Connecticut's Outpatient Psychiatric Clinics for Children

FISCAL YEAR 2025 ANNUAL REPORT

Child Health and Development Institute

CONNECTICUT Children & Families

Connecticut's Outpatient Psychiatric Clinics for Children

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This report was developed for the Connecticut Department of Children and Families (DCF) by the Child Health and Development Institute (CHDI). For more information, contact Katie Newkirk at **knewkirk@chdi.org.**

CONTENTS

I. EXECUTIVE SUMMARY

The Outpatient Psychiatric Clinics for Children (OPCC) network consists of 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. The Child Health and Development Institute (CHDI) supports this network through DCF funding by offering continuous quality improvement (QI), clinical training/workforce development, technical assistance and data analysis, and reporting from the DCF Provider Information Exchange (PIE).

This report summarizes the OPCC network's performance and CHDI's QI work during state fiscal year (FY) 2025 (July 1, 2024, through June 30, 2025) and summarizes key trends. OPCC providers faced growing youth and family needs and workforce challenges but continued to deliver strong results in access, quality, and outcomes.

KEY FINDINGS FY25:

26,256
Children received OPCC services statewide, maintaining a high volume of service utilization

16.5%
Of children discontinued treatment before four sessions. Black and Hispanic youth were less likely to complete **4+** sessions compared to White youth

Treatment episodes averaged
22 sessions,
consistent with **FY24**

46.3% of all children received an EBP (down from **FY24**).

- **342 OPCC clinicians** were trained in DCF-supported EBPs or best practices.
- Black and Hispanic youth were less likely to receive a DCF-supported EBP compared to White youth.

66.7% of children met treatment goals per clinician report (benchmark: **60%**).

- Children receiving EBPs were more likely to meet them **(73.6%)** compared to those who did not **(66.2%)**, and met treatment goals at equivalent rates across race and ethnic groups when receiving EBPs, but not when receiving other types of treatment

The most common primary presenting problems were:

- Anxiety **(24.0%)**
- Disruptive Behavior **(18.8%)**
- Depressive Disorders **(16.1%**
- Trauma/PTSD **(12.4%)**

51% - 54% of children showed significant improvement in Ohio Scale Problem Severity (Benchmark: **50%**).

Children receiving DCF-supported EBPs had greater improvement in Problem Severity and Functioning. Black youth and DCF-involved youth had less improvement.

KEY RECOMMENDATIONS:

- Promote the use of briefer evidence-based screening and brief intervention (e.g. A-SBIRT, T-SBIRT), to improve identification of youth in need of evidence-based treatments for trauma and access to needed treatment in a shorter amount of time.
- Integrate data on early discontinuation by provider into consultation to prioritize targeted strategies for improving youth and family engagement, particularly for Black and Hispanic youth and families.
- Provide training on using EBPs in culturally responsive ways to increase clinician self-efficacy around using EBPs with Black and Hispanic youth.

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 the Outpatient Psychiatric Clinics for Children (OPCC) network.

CHDI creates centralized support for the statewide network of OPCC providers through the following:

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

This report summarizes the network's performance and CHDI's QI work for state fiscal year (FY) 2025 (July 1, 2024 through June 30, 2025).

Background

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

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

These facilities use 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 four domains in this report: providing **equitable access, quality, and outcomes** for children and families served in the OPCC network, and OPCC **workforce training and development**. 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. Highlights included:

- **Youth and family engagement:** Improving early discontinuation was a focus of QI efforts in FY25. CHDI monitored early discontinuation rates by race and ethnicity for each provider and will integrate that information into QI reports in FY26. The EBP Conference in May 2025 offered several workshops on family engagement to enhance clinicians' skills and confidence in improving engagement.
- **Promoting Use of More Flexible EBPs:** To expand options available to clinicians and increase engagement for families and youth who are at higher risk of early discontinuation, CHDI offered trainings in more flexible EBPs for trauma, including ARC and T-SBIRT, and co-occurring disorders, including A-SBIRT and MET/CBT.
- **Training to improve rapport and engagement with BIPOC youth:** To improve provider competency and sensitivity to the needs of the diverse populations served in OPCC settings, CHDI held two trainings on Cultural Sensitivity. Twenty OPCC clinicians attended a workshop on how to apply cultural sensitivity in their therapeutic work with clients that yielded concrete strategies to strengthen therapeutic relationships. Twenty-eight OPCC supervisors attended a training on culturally sensitive supervision focusing on strategies for providing culturally sensitive supervision that acknowledges and addresses the intersectionality of supervisees' identities. As a result of strong interest and demand for this training, it was also conducted at the 2025 EBP Conference for 40 more supervisors.
- **Engagement with data:** To increase transparency and engagement in outpatient Quality Improvement efforts, CHDI developed an interactive OPCC data report in consultation with DCF and a committee of OPCC provider representatives over the course of FY25. This report will go live starting with FY26Q1 data. CHDI also shared findings from FY24 Annual Reports and several ad hoc data analyses in monthly OPCC meetings to engage providers with program data and gain their input on trends.
- **Promote use of provider performance incentive funds for staff retention:** CHDI integrated language into provider performance incentive fund letters to encourage the use of sustainability funds for staff retention. CHDI also facilitated a presentation from a provider on how they successfully incentivize clinicians to use EBPs in a monthly OPCC provider meeting.
- **Race and Ethnicity Data:** In June 2024, DCF implemented updated race, ethnicity, and language data collection standards, requiring a shift in how these data were collected. CHDI supported providers in making these changes while continuing to improve rates of race and ethnicity data collection. Missing race and ethnicity data continued to decrease in FY25 (7.3%) compared to FY24 (7.9%) and FY23 (14%). Efforts were more apparent in the decrease in missingness for new intakes, which was down to 3.4% in FY25 from FY24 (8%) and FY23 (14%).

III. ACCESS TO OPCC SERVICES IN CONNECTICUT

Across the network of 22 OPCC providers, a total of **26,256** children were served in FY25. Figure 1 shows outpatient episode volume across the state. The map indicates the rate of outpatient episodes in each town during FY25 relative to each town's child population (episodes per 10,000 children). Table 1 describes characteristics of the children served by OPCCs in FY25 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 (52.5%). 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 decreased slightly in FY25 but remains higher than the years during and prior to the Covid-19 pandemic (Figure 2). Children served included 11,224 who initiated treatment during FY25, and 15,032 whose treatment episodes began prior to the fiscal year.

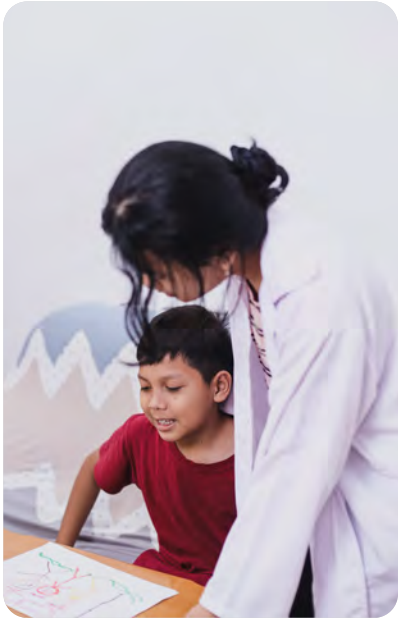


Figure 1. Map of OPCC Sites and Children Served in FY25

OPCC Open Episodes per 10,000 Children SFY 2025

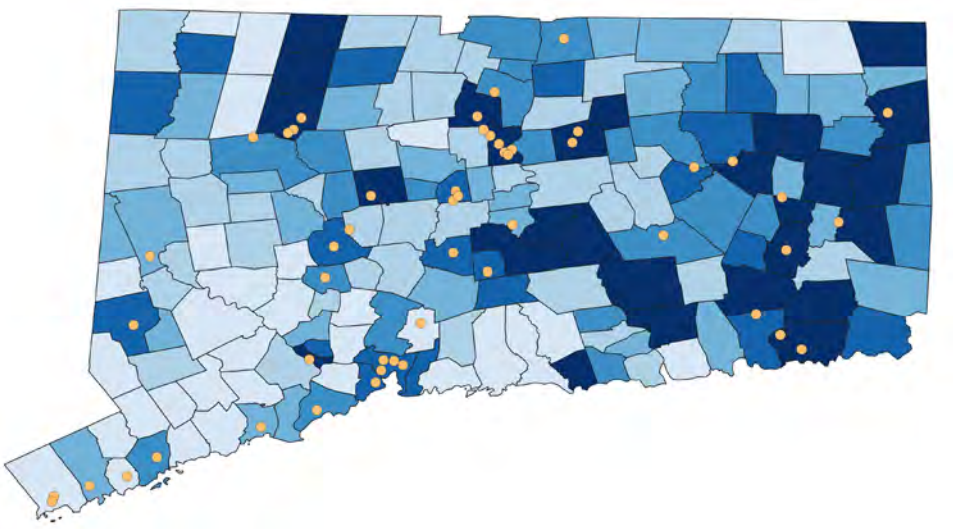
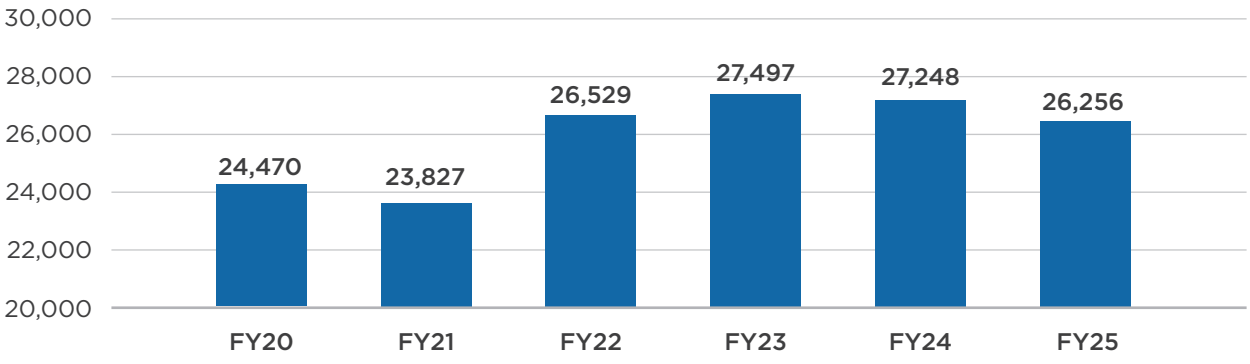


Table 1. Characteristics of children receiving OPCC services, with comparisons (n= 26,256)			
	OPCC		CT pop[2]
	N	%	%
Sex			
Male	12840	48.9	51.2
Female	13416	51.1	48.8
Race			
American Indian or Alaska Native	114	0.4	0.4
Asian	307	1.2	5.1
Black or African American	4377	16.7	12.2
Native Hawaiian or Pacific Islander	42	0.2	0.1
White	13797	52.5	53.2
Other Race/Ethnicity (includes multiracial/ethnic)	909	3.5	29.0
Missing/Declined	6710	25.6	-
Hispanic, Latino, or Spanish (any race)	9645	36.7	28.8
Age[3] (years)			
Under 6 years	2734	10.4	30.2
6–11 years	12014	45.8	32.6
12–17 years	11457	43.7	37.2
Child Primary Language			
English	20466	77.9	77.2
Spanish	2654	10.1	14.3
Neither English nor Spanish	501	1.9	8.5
Nonverbal	235	0.9	-
Missing	2400	9.1	-
Child Welfare Involvement During Treatment	**3409**	**13.0**	**2.3[4]**
JJ Involvement During Treatment	**303**	**1.2**	**N/A**

Figure 2. Youth Served in OPCC FY20-FY25



2. American Community Survey 2023 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 2023 National Child Abuse and Neglect Data System (NCANDS) data for children subject of an investigated report alleging child maltreatment.

OPCC Youth Discharged in FY25

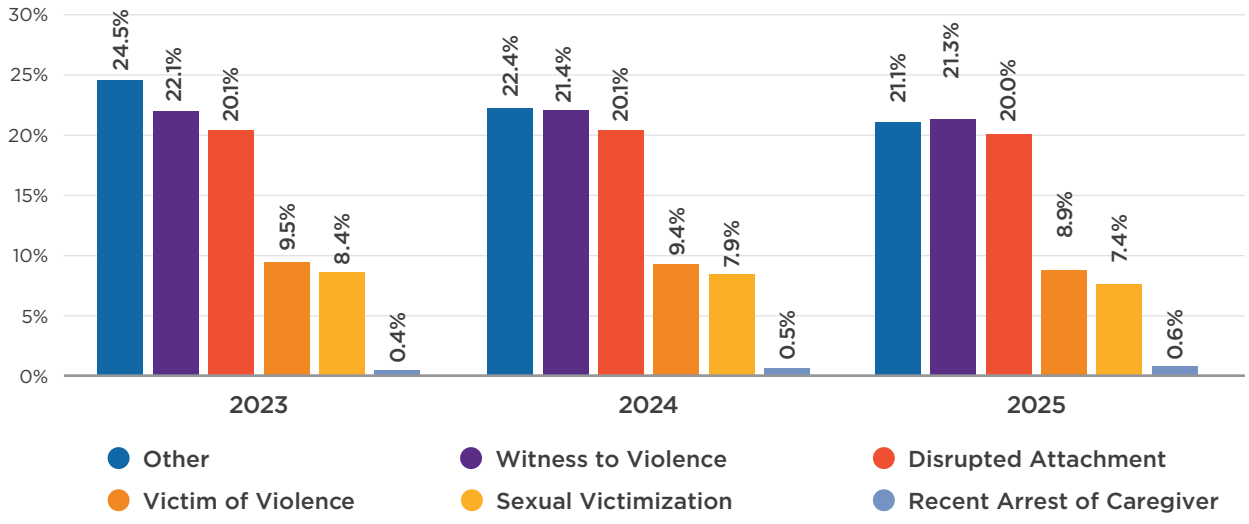
A total of 10,751 children aged 0-18 were discharged in FY25. *Of note, one provider conducted a mass discharge of approximately 200 old cases that had been missed, therefore findings related to outcomes and data availability could be skewed by those cases.* Children who were referred for an evaluation 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 13.1% of children discharged. These episodes are considered "evaluation only," excluding them from most data collection requirements. Of the children discharged, 86.9% 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 9,210 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 FY25, over half (53.2%) 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 exposure 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 (55.7%) youth were more likely to report having any trauma exposure than youth of Another Race or Ethnicity (50.3%). Female youth reported experiencing trauma exposure at higher rates (56.0%) than males (50.1%).

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 FY25 rates of reporting any drug or alcohol use in the previous month ranged from 13.1% - 16.1% across reporters. This represents a decrease over FY23 (13.8%-16.5%) and FY24 (13.3%-17.9%).

Presenting Problem

Among children discharged in FY25, the most common presenting problem categories were Anxiety (24.0%) followed by Disruptive Behavior (18.8%), Depressive Disorders (16.1%), and Trauma (12.4%). Anxiety continued its post-pandemic trend as the most common presenting problem, with disruptive behavior 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 problems by race/ethnicity[5].

Figure 4. OPCC Primary Presenting Problem at Intake

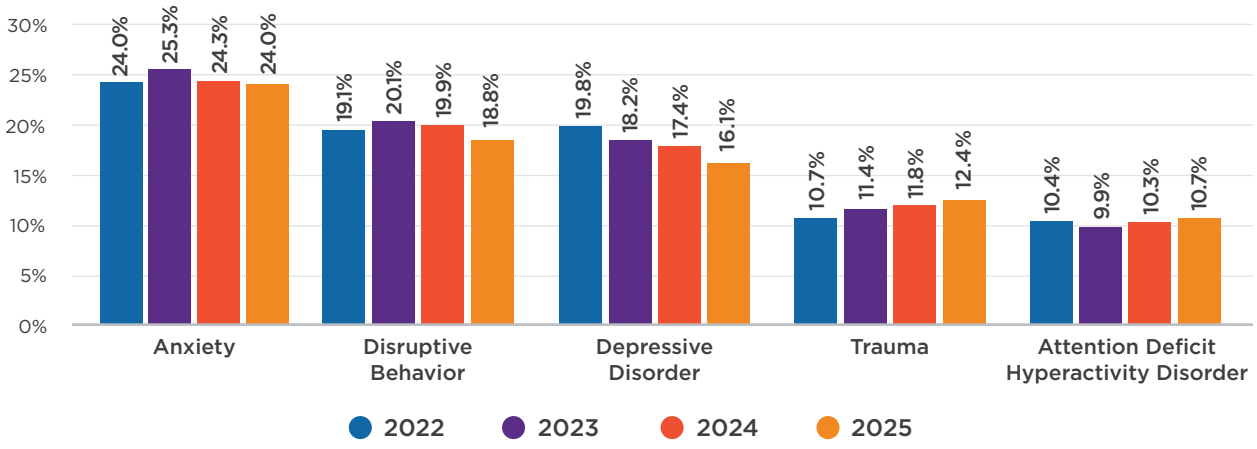
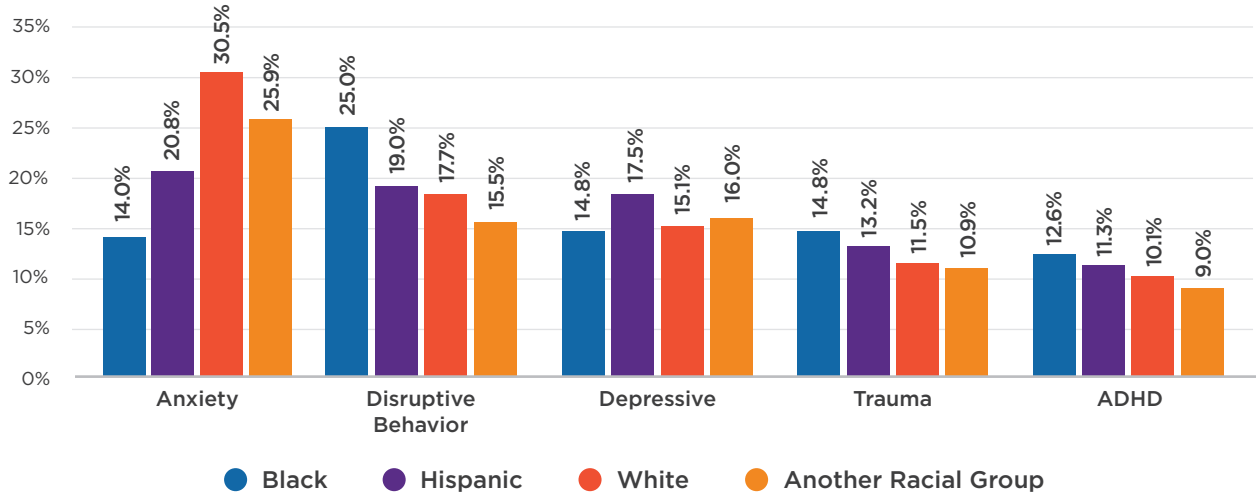


Figure 5. Racial/Ethnic Differences in Primary Presenting Problem



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 (74.7%), Multiracial (15.1%) and Asian (7.4%)

DIFFERENCES IN PRIMARY PRESENTING PROBLEM BY RACE/ETHNICITY:

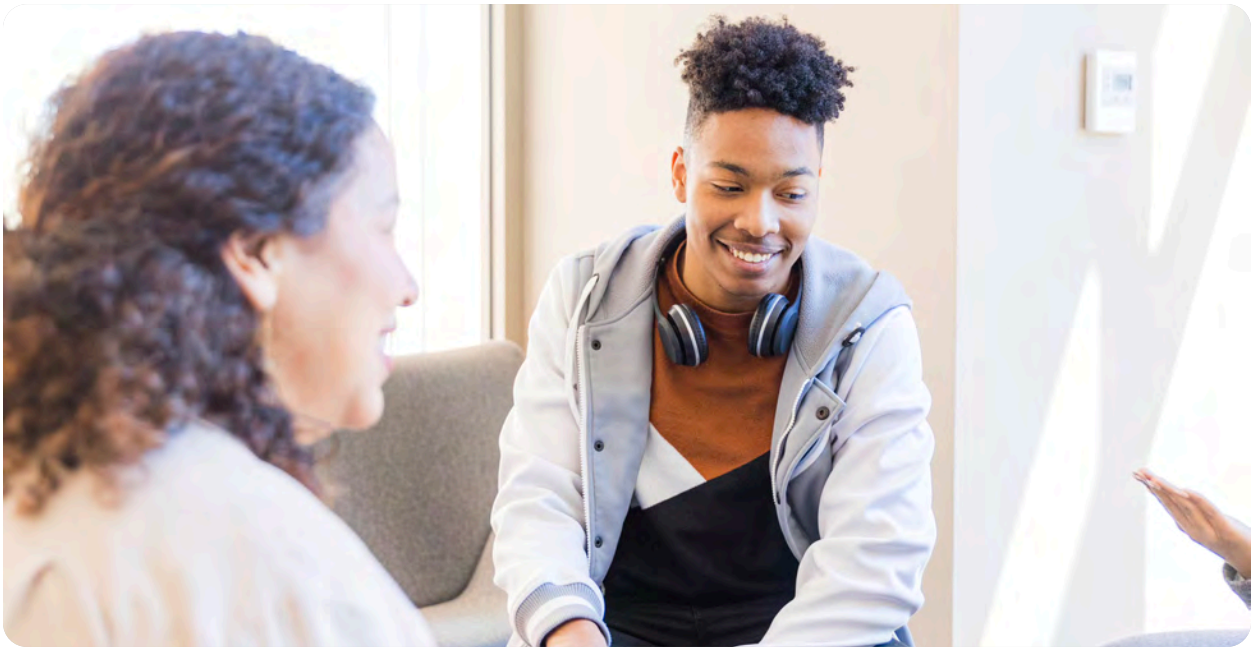
Anxiety
Highest rates for White youth, but all groups differed.

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

Depression
Higher % for Hispanic youth than for all other youth.

ADHD
Higher % for Black youth than for all other youth.

Trauma
Higher % for Black youth than for all other youth.



IV. QUALITY OF OPCC SERVICES IN CONNECTICUT

Treatment Information

Treatment information is primarily derived from activity data, which is date-based, session-level information entered during the episode or at discharge about the type of treatment provided. Of the 9,211 discharged who received treatment with data requirements, 6,989 (75.9%) had at least one activity data record corresponding to a treatment session[6], an improvement over FY24 (72%).

Number of Sessions

The overall number of treatment sessions quantifies the dose of treatment received by a child. Of the children discharged in FY25, the mean number of sessions was 22.0 (SD= 22.2) and the median (50th percentile) was 13 sessions, which was similar to FY24[7].

Early Discontinuation

In FY25, a total of 10,751 children were discharged from outpatient treatment, and 13.1% (n=1,409) 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 1,087 episodes marked as evaluation only due to early discontinuation (10.1% of all discharged episodes) and an additional 682 treatment episodes had less than four sessions and were not designated by the clinician as evaluation only. There were also 2,676 episodes that did not have session level data available (24.9% of all discharged episodes). Overall, 1,769 (16.5%)

discharged cases discontinued treatment with less than four sessions, which was a slight decrease from FY24 (16.9%). While all groups improved, youth of Another Race improved 3% while others improved less than 1%. **White youth (14.0%) and youth of Another Race (14.9%) were less likely to have fewer than four treatment sessions than Black (20.1%) and Hispanic youth (18.0%)** when controlling for other demographic factors (Appendix B, Table B2).

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 TF-CBT and MATCH-ADTC only). Though some discrepancies

6. Excludes cases with activity for an intake only with no subsequent treatment sessions.
7. Number of sessions was winsorized to address 251 cases that were extreme outliers (based on 3*Interquartile Range above the 75th percentile) with 89-305 sessions.

between these data points existed, across the information available on EBPs, 46.3% (n=4,262) of children received an EBP during their treatment, a decrease from FY24's 50.8% (n=4,663). Of these, 3,286 (77.1%) received Cognitive Behavioral Therapy, 814 (19.1%) received Motivational Interviewing, 671 (15.7%) received Dialectical Behavior Therapy (DBT), 507 (11.9%) received Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), 440 (10.3%) received Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct (MATCH-ADTC), and 391 (9.2%) received Solution-Focused Brief Therapy (SFBT). Children may have received more than one EBP during their treatment 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% of OPCC episodes, with the rates ranging from 1% - 22.2% across providers.

In analyses accounting for age, race and ethnicity, 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 White youth were more likely to receive them compared to all other youth. Analysis controlling for the provider for the episode only found **higher odds of receiving MATCH or TF-CBT for female and DCF-involved youth, with smaller differences for Black and Hispanic youth, and no significant differences for youth of Another Race.** This suggests differences may be largely due to varying uptake of providers serving different populations.

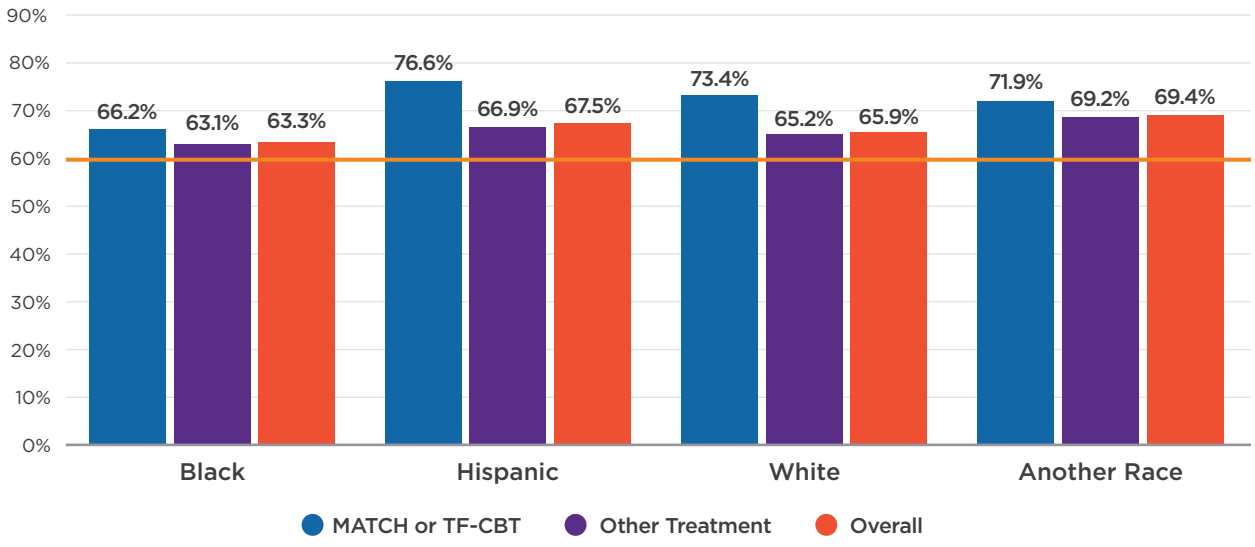
V. OUTCOMES OF CHILDREN RECEIVING OPCC SERVICES

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 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; for each overall outcomes as well as relevant subgroup breakdowns are given.

Treatment Goals

DCF's benchmark for meeting treatment goals for each individual agency in FY25 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, 66.7% of children met treatment goals; 13 of 22 (59%) agencies met the benchmark, representing an increase compared to FY24. **Episodes of care in which a DCF-supported EBP with fidelity was used met treatment goals 73.6% of the time compared to only 66.2% for episodes with treatment as usual or another EBP**. Figure 6 shows racial and ethnic group percentages that met treatment goals. **Youth receiving a DCF-supported EBP met treatment goals at statistically equivalent rates across race and ethnicity, but those receiving other treatments did not.** Specifically, for youth receiving other treatments Another Race youth met treatment goals at significantly higher rates than Black and White youth, and Hispanic youth met treatment goals at significantly higher rates than Black youth.

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



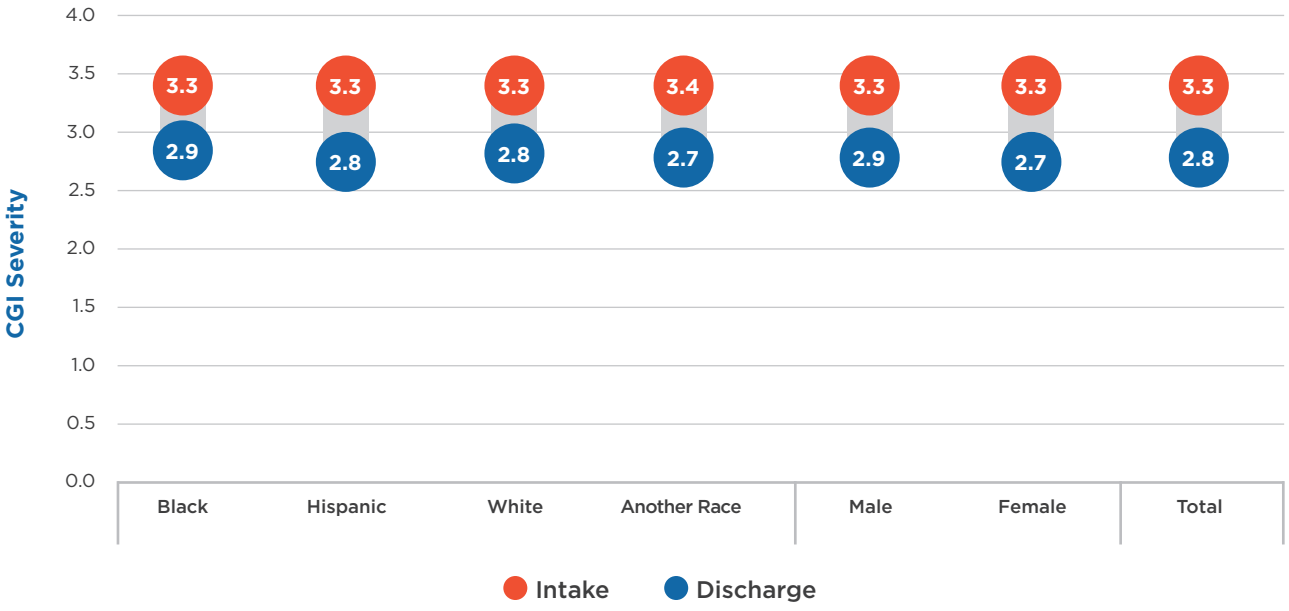
8. Ogles, B. M., Melendez, M. S., Davis, D. C., & Lunnen, K. M. (2001). The Ohio Scales: Practical Outcome Assessment. *Journal of Child and Family Studies*, *10*, 199-212.

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 7,714 cases where CGI-I was completed, clinicians reported that improvement was made in 62.8% of discharged episodes.

Of the 6,974 cases with CGI-S at intake and discharge, 44.0% changed from a "more severe" to a "less severe" category from intake to discharge. An additional 41.0% showed no change on the CGI-S. There were significant differences in change in the CGI-S by race. **Youth of another race/ethnicity and Hispanic youth have significantly greater improvement from intake to discharge on the CGI-S than Black youth.** Males showed significantly less improvement on CGI-S than females, as seen in Figure 7. 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

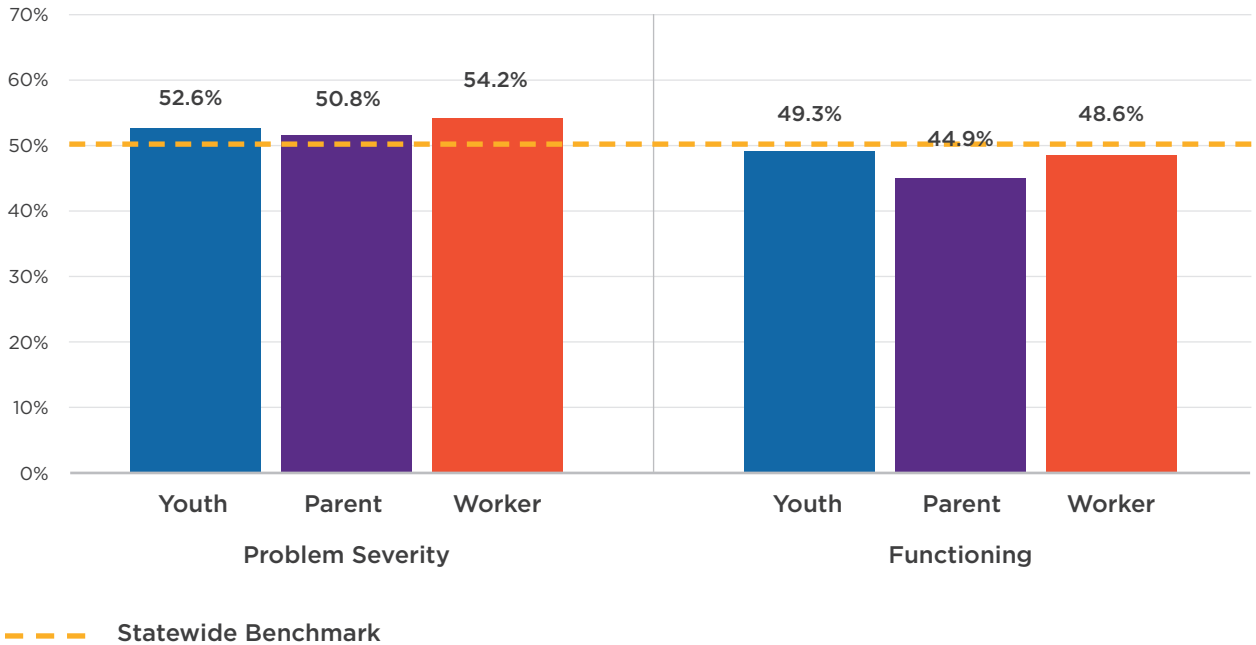
The Ohio Scales include 40 items that measure the degree of problems a child is currently experiencing (Problem Severity) and the degree to which a child's problems affect their day-to-day activities (Functioning). There are three versions: Youth-report, Parent-report, and Worker-report completed by 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 FY25 was 32.8% for Youth report, 29.0% for Parent report, and 66.6% for Worker report, with no differences by race, ethnicity, or sex for Youth report (Appendix B, Table B3) and consistently lower rates of Worker and Parent report availability for Black and Another Race youth and older youth, when controlling for other child factors (Appendix B, Tables B4-B5). Availability for all reporters was slightly lower than in FY24. Further information on data availability can be found in Appendix A.

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 FY25, rates of improvement for all reporters exceeded the 50% benchmark for Problem Severity, however none of the reports exceeded the benchmark for Functioning. Statewide results on these indicators are shared in Figure 8 below.

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

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



DCF status) and EBP receipt on Worker-reported symptom improvement, the only consistent findings showed **Black youth and DCF-involved youth had less improvement and youth who received DCF-supported EBPs (TF-CBT, MATCH) had greater improvement in Problem Severity and Functioning** (Appendix B Table B6). Intake and discharge scores for Problem Severity and Functioning by race/ethnicity can be found in Appendix C.

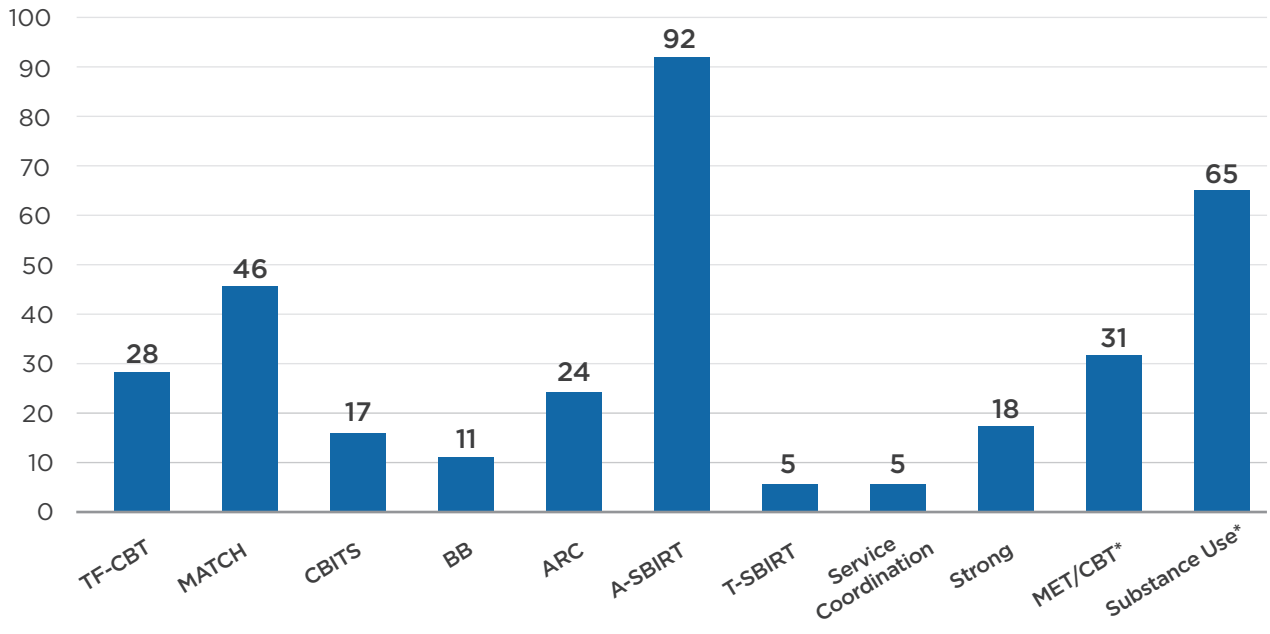
9. A substantial portion of Ohio scale data showed identical responses to all items at both timepoints, suggesting an intake Ohio was duplicated for the discharge Ohio. For Problem Severity there were 533 and for Functioning there 542 exact duplicates for all items on the Worker report. These cases were 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 treatments such as 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); Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Attachment, Self-Regulation, and Competency (ARC) model, and Supporting Transition Resilience of Newcomer Groups (STRONG). In addition to these EBPs, CHDI provides training for OPCC providers in Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT) through SAMHSA funding, and Screening, Brief Intervention, and Referral to Treatment (SBIRT, which includes the adolescent adaptation, A-SBIRT), and Service Coordination though Connecticut's 1115(a) Demonstration Waiver. CHDI, in collaboration with DCF, also piloted Trauma Screening Brief Intervention and Referral to Treatment (T-SBIRT) this fiscal year. **In FY25, 126 OPCC clinicians were trained in one or more of the trauma-focused EBPs and an additional 216 were trained in other EBPs and best practices** (Figure 9).

In addition to these EBPs, CHDI hosted the 2025 Evidence-Based Practice Conference, which provided 182 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 FY25



*MET/CBT and Substance Use trainings were funded by a SAMHSA grant

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 FY25, CHDI co-chaired and coordinated 9 meetings. In-person meetings were held in October 2024 and March 2025. CHDI and DCF offered 6 supplemental Data Meetings.

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 integrate inclusivity and equity into those goals. Agencies worked on improving strong data collection and high quality of care in FY25 focusing on symptom improvement and reducing disparities in 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 FY25, CHDI developed more comprehensive public-facing cross-provider data dashboard in collaboration with DCF and providers. The dashboard will be made available starting in FY26 Q1 to improve accessibility and transparency of OPCC performance data. CHDI also started tracking early discontinuation rates by race/ethnicity by provider and will include that information in provider reports starting in FY26 to support reduction of disparities in treatment engagement and to address treatment gaps with an upstream approach.

Connecticut Provider Support Survey (CT-PSS)

CHDI conducted the annual CT-PSS in August-October of 2024. Respondents included clinicians, supervisors, and administrators within the OPCC network, as well as those who provide DCF-supported evidence-based practices (EBPs). There were 314 respondents at OPCC agencies who fully completed the survey and 19 who completed the vast majority of the survey, representing a 52% response rate. Topics covered within the survey fell into four main categories: (1) General Background Information, (2) Organizational and Staff Wellness, (3) EBPs, and (4) Service Delivery. Results from respondents at OPCC agencies can be found in the statewide report (Appendix C). Broadly, results showed that:

- Since 2023, there has been a small increase in perceived workplace support for implementing EBPs and positive perceptions of the work environment.
- Since 2023, there has been a slight decrease in average burnout scores, with the top contributors to burnout being "Administrative burden, including paperwork and data entry", "Too large of a caseload", and "High symptom acuity among clients".
- Since 2023, there was a small decrease in turnover intention, with top strategies to increase retention being "Increased compensation, such as salary increases and cost of living adjustments", "Student loan forgiveness", "Decreased workload", and "Decreased paperwork/non-clinical expectations".
- The top training topics of interest were (1) vicarious and secondary trauma, (2) intellectual developmental disability/autism, (3) first-episode psychosis, (4) suicide prevention, (5) single session/briefer EBP interventions, (6) providing supervision, and (7) co-occurring disorders.
- Racial justice and equity remain a strong priority across the OPCC network, though scores have decreased since 2023.
- Since 2023, there has been a decrease in measurement-based care practices.

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

VIII. SUMMARY & CONCLUSIONS

The OPCC network of providers continued its four-year trend of serving a higher number of children and youth compared to prior years despite ongoing challenges for families and the workforce. Treatment intensity was consistent with recent years, with an average of 22 sessions and a median of 13. Outcomes suggest that the majority of youth benefited from treatment, with 66.7% meeting treatment goals, representing an increase from FY24, and over half showing significant improvement in problem severity across reporters. Across both indicators, children and youth receiving DCF-supported EBPs had better outcomes.

Turning to data quality and availability, FY25 showed both gaps and areas of improvement. Worker-reported outcome data collection rates declined slightly in FY25, which may be due to a mass administrative discharge of 200 treatment episodes by one provider, as those episodes were unlikely to have outcome data. Clinical improvement rates (e.g. Ohio improvement and CGI improvement) declined slightly while rates of meeting treatment goals improved. Given that CGI Improvement is meant to be the primary factor in the Met Treatment Goals indicator, there may have been drift from adhering to this definition. Despite those challenges, collection of race and ethnicity data at intake continued to improve, with only 3.4% of intakes missing this information, compared to 8% and 14% in FY24 and FY23, respectively. CHDI added race and ethnicity data to provider consultation reports in FY25 and worked with providers to improve race and ethnicity data collection. CHDI also partnered with DCF and providers to design a public-facing interactive statewide dashboard displaying quality improvement indicators for each provider. This dashboard aims to improve engagement with data and strengthen cross-provider communication and will go live starting with FY26Q1.

Turning to service needs, increasing rates of trauma as a primary presenting problem over the last four years, particularly for BIPOC youth, underscore the need for greater access to trauma-focused EBPs. Yet fewer youth received these EBPs than in the prior two years. As in previous years, these EBPs resulted in greater improvement in problem severity and functioning

and higher rates of meeting treatment goals in FY25 compared to other treatments. The reduced provision of EBPs may disparately impact BIPOC youth, who had the highest rates of trauma presenting problems, the highest rates of early discontinuation, and the lowest rates of EBP receipt. Black youth had the highest rates of trauma exposure and the highest rates of disruptive behavior presenting problems, which can have overlapping symptoms with posttraumatic stress. Training clinicians on how trauma and disruptive behavior symptoms may overlap, and expanding the array of EBPs for youth with disruptive behavior disorders may help reduce disparities in EBP access and improve clinical outcomes for Black youth.

In response to these disparities, CHDI made a concerted effort to improve equitable access in FY25. These efforts included working with providers to increase race and ethnicity data availability, reviewing EBP access rates by race and ethnicity with providers each quarter, and setting SMARTIE goals for improvement. CHDI also offered trainings on topics such as Cultural Sensitivity. The FY25 EBP Conference supported clinicians' use of EBPs with BIPOC youth with 17.6% of workshops meeting NASW CE Cultural Competency requirements.

Looking ahead, efforts in FY26 should focus on supporting clinicians so that they can improve youth and family engagement and deliver effective care more broadly, and particularly for BIPOC youth. Clinicians who feel recognized for their efforts and who feel effective are less likely to experience burnout (Finkelstein et al., 2015[10]; Gunduz, 2012[11]), have greater EBP uptake (Lau et al, 2020[12]) and achieve better outcomes for clients (Yang & Hayes, 2020[13]). Supports for clinicians to reduce strain and improve EBP uptake can include workshops on

reducing burnout and the use of EBP sustainability funds to reduce productivity requirements or provide other tangible recognition of clinicians' efforts. Improving clinician self-efficacy through training opportunities can also reduce strain while improving engagement and outcomes. Trainings that increase clinicians' comfort and confidence in delivering EBPs in the communities they serve, particularly when serving BIPOC families, can enhance clinician self-efficacy and client engagement.

Beyond clinician-level support, consultation and training efforts can use data strategically at the provider-level to increase EBP availability at sites serving larger numbers of BIPOC youth and families. For example, information on the ratio of EBP clinicians per youth served and the proportion of EBP clinicians active in the model at sites serving high proportions of BIPOC youth could inform whether to focus on increasing existing clinician uptake or training additional team members.

10. Finklestein M, Stein E, Greene T, Bronstein I, & Solomon Z. (2015). Posttraumatic Stress Disorder and Vicarious Trauma in Mental Health Professionals. Health & Social Work, 40(2), e25–e31. doi: 10.1093/hsw/hlv026.
11. Gunduz B. (2012). Self-efficacy and burnout in professional school counselors. Educational Sciences: Theory and Practice, 12(3), 1761–1767.
12. Lau AS, Lind T, Crawley M, Rodriguez A, Smith A, & Brookman-Frazee L. (2020). When do therapists stop using evidence-based practices? findings from a mixed method study on system-driven implementation of multiple EBPs for children. Administration and Policy in Mental Health and Mental Health Services Research, 47(2), 323–337.
13. Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. Psychotherapy, 57(3), 426–436. https://doi.org/10.1037/pst0000317

Intervening upstream around treatment engagement is also crucial for improving EBP uptake and treatment outcomes. FY25 saw overall improvement in engagement; however, Black and Hispanic youth continued to have similarly lower rates of engagement compared to White youth. A focus on youth and family engagement could improve disparities in clinical outcomes, outcome data availability, and access to EBPs. Including engagement metrics (e.g. receiving at least 4 treatment sessions) in quarterly reports will allow for setting engagement-related goals in consultation. Support for use of T-SBIRT, especially for providers serving BIPOC youth, can also improve both treatment engagement for youth with post-traumatic symptoms and increase referrals to trauma-focused EBPs through enhanced identification and motivation for treatment. Expanding the availability of other brief EBPs may also increase the benefit of treatment for families for whom lengthier models are not an option.

Overall, FY25 highlighted both the strengths of the OPCC network and the challenges in providing equitable care. Continued focus on supporting clinician efficacy, strategic EBP expansion, and engagement-centered practices will position providers to deliver more equitable and effective care. With new data tools and targeted quality improvement efforts in FY26, the network is poised to build on this progress and further improve outcomes for all children and families.

In line with the findings in this report, CHDI has the following recommendations:

IX. RECOMMENDATIONS

- **Promote the use of evidence-based screening and brief intervention models (e.g. A-SBIRT, T-SBIRT)**. These models can improve clinicians' skills and comfort in discussing trauma and substance use, increase the identification of youth in need of evidence-based treatments for trauma, and facilitate access to needed substance use treatment in a shorter amount of time.
- **Integrate data on early discontinuation by race and ethnicities into provider consultation reports**. Having this data easily accessible facilitates developing targeted strategies for improving youth and family engagement, particularly for Black and Hispanic youth and families.
- **Provide training on using EBPs in culturally responsive ways**. While all youth tend to do better when they receive an EBP, there continues to be a gap in who receives an EBP with Black and Hispanic youth less likely to receive a treatment model. Training efforts explicitly on helping clinicians tailor approaches to using EBPs with Black and Hispanic youth can help improve engagement in treatment for these youth.
- **Monitor Ohio Worker availability**. This is an important metric that dipped in FY25. Focusing on this in FY25, reporting it by provider in the public-facing cross-summary report, and targeting efforts to improve discharge Ohio collection specifically with providers whose data collection declined can help improve rates in FY26.
- **Investigate changes in the association between Met Treatment Goals and CGI Improvement**. CGI-I is intended to be the primary determinant of the Met Treatment Goals designation, and drift from that definition may require reminding and retraining clinical staff on how CGI and Met Treatment Goals are connected.

- **Improve treatment options and outcomes for disruptive behavior presenting problems by expanding the array of EBPs for disruptive behavior disorders**. This is a clear need from the OPCC data. Introducing appropriate EBPs and then supporting their effective use of available EBPs, while ensuring that clinicians trained in trauma-focused EBPs understand the overlap between post-traumatic symptoms and disruptive behavior, can help target this need. Given that disruptive behavior presenting problems maintained the second highest prevalence and that they are more common for Black youth, who are also less likely to receive EBPs, there is a clear need to improve treatment for such symptom presentations to improve outcomes and equity of services.

X. APPENDIX A: DATA AVAILABILITY

OPCC providers use several clinical scales to track client progress and outcomes for discharged episodes. As described on page 8, these measures are required for episodes with intakes after July 1, 2018, who are not designated as "Evaluation Only." In FY25 there were 9,211 youth discharged from OPCC services with data collection required.

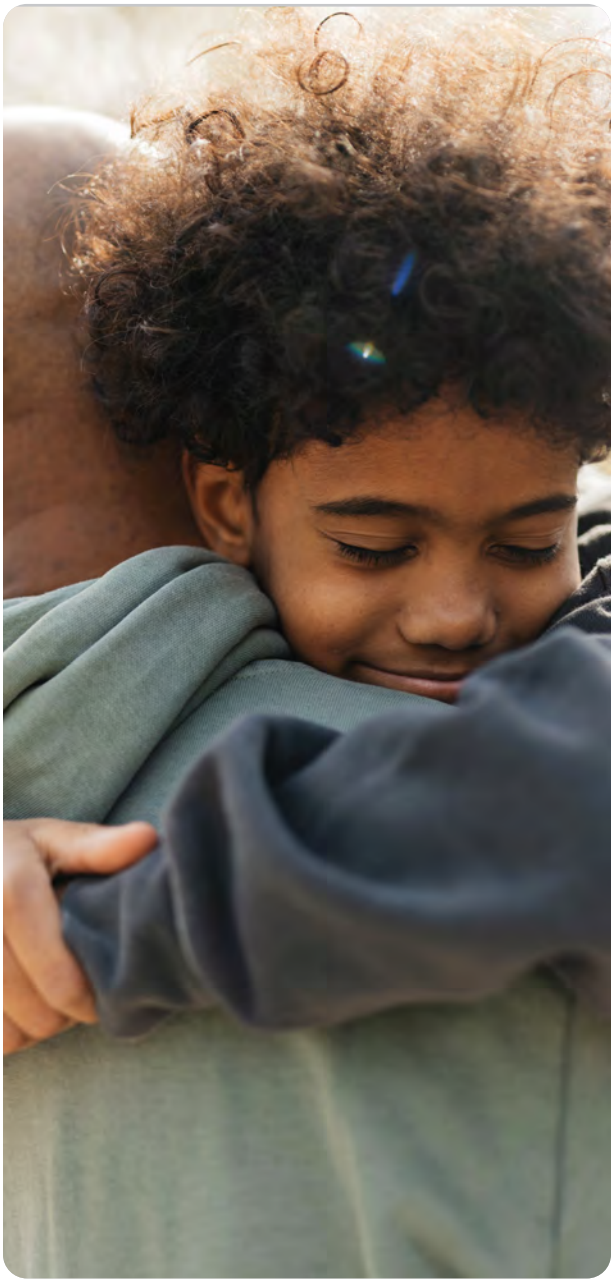
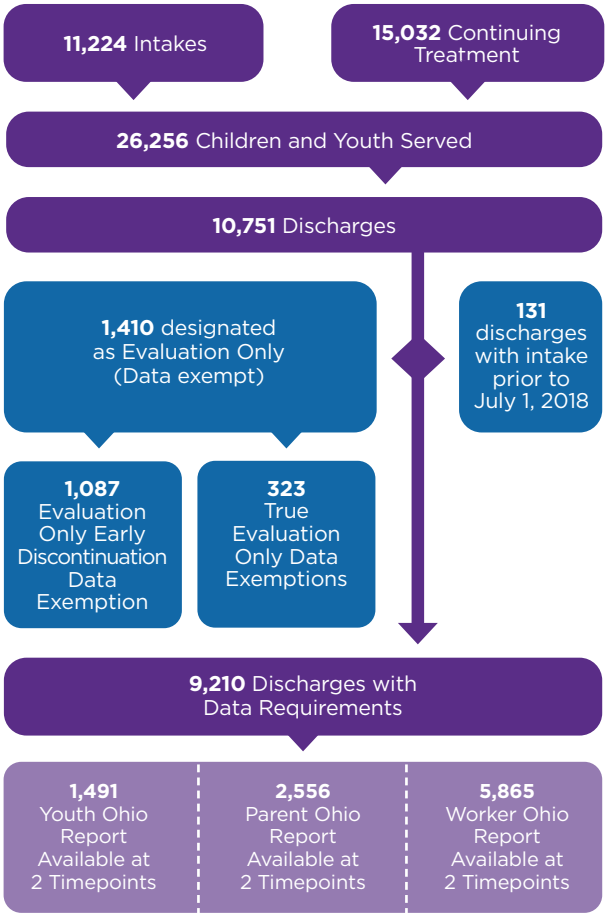


Figure A1 shows a flowchart of youth served in OPCC, their pathway to discharge, and their outcomes data availability.

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 32.8% for Youth report, 29.0% for Parent report, and 66.6% for Worker report.

Figure A2. Baseline Data

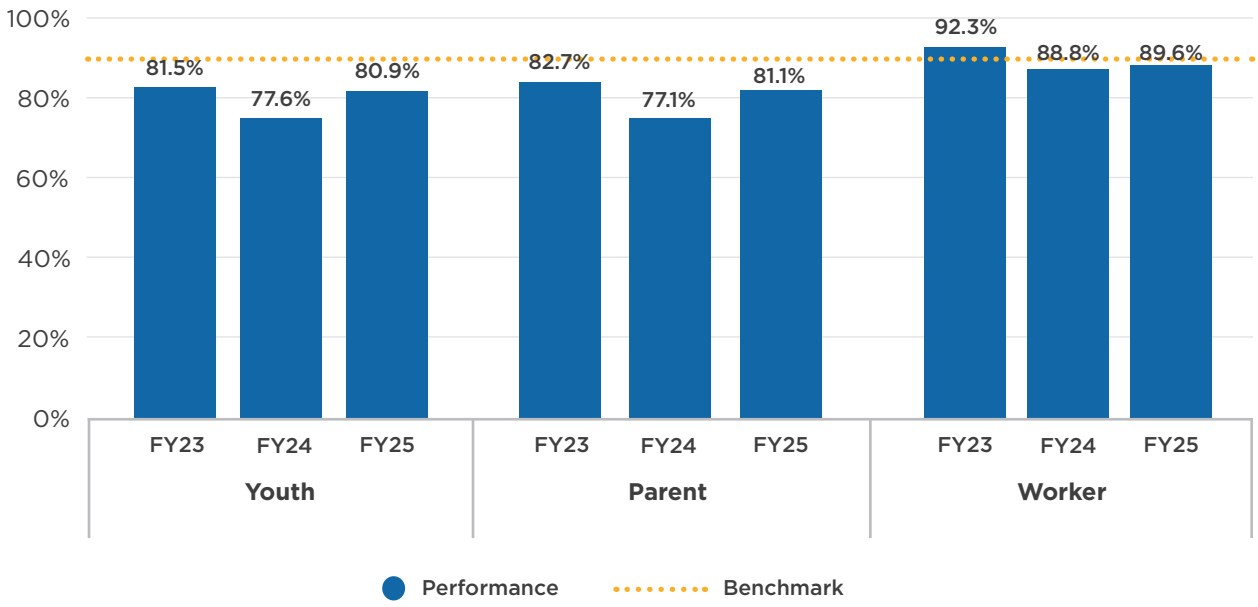


Figure A3. Outcome Data

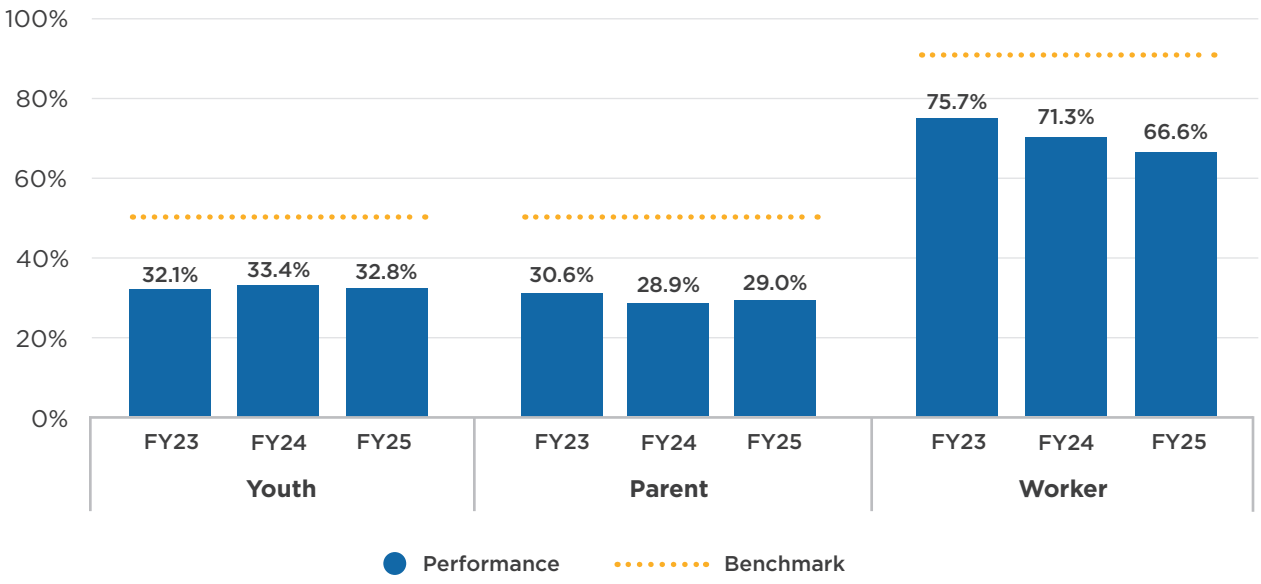
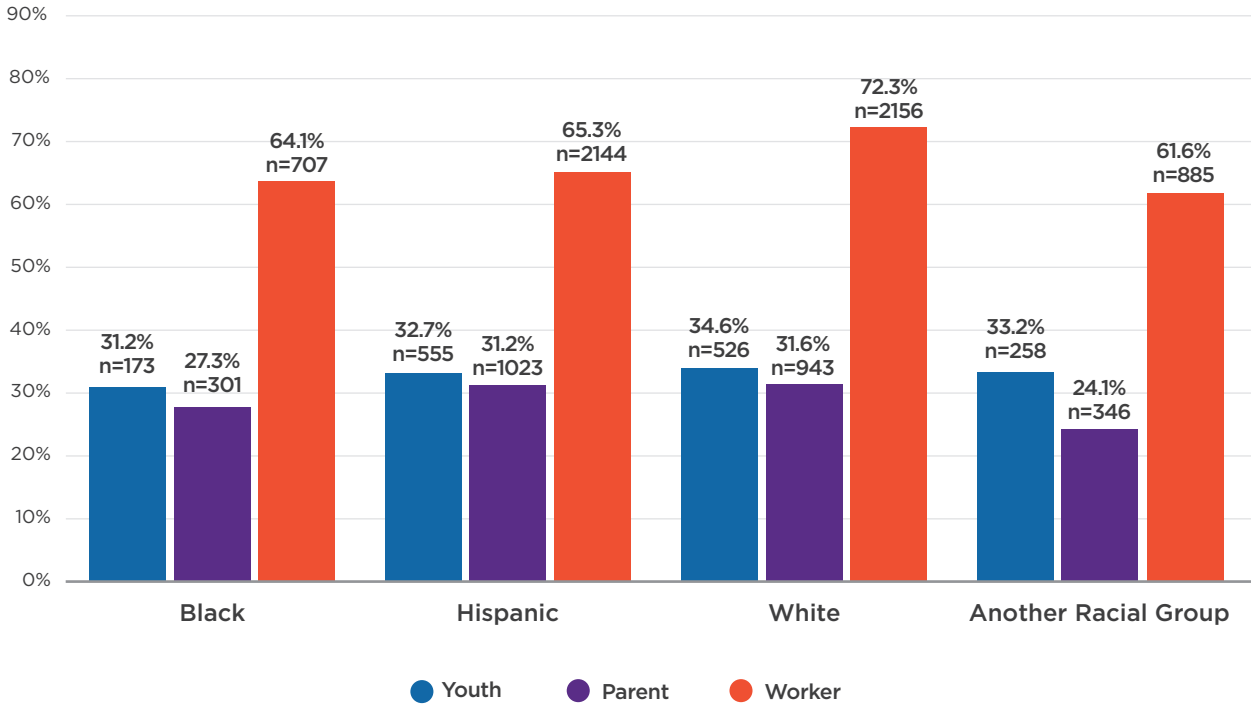


Figure A4 shows the percentage of youth with outcome data available for each of the three reporters by racial group. **Availability of outcome data was equivalent across race and ethnicity for Youth report (Appendix B, Table B3), but Parent report had lower availability for Black and Another Race youth compared to White and Hispanic youth, and Worker report availability was lower for Black, Hispanic, and Another Race youth than for White youth** (Figure A4) and these differences remained when controlling for other child characteristics (Appendix B, Tables B4-B5). Older children were slightly less likely to have Parent and Worker data available, and youth with DCF involvement were less likely to have data available for any reporter.

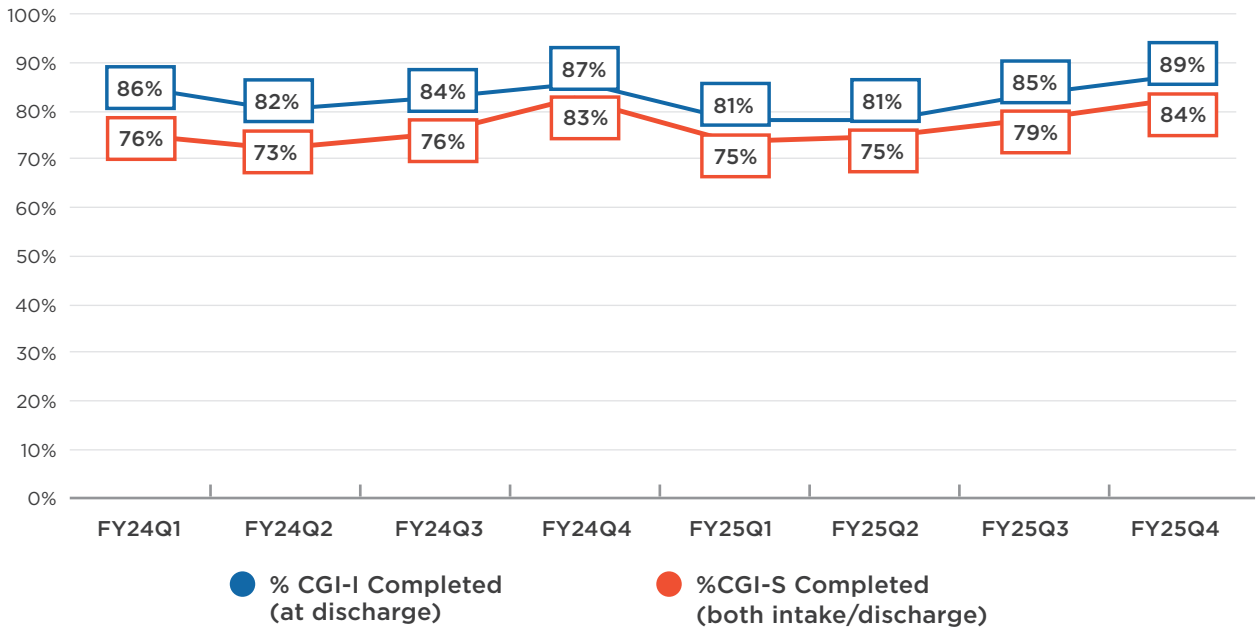
Figure A4. Data Availability by Race and Ethnicity



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. Eighty-four percent of episodes discharged in FY25 had the CGI-I scale completed, which was similar to FY24, and 74.5% had the CGI-S completed, which was a slight decrease from FY24 (76.4%). Trends in CGI data completion over the last two fiscal years 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 Controlling for Provider

Variable	*N*	β	*SE*	*Wald*	e^B*(95% CI)*
Black Non-Hispanic	1166	-0.331*	0.152	4.724	0.718 (0.533,0.968)
Hispanic	3445	-0.201*	0.102	3.871	0.818 (0.669,0.999)
Another Race Non-Hispanic	1492	-0.235	0.138	2.889	0.791 (0.603,1.037)
Sex Male	4375	-0.688**	0.091	57.660	0.503 (0.421,0.600)
Child Age at Intake	9211	0.020	0.012	2.826	1.020 (0.997,1.044)
DCF Involved "No"	7873	-0.464**	0.109	18.128	0.629 (0.508,0.779)
Constant		-2.023	0.214	85.579	0.132

*p<.05 As compared to White Non-Hispanic Females at the provider with the median percent of youth receiving EBPs.
**p<.001 The 21 provider effects are excluded from this table due to space, but ranged from -2.44 to 1.24

Table B2. Logistic Regression for Any Early Discontinuation

Predictors	*N*	β	*SE*	*Wald*	*eB (95% CI)*
Black Non-Hispanic	1421	0.425**	0.082	26.66	1.530 (1.302, 1.798)
Hispanic	4101	0.296**	0.063	21.812	1.345 (1.188, 1.523)
Another Race Non-Hispanic	1711	0.081	0.084	0.937	1.084 (.920, 1.277)
Sex Male	5196	0.190**	0.053	12.917	1.210 (1.090, 1.342)
Child Age at Intake	10751	0.009	0.007	1.644	1.009 (.995, 1.023)
DCF Involved "No"	9142	-0.212*	0.070	9.199	.809 (.705, .928)
Constant	10751	-1.829	0.111	271.909	0.161

*p<.05 As compared to White 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 Youth Ohio Available

Predictors	*N*	β	*SE*	Wald	*eB (95% CI)*
Black Non-Hispanic	554	-0.150	0.109	1.898	.861 (.695, 1.065)
Hispanic	1698	-0.068	0.076	0.785	.935 (.805, 1.085)
Another Race Non-Hispanic	777	-0.004	0.095	0.002	.996 (.827, 1.199)
Sex Male	1787	-0.022	0.066	0.115	.978 (.860, 1.112)
Child Age	4550	0.005	0.019	0.062	1.005 (.968, 1.044)
DCF Involved "No"	3992	0.412**	0.105	15.318	1.510 (1.229, 1.857)
Constant	4550	-1.172	0.293	16.02	0.310

*p<.05 As compared to White females
**p<.001 Data considered "available" if either Ohio Problem Severity or Functioning data were available at two time points and were not exact item-for-item duplicates.

Table B4. Logistic Regression for Parent Ohio Available					
Predictors	***N***	**β**	***SE***	**Wald**	***eB (95% CI)***
Black Non-Hispanic	1103	-0.241**	0.081	8.854	.786 (.671, .921)
Hispanic	3281	-0.029	0.056	0.272	.971 (.870, 1.084)
Another Race Non-Hispanic	1437	-0.333**	0.075	19.894	.717 (.619, .830)
Sex Male	4113	-0.044	0.049	0.827	.957 (.870, 1.052)
Child Age at Intake	8801	-0.048**	0.007	48.102	.953 (.941, .966)
DCF Involved "No"	7529	0.237**	0.071	11.206	1.267 (1.103, 1.456)
Constant	8801	-0.523	0.108	23.629	0.593

*p<.05 As compared to White females

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

Table B5. Logistic Regression for Worker Ohio Available					
Predictors	***N***	**β**	***SE***	**Wald**	***eB (95% CI)***
Black Non-Hispanic	1103	-0.330**	0.073	20.666	.719 (.623, .829)
Hispanic	3281	-0.299**	0.053	32.056	.741 (.669, .822)
Another Race Non-Hispanic	1437	-0.371**	0.066	31.419	.690 (.606, .785)
Sex Male	4113	-0.122*	0.045	7.398	.885 (.811, .967)
Child Age at Intake	8801	-0.018*	0.006	8.115	.982 (.970, .994)
DCF Involved "No"	7529	0.116	0.062	3.448	1.123 (.994, 1.269)
Constant	8801	0.866	0.100	75.740	2.378

*p<.05 As compared to White females

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

Table B6. Multiple regression on Ohio Scales Outcomes - Worker Report								
	Problem Severity				***Functioning***			
Predictors	**β**	***SE***	**95%CI**	***Effect Size***	**β**	***SE***	**95%CI**	***Effect Size***
Constant	-6.580	0.555	(-7.668, -5.492)		4.809	0.526	(3.777, 5.840)	
Hispanic	-0.657	0.352	(-1.347, .034)	-0.025	0.476	0.334	(-.179, 1.132)	0.018
Another Race Non-Hispanic	-0.643	0.449	(-1.523, .236)	-0.019	0.024	0.426	(-.811, .858)	0.001
Black Non-Hispanic	1.635**	0.489	(.675, 2.594)	0.045	-1.725**	0.464	(-2.636, -.815)	-0.048
Sex Male	0.286	0.302	(-.307, .879)	0.013	-0.306	0.287	(-.869, .256)	-0.014
Child Age at Intake	-0.053	0.040	(-.131, .025)	-0.018	0.065	0.038	(-.009, .138)	0.022
DCF Involved	1.350**	0.423	(.520, 2.179)	0.043	-1.025*	0.401	(-1.811, -.238)	-0.033
Had any EBT	-1.238*	0.585	(-2.385, -.090)	-0.029	1.734*	0.555	(.645, 2.822)	0.040
R^2	0.008							
F	6.357							

*p<.05 As compared to White females EBTs = TF-CBT and MATCH-ADTC.

**p<.001 Outliers were identified using the 1.5*QI rule and were winsorized for Worker PS (n=108) and FX (n=113) 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

Reporter	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	1518	23.52	16.33	2606	21.94	15.68	5890	22.6	16.15
		(13.83)	(12.61)		(12.93)	(12.04)		(10.94)	(10.68)
Black	172	23.61	16.47	300	20.17	15.93	707	21.84	17.27
		(14.22)	(12.83)		(12.23)	(11.56)		(10.43)	(10.94)
Hispanic	557	23.29	15.12	1019	21.01	14.59	2146	22.39	15.53
		(14.15)	(12.35)		(13.3)	(12.24)		(11.11)	(10.65)
White	530	23.9	17.73	943	23.37	17.01	2153	23.26	16.9
		(13.27)	(12.62)		(12.62)	(11.88)		(10.83)	(10.6)
Another Racial Group	259	23.16	15.97	344	21.82	15.04	884	22.14	14.95
		(14.06)	(12.81)		(12.94)	(11.95)		(11.13)	(10.51)

Table C2. Mean Pre and Post Ohio Scales Functioning Scores

Reporter	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	1496	52.48	58.83	2563	50.95	55.97	5869	49.27	54.51
		(13.36)	(12.38)		(14.3)	(14.64)		(10.87)	(11.99)
Black	169	52.95	58.82	295	51.11	55.01	706	49.14	52.5
		(12.51)	(11.41)		(14.16)	(14.4)		(11.22)	(12.06)
Hispanic	550	51.6	59.06	1002	51.54	56.86	2134	49.23	54.96
		(13.45)	(12.81)		(14.03)	(14.82)		(10.71)	(12.13)
White	525	53.04	58.42	928	50.17	55.03	2194	49.32	54.65
		(13.48)	(12.57)		(14.75)	(14.46)		(11.06)	(11.89)
Another Racial Group	252	52.92	59.18	338	51.16	56.71	880	49.39	54.71
		(13.45)	(11.69)		(13.89)	(14.66)		(10.53)	(11.71)

XIII. APPENDIX D. CT-PSS STATEWIDE REPORT

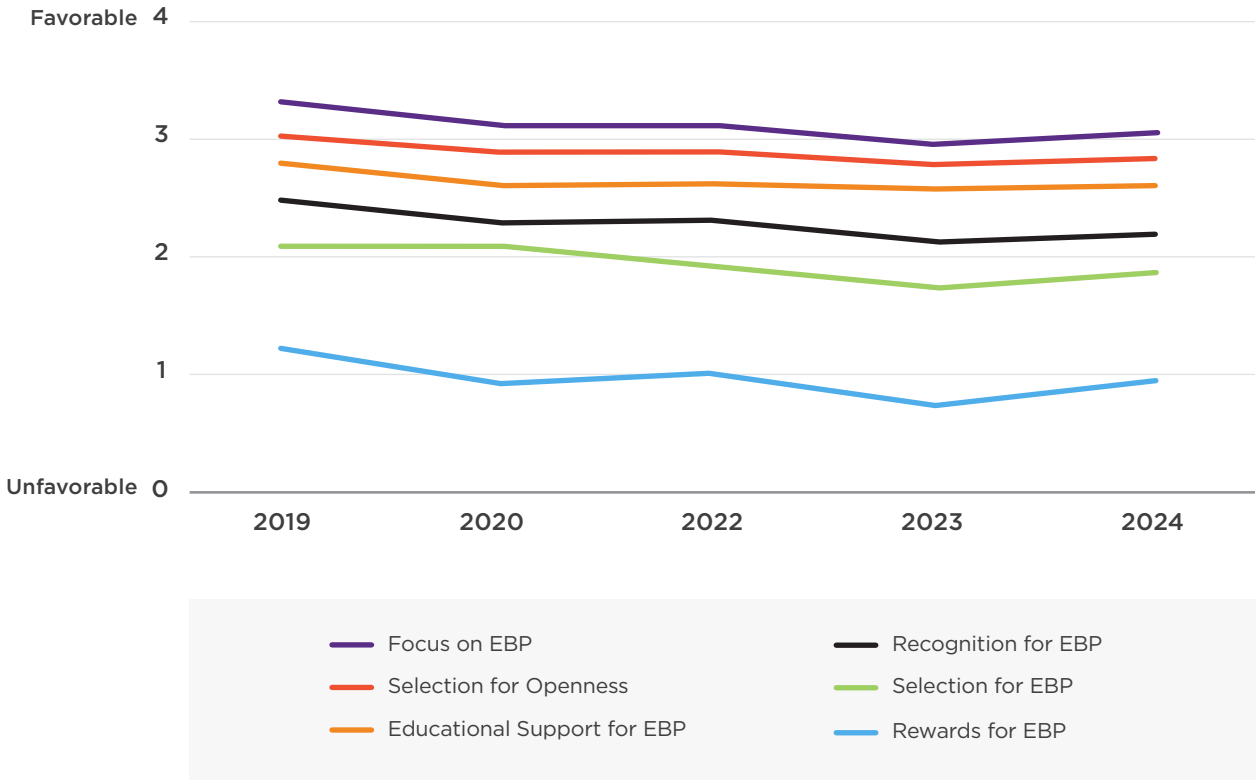
Connecticut Provider Support Survey (CT-PSS) OPCC Statewide Providers - 2024 Results

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 314 OPCC providers who fully completed the survey and 19 OPCC providers who completed the vast majority of the survey, representing a 52% response rate. The higher the response rate, the more confident we are that the results represent those within the state.

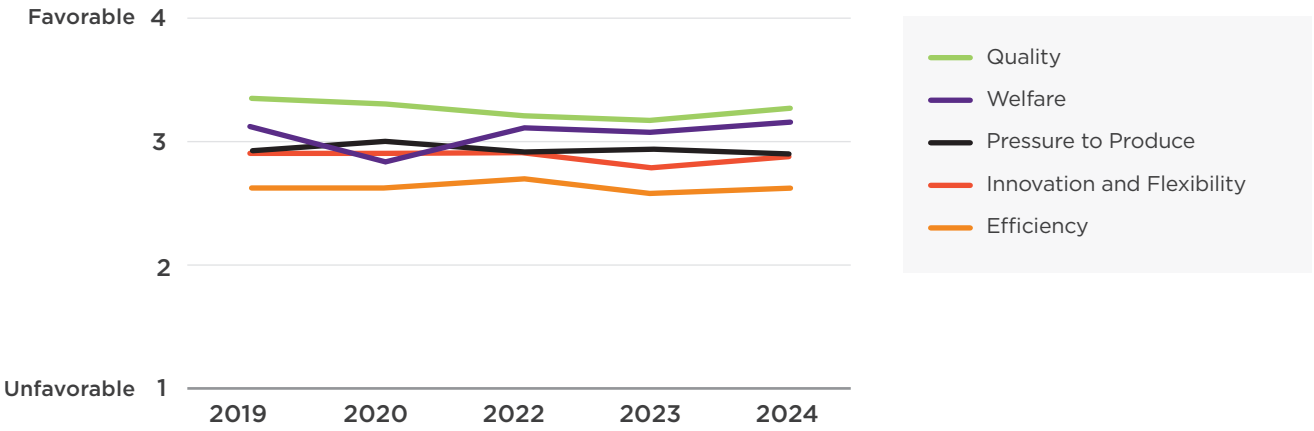
Perceptions of Workplace Factors that Facilitate the Implementation of EBP

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

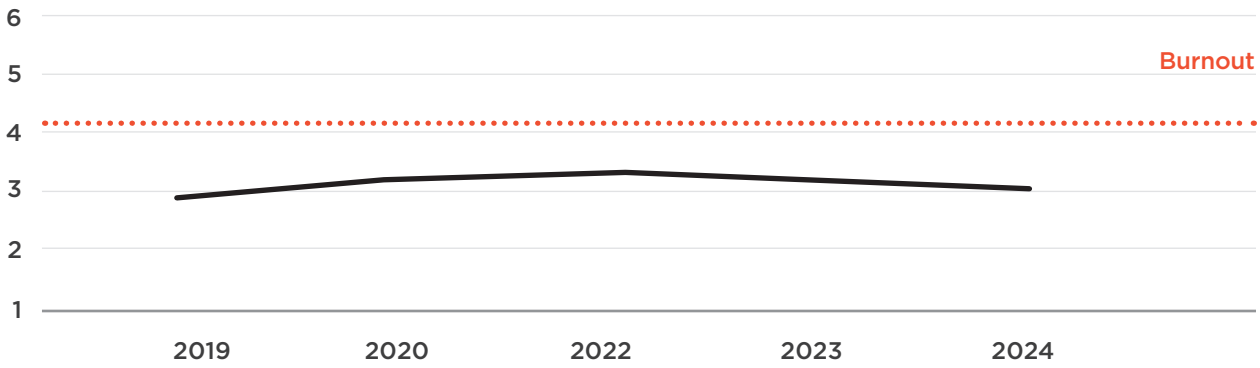
The Organizational Climate Measure (OCM) assesses workers' perceptions of their work environment



Workforce Wellness

Burnout

The Burnout Scale assesses emotional exhaustion and depersonalization. Since 2019, burnout has increased by 6.3%, though there was a 4.4% decrease in burnout between 2023 and 2024. The top two contributors to burnout listed by staff were "Administrative burden, including paperwork and data entry" (53.5%), "Too large of a caseload"(44.4%) and "High symtom among clients." (34.8%).



Turnover

The Turnover Intention Scale (TIS-6) assesses employees' intent to stay with their organization. This year, the average score was 2.39 on a scale of 1 to 5, indicating employees had neutral intention to leave the organization. This represents a 5.9% decrease from 2023.

Top three strategies to increase retention:

1. Increased compensation, such as salary increase and cost of living adjustments **(81.1%)**
2. Student loan forgiveness **(37.8%)**
3. Decreased workload **(25.5%)**
4. Decreased paperwork/non-clinical expectations **(25.5%)**

Workforce Development

Top Training Topics of Interest:

1. Vicarious and Secondary Trauma **(30.9%)**
2. Intellectual Developmental Disability, Autism **(26.7%)**
3. First-episode Psychosis **(21.6%)**
4. Suicide Prevention **(20.1%)**
5. Single Session/Briefer EBT Interventions **(18.9%)**
6. Providing Supervision **(17.7%)**
7. Co-occuring Disorders **(16.5%)**

Top Two Training Topics for Therapists/Clinical Staff Listed by Managers/Supervisors:

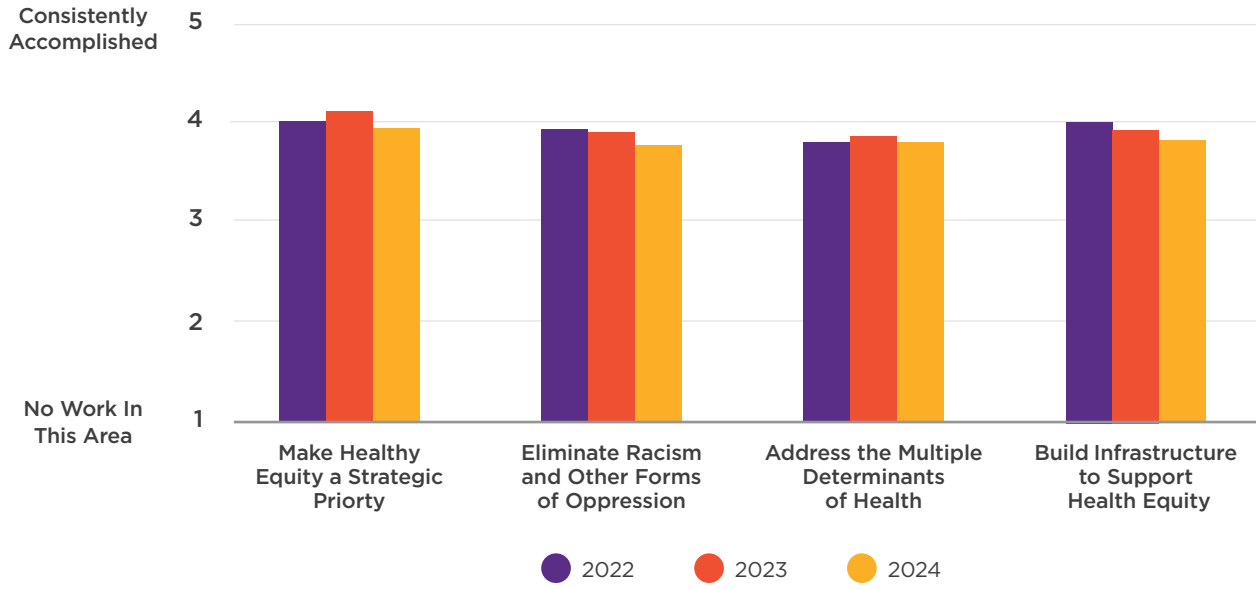
1. Increasing Staff Support/Morale/ Retention **(59.8%)**
2. Professional Development **(52.2%)**

Top Two Training Topics for Managers/Supervisors Listed by Therapists/Clinical Staff:

1. Increasing Staff Support/Morale/ Retention **(64.1%)**
2. Professional Development **(39.8%)**

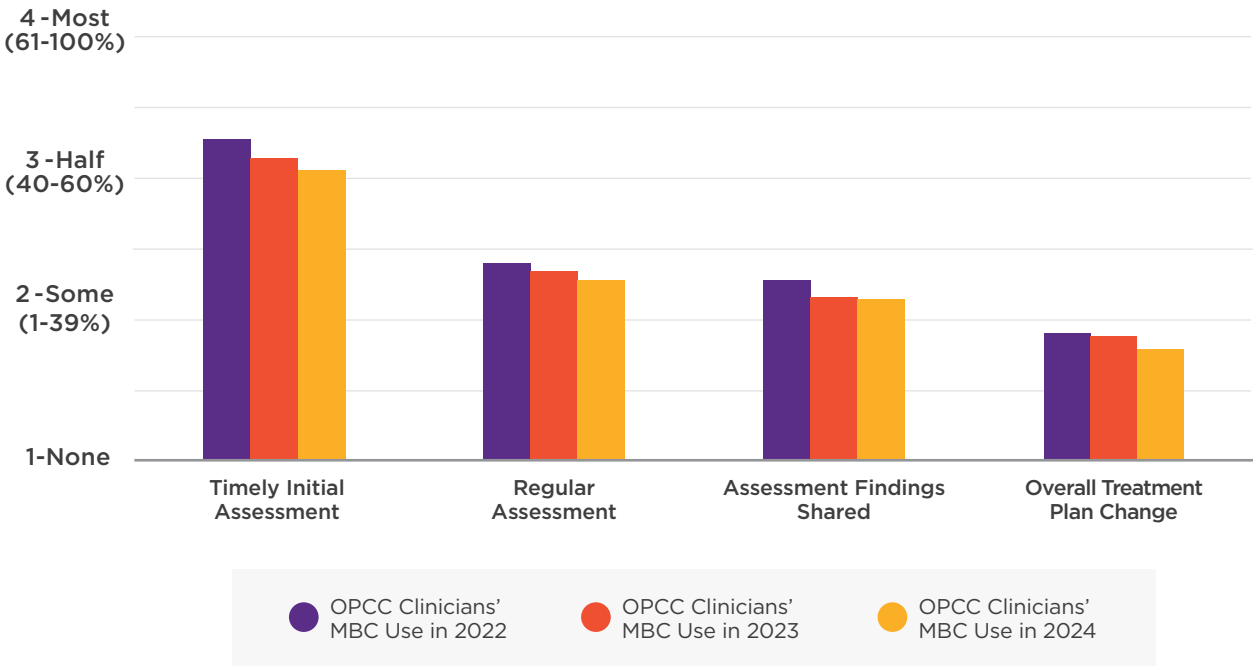
Racial Justice and Equity

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
MET/CBT	Motivational Enhancement Therapy combined with Cognitive Behavioral Therapy
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
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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