paperwork and data entry" and "Too large of a caseload".




### Turnover

The Turnover Intention Scale (TIS-6) assesses employees' intent to stay with their organization. This year, the average score was 2.54 on a scale of 1 to 5, indicating employees had neutral intention to leave the organization. This represents a 1.3% increase from 2022.

### Top three strategies to increase retention:

1. Increased compensation **(71.7%)**
2. Loan forgiveness **(34.8%)**
3. Decreased workload **(29.2%)**

## Workforce Development

**Top Training Topics of Interest:**

1. Vicarious and secondary trauma **(39.7%)**
2. Intellectual developmental disability, autism **(31.1%)**
3. Substance abuse **(19.7%)**
4. Self-care strategies **(19.7%)**
5. First-episode psychosis **(19.4%)**
6. Structural/social determinants (e.g., attention to poverty, housing instability, community violence, etc.) **(18.2%)**
7. Single session/briefer EBT interventions **(18.2%)**

**Top Two Training Topics for Therapists/Clinical Staff:**

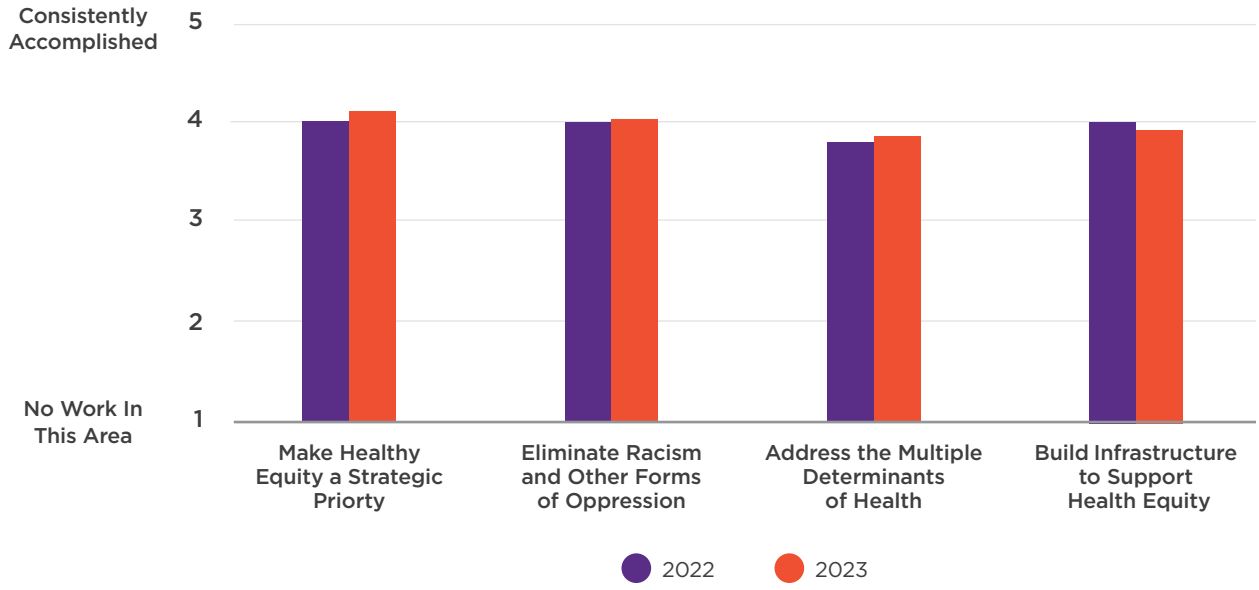
1. Increasing staff support/morale/retention **(16.6%)**
2. Professional development **(11.1%)**

**Top two training topics for Managers/Supervisors:**

1. Increasing staff support/morale/ retention **(45.8%)**
2. Collaborative decision making **(27.1%)**

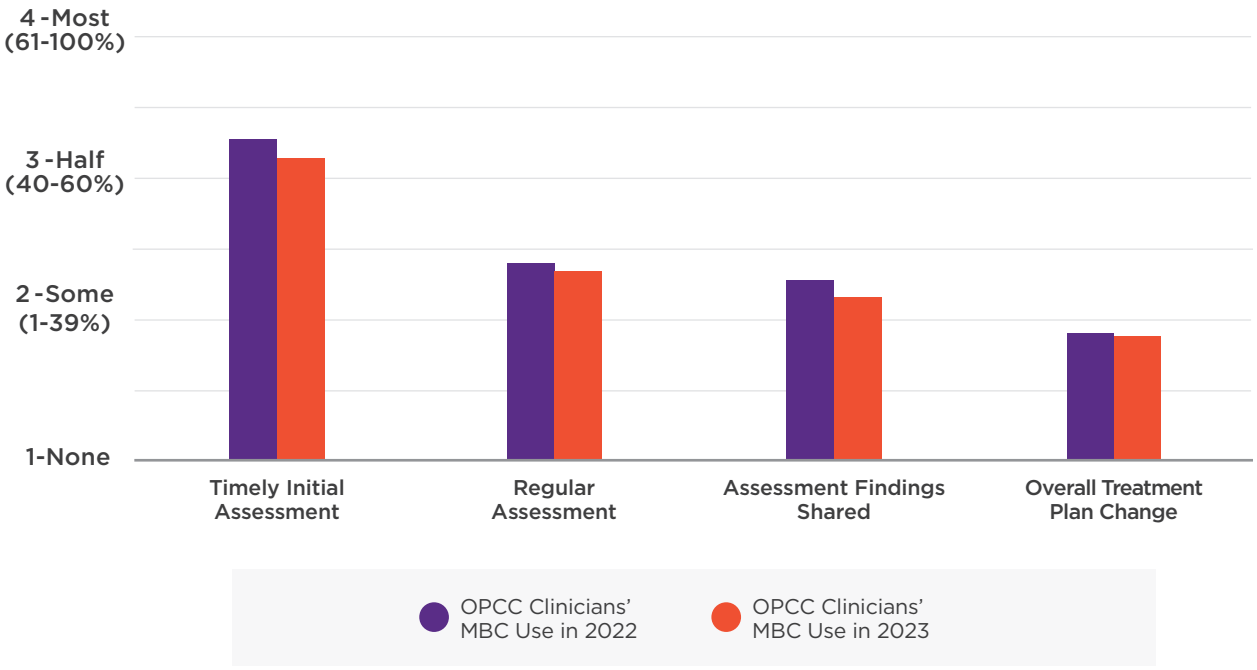
## Racial Justice and Equity

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.




**National average ranges for MBC use among clinicians engaged in treatment as usual, as measured by the CAPER, include:**

Timeline Initial Assessment: **2.12 to 3.17**

Regular Assessment: **1.56 to 1.88**

Assessment Findings Shared: **1.6 to 2.31**

Overall Treatment Plan Change: **1.48 to 1.54**

# XIV. APPENDIX E: 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 |
| **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 |
| **SMARTIE** | Specific, Measurable, Attainable, Relevant, Time-Bound, Inclusive, and Equitable |
| **SSC** | Single-Session Consultation |
| **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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Child Health and Development Institute

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