Cognitive Behavioral Intervention for Trauma in Schools

CONNECTICUT'S EVIDENCE-BASED
TREATMENT COORDINATING CENTER

CHDI® Child Health and
Development Institute

DCF CONNECTICUT

Connecticut CBITS/BB Coordinating Center

The authors retain full responsibility for all opinions and content.

CONTENTS

I. EXECUTIVE SUMMARY

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

The Coordinating Center now supports a network of 32 teams that have been implementing CBITS and/or BB. Given the increase in demand for children's behavioral health services, CBITS and BB providers ensured strong access, quality, and outcomes for Connecticut youth. This report summarizes the work of the Coordinating Center for state fiscal year (FY) 2023 (July 1, 2022 through June 30, 2023).

KEY FINDINGS OF FY23:

High satisfaction with CBITS/BB treatment among children **(79%)** and caregivers **(97%)**.

2,212 students were screened for trauma exposure and associated symptoms, up from **1,749** the previous year.

61 new clinicians were trained in CBITS and **42** new clinicians in BB.

777 students received CBITS or BB across **101 CBITS** and **92 BB** groups.

Most youth receiving CBITS and BB experienced reliable PTSD symptom reduction (**64.4%** and **64.9%** of children, respectively)

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

More than **70%** of children successfully completed CBITS/BB treatment.

113 schools and **2** other community-based organizations offered CBITS and/or BB.

For CBITS, Hispanic and older youth experienced greater improvement in trauma symptoms. For BB, Black girls experienced the greatest improvement in trauma symptoms.

KEY RECOMMENDATIONS:

- Incorporate EdSight statewide public school and available school-based data in statewide consultation to examine proportional rates for youth racial and ethnic subgroups who receive trauma screening and may be eligible for CBITS/BB services.

- Develop SMARTIE (Specific, Measurable, Attainable, Relevant, Time-bound, Inclusive, and Equitable) goals with providers to examine the demographics of children served and the barriers related to completion of treatment.

- Increase the percentage of clinicians providing CBITS/BB groups to 50% by establishing team-based CBITS/BB goals during site-based consultation to ensure that active clinicians conduct one group with at least 3 youths during the year.

II. INTRODUCTION

TThe Cognitive Behavioral Intervention for Trauma in Schools (CBITS)[1] model is a short-term, manualized, trauma-focused group intervention designed for children in grades 5 through 12 that are experiencing post-traumatic reactions due to exposure to violence, abuse, and other forms of trauma. Bounce Back (BB) is an adaptation of CBITS for elementary-aged children[2] in kindergarten through grade 5. Recognizing the need to provide school with resources for supporting students exposed to trauma in 2014, DCF partnered with CHDI to serve as the CBITS Coordinating Center. By the end of FY23, the network consisted of 32 providers. The figure below illustrates the goals and primary activities of the Coordinating Center.[3]

1. Jaycox, L.H., Langley, A.K., Hoover, S.A. (2018). Cognitive Behavioral Intervention for Trauma in Schools, second edition (revised). Santa Monica, CA: RAND Corporation

2. Langley, A. K., Gonzalez, A., Sugar, C. A., Solis, D. & Jaycox, L. (2015). Bounce back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. *Journal of Consulting and Clinical Psychology, 83*(5), 853-865. Doi: 10.1037/ccp0000051.

3. A detailed accounting of these activities during FY23 can be found in Appendix A

CBITS/BB COORDINATING CENTER GOALS AND ACTIVITIES

EQUITY

ACCESS

Increase Access to CBITS/BB

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

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

Do all groups have equal access to CBITS/BB?

QUALITY

Ensure Quality of CBITS/BB

Activities: Credentialing & certification of clinicians, site-based implementation & consultation, data collection & reporting.

Measured by: Clinicians meeting credentialing requirements; performance on quality improvement (QI) indicators and fidelity measures.

Are all groups receiving high quality CBITS/BB treatment?

OUTCOMES

Improve Outcomes for Children Receiving CBITS/BB

Activities: Ongoing quality improvement work with agencies and school districts and periodic collection of assessment measures to monitor child symptoms and track changes.

Measured by: Children experiencing reliable & significant improvement in PTSD symptoms, depression, problem severity or functioning.

Are all groups benefiting from CBITS/BB?

This FY23 report is framed across access, quality, outcome, and equity goals. Summary, conclusions, and recommendations are shared to guide future work.

III. ACCESS TO CBITS/BB IN CONNECTICUT

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

Service Availability Across the State

During FY23, CBITS was available at 62 schools and 2 community-based settings across 28 different providers; BB was available at 55 schools and 2 community-based settings across 23 different providers. A total of 101 CBITS and 92 BB groups were held in FY23.

Figure 1. Map of CBITS/BB Intakes per 10,000 Children SFY 2023

Legend

● CBITS/BB Sites

Intakes per 10,000
children ages 5-19 years

○ No Intakes
○ 0-7
○ 7-16
○ 16-28
○ 28-46
○ 46-232
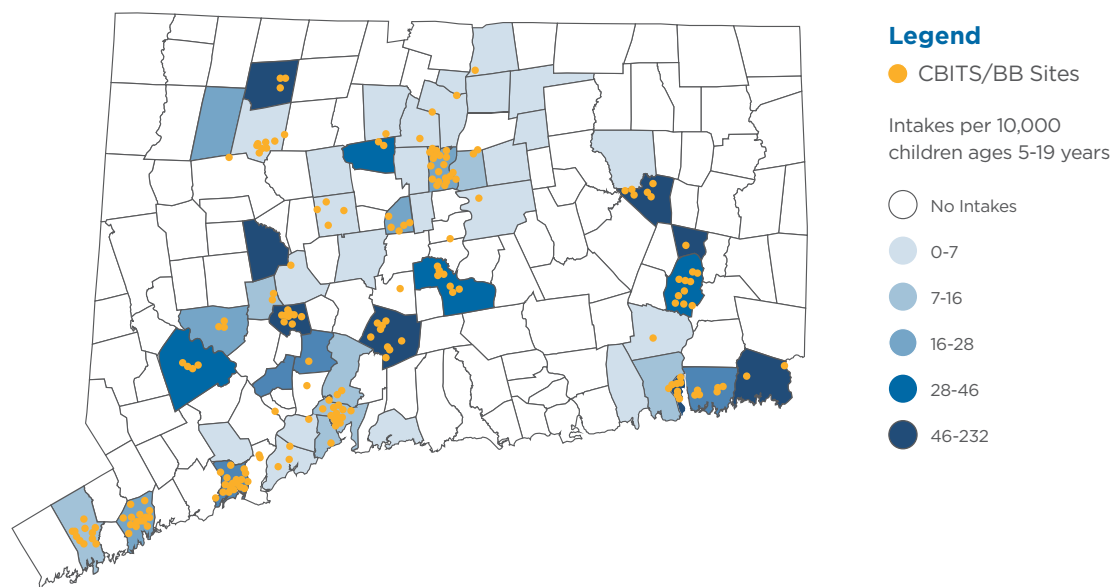
This year, providers trained 61 CBITS and 42 BB clinicians, which was an increase from last year. This allows providers to meet training demand and address staff turnover. To support high quality service delivery, 95 CBITS and 49 BB clinicians attended booster trainings and 11 CBITS and 10 BB clinicians achieved certification. Tables 1 and 2 show details about CBITS and BB teams.

Table 1. FY23 CBITS and BB Teams
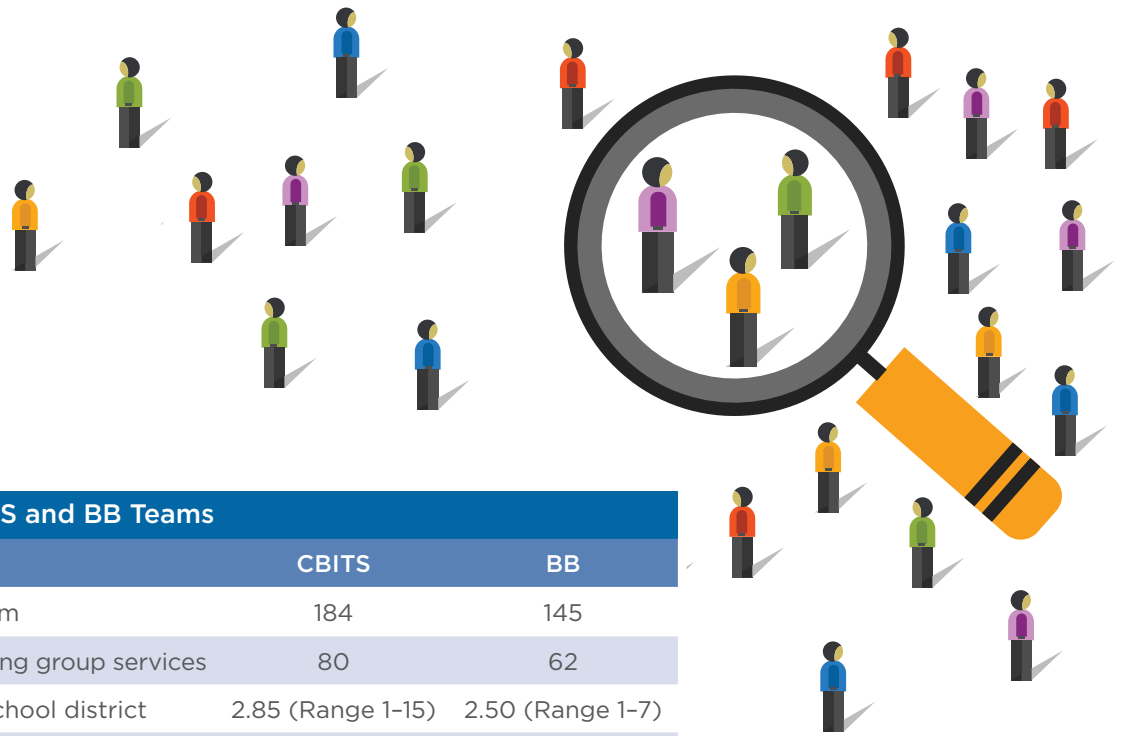
	CBITS	BB
# of clinicians on team	184	145
# of clinicians providing group services	80	62
Average team size-school district	2.85 (Range 1–15)	2.50 (Range 1–7)
Average team size-community based	3.00 (Range 1–5)	2.00 (Range 1–4)

Table 2. Trends in CBITS/BB Provider Network

	FY 2020	FY 2021	FY 2022	FY 2023	Cumulative Since 2015
Schools					
CBITS	47	43	58	**62**	228*
BB	55	35	47	**55**	
School Districts					
CBITS	18	16	26	**26**	39*
BB	18	17	20	**21**	
Community-Based Settings**					
CBITS	6	3	10	**2**	18*
BB	5	4	5	**2**	
Newly Trained Clinicians					
CBITS	69	49	57	**61**	673*
BB	47	42	39	**42**	
# Newly Certified					
CBITS	0	1	6	**11**	59*
BB	0	2	4	**10**	
Clinicians Providing Treatment					
CBITS	59	50	69	**80**	377*
BB	60	43	56	**62**	

*Unique total (only counted once if trained in/certified in/provided both models, or if site provides both models)

**Community based settings include outpatient clinical and extended day treatment settings

Children Who Received CBITS/BB

In FY23, 2,212 children were screened for trauma exposure and traumatic stress and 1,119 were eligible to participate in a group. Of the children screened that were found eligible only 69% (777 of 1,119 children) participated in treatment. This is a decrease from FY22, where 86% of children received treatment. Of the 1,119 children who were screened, the percent referred to other services increased from 12% to 17% and the number of youth that declined services decreased from 14% to 11%. The number of children receiving CBITS that were referred to higher levels of care this fiscal year grew from 2.8% to 4.4%.
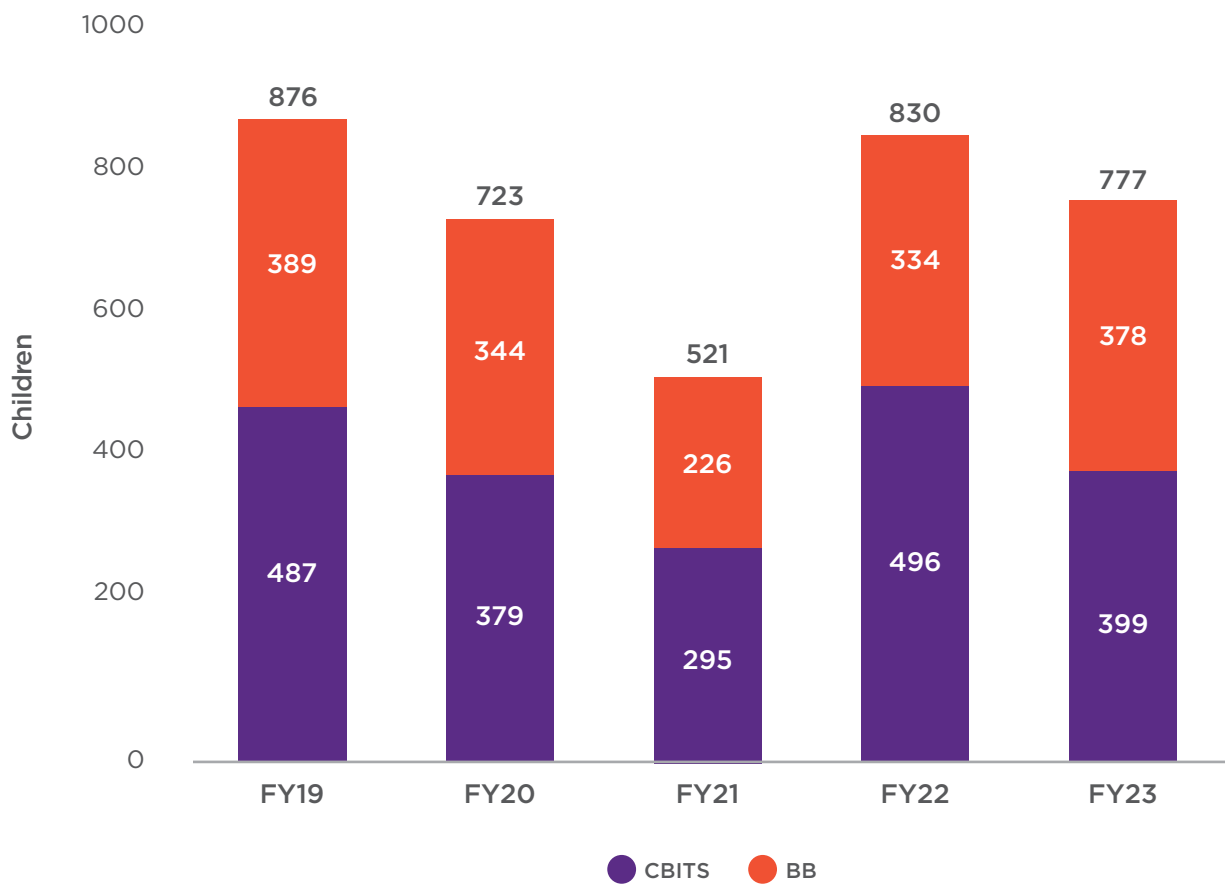
During the year, 399 children received CBITS and 378 children received BB. The average number of youth in a CBITS group decreased to 3.95 from 4.22 last year. Despite fewer children in CBITS groups, the average number of children in BB groups remained consistent from the previous year at 4.11 this year.

Children reported an average of 7.6 (CBITS) and 8.6 (BB) of 18 types of traumatic exposures. Figure 2 shows the number of children who have received CBITS and BB since FY19. To date, 2,906 children have received CBITS since 2015 and 1,876 children have received BB since 2017(4,782 total children served).

Figure 2. Children served since FY19

Children

	FY19	FY20	FY21	FY22	FY23
Total	876	723	521	830	777
BB	389	344	226	334	378
CBITS	487	379	295	496	399

● CBITS   ● BB

Child Demographics

Table 3 provides descriptive statistics for children who received CBITS and BB, as well as comparisons to those served in schools [as reported on Edsight.gov] and the general child population in Connecticut. In comparison to last year, the average age of youth receiving CBITS is 13.9 (SD=2.42), and 8.6 (SD=1.69) for those receiving BB. Children receiving CBITS and BB were more likely than the general population to be Black/African-American or Hispanic descent, and less likely to be White or Asian.

Table 3. Characteristics of children receiving CBITS (n=399) and BB (n=378) with comparisons						
	CBITS		BB		CT Schools	CT Pop
	N	%	N	%	%	%
Sex (Male)	136	34.1	185	48.9	51.5	51.2
Race						
American Indian or Alaska Native	*	*	*	*	0.3	0.4
Asian	*	*	*	*	5.2	4.9
Black or African American	108	27.1	72	19.0	12.5	11.7
Native Hawaiian or Pacific Islander	*	*	*	*	0.1	0.0
White	219	54.9	267	70.6	47.5	53.5
Another Racial Group (includes multiracial/ethnic)	71	17.8	33	8.7	4.5	29.4
Hispanic, Latino, or Spanish (Any Race)	190	47.6	163	43.1	30.0	26.5
Age (Years)						
Under 6 years	*	*	18	4.8	N/A	29.8
6–11 years	65	16.3	355	93.9	N/A	33.2
12–17 years	311	77.9	*	*	N/A	37.0
18 and older	22	5.5	*	*	N/A	N/A
Grade						
Elementary	24	6.0	362	96.0	43.6	N/A
Middle	169	42.4	15	4.0	23.1	N/A
High	206	51.6	*	*	33.4	N/A
Child Welfare Involvement During Treatment	40	10.0	48	12.7	N/A	2.9

Table 3. Characteristics of children receiving CBITS (n=399) and BB (n=378) with comparisons

	CBITS		BB		CT Schools	CT Pop
	N	%	N	%	%	%
Juvenile Justice Involvement During Treatment	7	1.8	*	*	N/A	N/A
Child Primary Language						
Spanish	26	6.5	19	5.0	N/A	13.8
Neither Spanish nor English	*	*	*	*	N/A	7.8
Caregiver Speaks English (No)	9	2.3	38	10.1	N/A	N/A

[i]Data obtained from CT Dept. of Education: edsight.ct.gov for 2021–22 school year. Age and language spoken not available

[ii]American Community Survey 2019 1 yr. estimates. Caution should be used with comparison to CT schools and CBITS/BB child demographics. Census language is only available by language spoken, not primary language. Age is percentage of children 0–17 years.

[iii]Based on FY20 CT Data for total number of CPS reports and 2020 U.S. Census estimates for 0–19 year olds.

ACCESS AND EQUITY:

399 children received CBITS and **378** children received BB.

Child welfare involvement was **10%** for CBITS and **12.7%** for BB, while the general school population was **2.9%**

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

# IV. QUALITY: CLINICAL IMPLEMENTATION AND IMPROVEMENT

Treatment Dose and Duration

A total of 92 BB and 101 CBITS groups ran this fiscal year. The CBITS and BB models include 10 group sessions and 1–3 individual sessions. Youth receiving CBITS completed an average of 9.3 (SD=1.5) group and 1.6 (SD=1.0) individual sessions over an average of 2.7 months. Youth receiving BB completed 9.6 (SD=0.8) group and 2.0 (SD=1.2) individual sessions over an average of 3.1 months.

Quality Improvement Indicators

In FY23, nearly all children receiving CBITS/BB had a baseline assessment (98% CBITS; 98% BB) and most had both baseline and post-group assessment data available (81% CBITS; 86% BB). Quality improvement (QI) indicators demonstrate progress across the statewide initiative during the fiscal year. All QI indicators demonstrated improvement or showed only very small decreases and were above the benchmark by the end of the year for both models except for symptom improvement; there were decreases for both models in PP2, and the percentage with symptom improvement was just below the benchmark for youth receiving BB (see Appendix D for additional QI Indicators information).
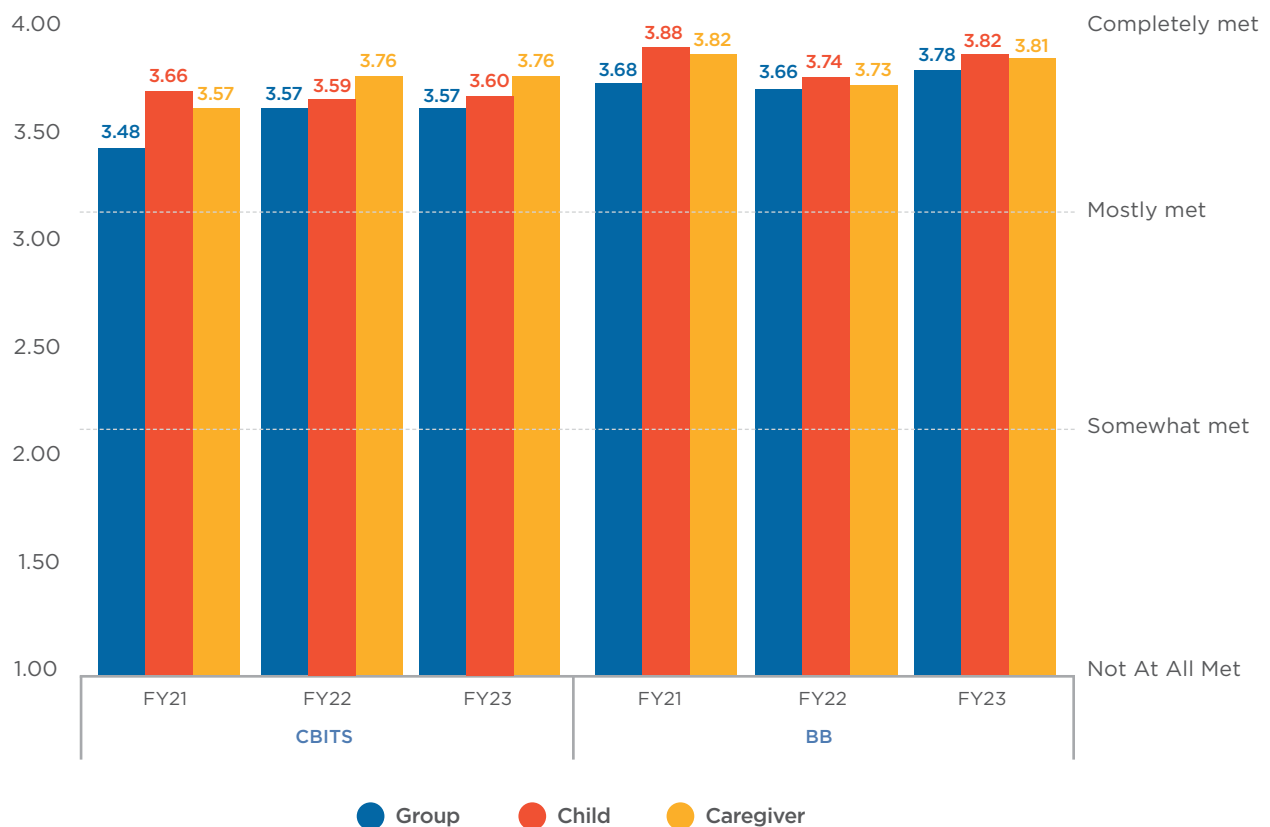
Figure 3. FY23 QI Indicators
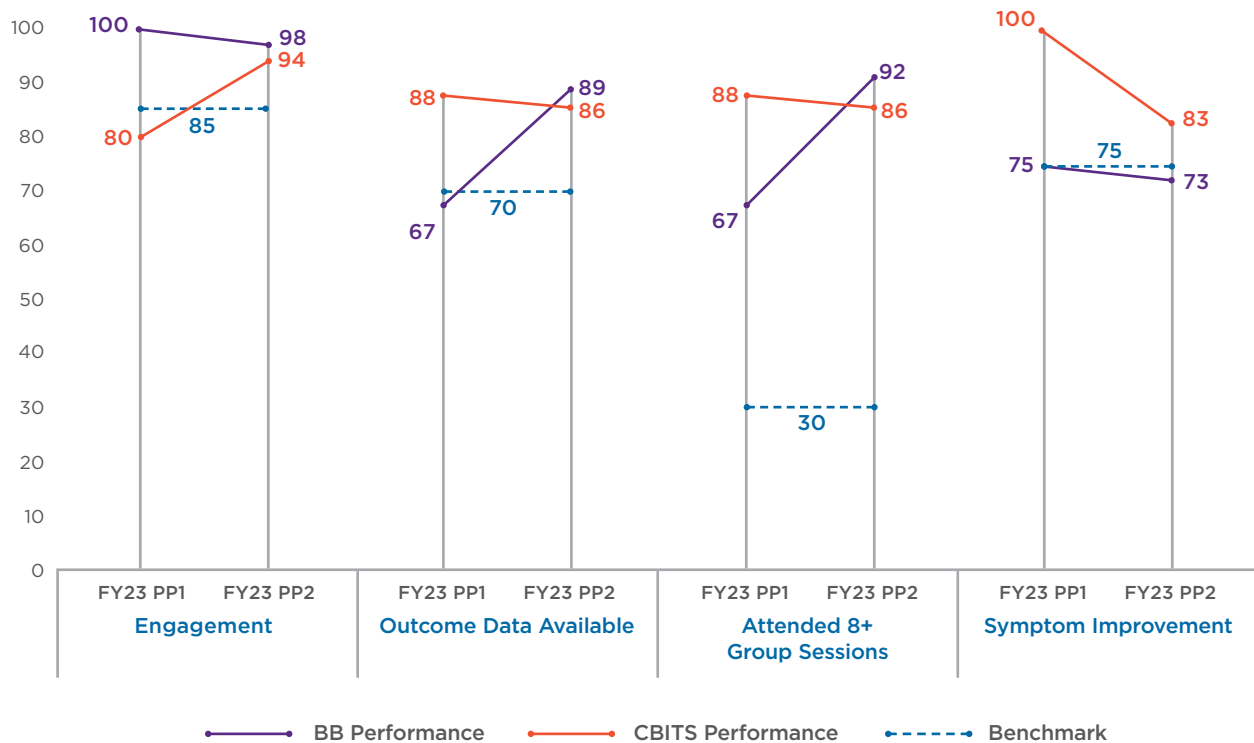
Session Ratings by Clinicians

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

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

Satisfaction

In FY23, 169 children and 31 caregivers completed Ohio Satisfaction assessments about their CBITS/BB group. 79% percent of children and 97% of caregivers reported being moderately or extremely satisfied with treatment.

Satisfaction is rated on a scale of 1-6, with one indicating being extremely satisfied and six indicating being extremely dissatisfied. **For youth who received BB, Hispanic youth reported higher levels of satisfaction with their treatment (M = 1.49) compared to White youth (M = 2.09).**

QUALITY AND EQUITY:

79% percent of children and 97% of caregivers reported being moderately or extremely satisfied with treatment.

For youth who received BB, Hispanic youth reported **higher levels of satisfaction** with their treatment (M = 1.49) compared to White youth (M = 2.09).

V. OUTCOMES: IMPROVEMENT FOR CHILDREN RECEIVING CBITS/BB

Discharge Reason

A total of 428 children in CBITS and 392 youth in BB completed their treatment episode in FY23. Successful completion was the most common discharge reason for both treatment models (74.7% CBITS, 87.2% BB). Other common discharge reasons for CBITS included "other" (7.9%) and administrative discharge (CHDI-level discharge) (7.5%). Family discontinued was reported as the discharge reason for 3% of CBITS episodes, and referral to a higher level of care or other treatment was reported for 4.4% of CBITS episodes.

For BB, administrative discharge was reported for 5.4% of episodes. Family discontinued was reported for 2.3% of BB episodes, and 0.5% of children were referred to a higher level of care or other treatment.

Males were less likely to successfully complete treatment compared to females for CBITS (see Appendix B, Table B9).

Clinical Global Impressions (CGI) Scale

The clinical severity and overall improvement of children receiving CBITS and BB were measured using the CGI Severity (CGI-S) and Improvement (CGI-I) scales. These brief scales are not symptom specific and are completed by the clinician at the start and end of treatment. On the CGI-I, clinicians reported symptom improvement for 87.6% of youth receiving CBITS (n=204) and 92.7% of youth receiving BB (n=254). On the CGI-S, 61.1% of youth receiving CBITS (n=120) and 71.8% of children who received BB (n=176) changed from a more severe to a less severe category by the end of treatment. There were no significant sub-group differences on the CGI-S.

Figure 5. CGI Severity at Intake and Discharge by Subgroup
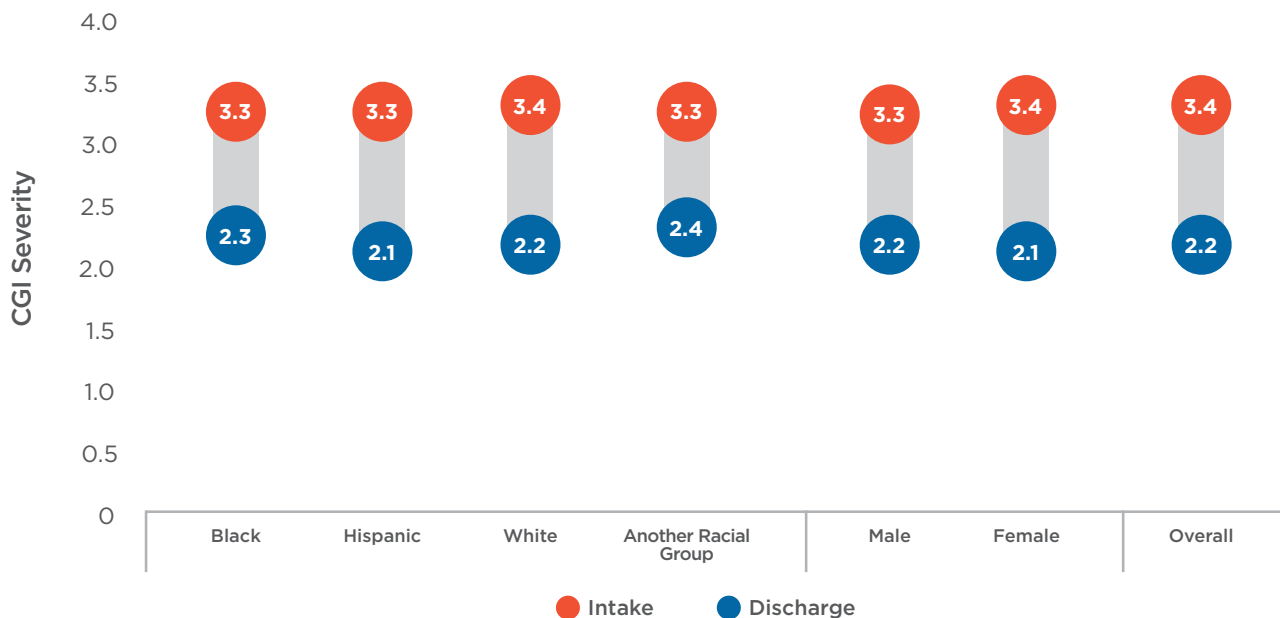
Symptom Improvement

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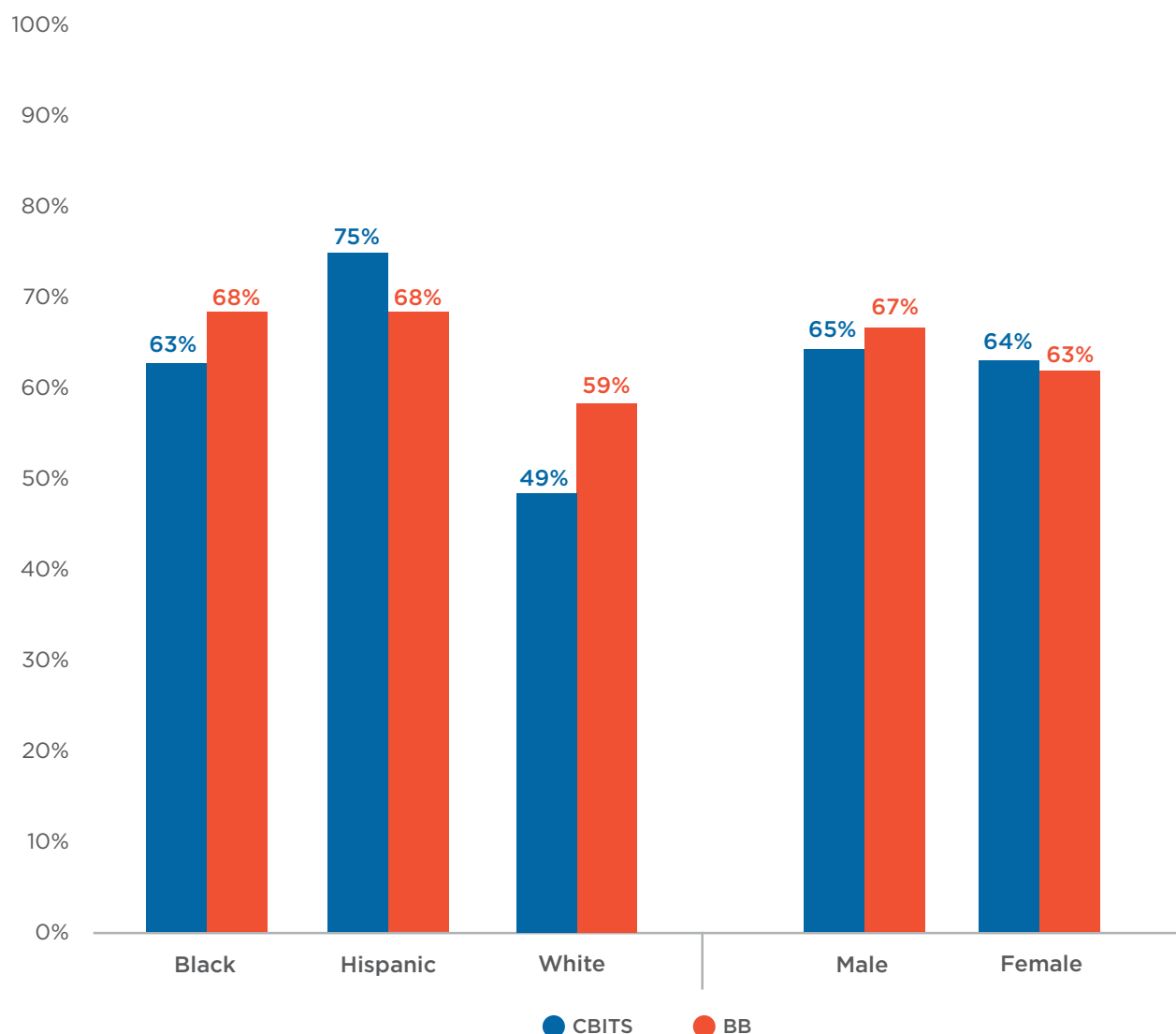
Overall Clinical Improvements Across Groups

For CBITS, Hispanic youth and older youth showed greater improvement in trauma symptoms. For BB, Black girls experienced the greatest improvement in trauma symptoms

Improvements within Subgroups

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

Hispanic youth had higher rates of reliable improvement than White youth for CBITS.

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

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

OUTCOMES AND EQUITY:

For CBITS, Hispanic youth and older youth showed **greater improvement** in trauma symptoms.

For BB, Black girls experienced the **greatest improvement** in trauma symptoms.

Hispanic youth had **higher rates** of reliable improvement than White youth for CBITS.

Males were **less likely** to successfully complete treatment compared to females for CBITS (see Appendix B, Table B9).

VI. SUMMARY AND RECOMMENDATIONS

During FY23, network providers screened over 2,200 youth for trauma exposure and provided care to 777 youth in CBITS or BB. CBITS and BB were widely used, but fewer than half of all trained clinicians provided CBITS/BB treatment services.

While the percentage of trained clinicians implementing CBITS and BB has increased since 2021, it remains lower than pre-COVID rates in SFY19 (CBITS, 50%; BB, 58%). However, both CBITS and BB demonstrated strong outcomes. Youth completed approximately 93% of group sessions in less than three (3) months, and the average session ratings were marked as nearly "Completely met" by clinicians. Within the year, all but one of the Quality Improvement (QI) indicators exceeded benchmarks; the QI symptom improvement for youth receiving BB fell short by two (2) points. Finally, most youth (79%) and nearly all caregivers (97%) reported satisfaction or high satisfaction with services.

Approximately 75% of youth receiving CBITS and 87% of youth receiving BB had completed the group successfully. The need for more trauma-focused services such as BB for young children was highlighted by providers with an increase in caregiver involvement than in previous years. As a result, a higher percentage of children completed BB than last year (72.5%).

Approximately two-thirds of youth had clinically meaningful reductions in post-traumatic stress symptoms in both CBITS and BB treatment models, 64.4% and 64.9% respectively. According to the CGI, overall improvements by the end of treatment were high for both models (CBITS, 87.6%; BB, 92.7%).

Child characteristics, service experiences, and providing quality care to all eligible children are important factors in determining equity in access, quality, and outcomes. Access was high for Black and Hispanic youth, who made up nearly twice the proportion of all youth served in CBITS/BB when compared to overall Connecticut school and population rates. Hispanic youth who received BB reported higher levels of satisfaction with their treatment than White youth who received BB. Regarding outcomes, for CBITS, Hispanic and older youth experienced greater improvements in trauma symptoms, and for BB, Black girls experienced the greatest improvements in trauma symptoms. Screening for trauma among children increased this year, with over 460 more youth screened than in 2022. However, among the children eligible for treatment, only 69% children received CBITS/BB, a decrease from last year. Engagement and retention efforts of eligible CBITS/BB youth should remain a focus for youth in care.

Recommendations

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

- Increase the percentage of clinicians providing CBITS/BB groups to 50% by establishing team-based CBITS/BB goals during site-based consultation to ensure that active clinicians conduct one group with at least 3 youths during the year.

- Utilize EdSight data to understand and determine if there are proportional rates in which youth are screened for CBITS/BB eligibility.

- Develop SMARTIE (Specific, Measurable, Attainable, Relevant, Time-bound, Inclusive, and equitable) goals with providers for when youth screened with trauma concerns are not getting access to treatment to ensure equitable access to CBITS/BB for children.

- Collaborate with CBITS/BB providers to examine and develop enhanced data collection procedures for trauma screening in schools to strengthen the link between youth screened eligible and those who receive services.

- Support teams in developing processes and protocols around crisis planning to better work within their understaffed buildings to maintain safety and improve group implementation feasibility.

- Develop strategies to assist teams in inputting data into EBP Tracker to improve accurate data collection.

- Establish strategies to improve caregiver engagement to support older youth receiving CBITS in an effort to decrease the percent of children who are unable to successfully complete treatment.

- Incorporate changes into EBT monthly dashboard demographic reporting, disaggregating by race, gender, and age.

- Continue to report annual CBITS/BB disproportionality by race and sex statewide.

- Explore the ability to expand the options for collecting gender identity data in intake processes and the EBP Tracker database to better align with best practices and enhance equitable care.

- Provide ongoing support to bilingual Spanish/English clinicians, through resources, to support the continuation of Hispanic youth showing greater improvement in trauma symptoms in CBITS.

- Establish activity-based resources and engagement strategies to support clinical staff who serve older children, in an effort to expand the number of children served per group and the number of group sessions in CBITS.

- Pilot practices that complement CBITS/BB, such as Supporting Transition Resilience of Newcomer Groups (STRONG) to better serve newcomer youth in Connecticut not being reached with CBITS/BB treatment in school settings.
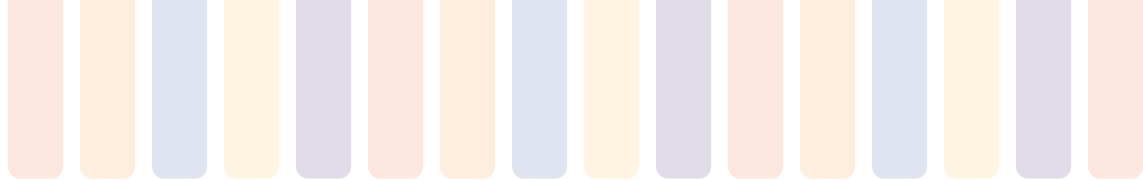
Conclusion

A greater number of clinicians trained and an increase in implementation efforts led to more schools being able to offer CBITS and BB. Overall, both CBITS and BB resulted in symptom improvement among many youth served, notably older Hispanic youth in CBITS and Black females in BB with greater improvement in trauma-related symptoms. While progress in screening youth has grown, efforts to ensure that children eligible for CBITS/BB receive access and that the completion of treatment, particularly among males in CBITS remains an essential focus of strong future service delivery.

VII. APPENDIX A: ACTIVITIES AND DELIVERABLES

In FY23, the Coordinating Center has supported CBITS/BB implementation goals through the following activities.

1. Training, Consultation, & Credentialing

- Coordinated two CBITS and two BB statewide new clinician trainings and two internal BB new clinician trainings for 61 CBITS and 42 BB staff.

- Coordinated six CBITS Booster trainings and three Bridgeport-specific CBITS Booster trainings for 95 clinical staff and six BB Booster trainings for 49 clinical staff.

- Coordinated five CBITS clinical consultation call groups with 60 total calls for 67 clinical staff.

- Coordinated five BB clinical consultation call groups with 60 total calls for 47 clinical staff.

- Developed, executed, and managed contracts for Site Based Trainers (SBT) to conduct statewide trainings and consultation calls to increase Initiative sustainability.

- Maintained a training and certification record database to track training and consultation attendance of all CBITS/BB providers.

- Convened the 15th annual EBP and Best Practice conference in person consisting of 34 workshops with 26.5% meeting the cultural competency CE requirement. A total of 356 unique participants from community providers, DCF, CSSD, and other partners attended the conference.

2. Implementation Support, Quality Improvement, & Technical Assistance

- Conducted 101 site visits and 38 non-clinical consultation calls (virtual or telephonic).

- Onboarded 5 new provider teams; Stonington Public Schools, Seymour Public Schools, BHcare, Inc., The Gilbert School, and Catholic Charities-Archdiocese of Hartford.

- Convened quarterly Senior Leader Call Series to support treatment fidelity, implementation, and network community-building.

- Provided monthly Data Dashboard, quarterly RBA, and annual reports.

3. Data Systems

- Continued development and maintenance of a secure, HIPAA compliant, online database that meets the needs of the increasing number of CBITS/BB providers and the children and families they serve, EBP Tracker.

- Maintained a public directory site that provides a searchable, public listing of CBITS and BB providers through EBP Tracker (https://ebp.dcf.ct.gov/ebpsearch/).

- Monitored, maintained, and provided technical assistance for online data entry for all CBITS and BB providers via the use of ebptrackerhelpdesk@chdi.org.

- Continued data-driven reporting and ad hoc data support requests as needed

4. Agency Sustainment Funds

- Analyzed and reported two aggregated and team-specific financial incentive reports for six-month performance periods and administered biannual performance-based sustainability funding.

- Distributed $340,527 in performance-based sustainment funds to agencies.

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

Assessment Name	Construct	Above Clinical Cutoff	First Score Mean (S.D.)	Last Score Mean (S.D.)	Change Score	T-Score	Effect Size (Cohen's d)	Remission
CPSS 5 Child (n=312)	Post-traumatic stress symptoms	206	38.16	25.51	-12.48**	-16.82	Large	111/206
		66.0%	(13.89)	(16.04)			0.95	53.9%
Ohio Problem Severity Child (n=300)	Severity of internalizing/ externalizing behaviors	158	28.64	20.45	-7.62**	-10.59	Medium	75/158
		52.7%	(15.95)	(14.43)			0.61	47.5%
Ohio Problem Severity Caregiver (n=22)		–	16.09	11.68	-4.27*	-2.67	Medium	–
		–	(7.26)	(7.65)			0.57	–
Ohio Functioning Child (n=300)	Child's adjustment and functioning	83	50.93	55.32	4.38**	6.91	Small	44/83
		27.7%	(11.32)	(12.52)			.40	53.0%
Ohio Functioning Caregiver (n=22)		–	55.79	55.91	3.14	1.21	Small	–
		–	(11.92)	(16.61)			.26	–

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

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

Assessment Name	Construct	Above Clinical Cutoff	First Score Mean (S.D.)	Last Score Mean (S.D.)	Change Score	T-Score	Effect Size (Cohen's d)	Remission
CPSS 5 Child (n=313)	Post-traumatic stress symptoms	160	32.95	20.89	-12.10**	-15.58	Large	98/160
		51.1%	(12.84)	(14.92)			0.88	61.3%
Ohio Problem Severity Child (n=82)	Severity of internalizing/ externalizing behaviors	29	22.70	11.39	-10.98**	-9.18	Large	18/29
		35.4%	(14.13)	(11.05)			1.01	62.1%
Ohio Problem Severity Caregiver (n=45)		17	20.44	30.08	-4.72**	-3.62	Medium	9/17
		37.8%	(12.54)	(5.01)			0.54	52.9%
Ohio Functioning Child (n=82)	Child's adjustment and functioning	12	55.12	64.59	9.03**	7.37	Large	11/12
		14.6%	(11.91)	(9.69)			0.81	91.7%
Ohio Functioning Caregiver (n=45)		9	54.36	57.56	3.20	1.77	Small	7/9
		20.0%	(11.51)	(10.56)			0.26	77.8%

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

Table B3. Multiple Regression Analyses of Selected Demographic Variables on Child CPSS5 Change Scores (CBITS)			
Variable	β	SE	95%CI
Constant	11.139	5.668	(-0.017, 22.294)
Trauma Exposure-TEC Child	**-1.069***	0.237	(-1.536, -0.603)
Child Discharged "Successful"	-4.96	2.889	(-10.645, 0.726)
Hispanic	-4.122	2.053	(-8.163, -0.081)
Black Non-Hispanic	-3.355	2.826	(-8.917, 2.207)
Sex (Male)	-4.006	3.048	(-10.006, 1.994)
Child age	-0.593	0.336	(-1.254, 0.067)
R^2	0.116		

 *p<.05   As compared to White Females
**p<.001   Another non-Hispanic race group removed due to low n
            Outliers were found and corrected for CPSS5 Child change score and age at intake
            Robust standard errors were used to address heterogeneity of variance

Table B4. Multiple regression analyses of selected demographic variables on child CPSS5 change scores (BB)			
Variable	β	SE	95%CI
Constant	-17.383*	8.384	(-33.883, -.882)
Trauma Exposure-TEC Child	**-0.883**	0.293	(-1.460, -0.306)
Child Discharged "Successful"	8.549	6.721	(-4.677, 21.775)
Hispanic	-1.928	2.226	(-6.308, 2.452)
Black Non-Hispanic	**-13.615***	3.608	(-20.714, -6.515)
Sex	**-5.493***	2.351	(-10.119, -.867)
Sex (Male)*Race Hispanic	5.149	3.258	(-1.263, 11.560)
Sex (Male)*Race Black Non-Hispanic	**19.300***	4.961	(-9.537, 29.063)
Child age	3.24	2.639	(-1.954, 8.434)
R^2	0.09		
F	**6.637***		

  *p<.05   As compared to White Females
 **p<.001   Another non-Hispanic race group removed due to low n
***p< .001   Outliers were found and corrected for CPSS5 Child change score and age at intake

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

Predictors	N	β	SE	Wald	e^B (95% CI)
Hispanic	186	0.291	0.32	0.829	1.338 (0.715, 2.506)
Other Non-Hispanic	11	-1.022	0.692	2.184	0.36 (0.093, 1.396)
Black Non-Hispanic	86	-0.434	0.372	1.365	0.648 (0.313, 1.342)
Sex (Male)	136	0.31	0.292	1.127	1.364 (0.769, 2.419)
Child Age	393	0.051	0.056	0.835	1.052 (0.943, 1.174)
Trauma Exposure from TEC	393	0.071	0.044	2.568	1.073 (0.984, 1.17)
Child Discharged as "Unsuccessful"	80	-3.336***	0.362	84.796	0.036 (0.017, 0.072)
Constant		0.11	0.812	0.018	1.116

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

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

Predictors	N	β	SE	Wald	e^B (95% CI)
Hispanic	163	0.124	0.248	0.25	1.132 (0.696, 1.841)
Black Non-Hispanic	50	-0.06	0.351	0.03	0.941 (0.473, 1.873)
Sex (Male)	182	0.117	0.23	0.261	1.124 (0.717, 1.763)
Child Age	368	0.061	0.069	0.768	1.062 (0.928, 1.217)
Trauma Exposure from TEC	368	0.094*	0.045	4.274	1.098 (1.005, 1.2)
Child Discharged as "Unsuccessful"	34	-3.105***	0.624	24.761	0.045 (0.013, 0.152)
Constant		-0.493	0.614	0.645	0.611

*p<.05   As compared to White Females
**p<.01   Another Non-Hispanic race group removed due to low n
***p< .001

Table B7. Logistic Regression Analyses for Predicting Successful Discharge from Selected Background Characteristics (CBITS)					
Variable	N	β	SE	Wald	eB(95%CI)
Hispanic	186	.058	0.302	0.037	1.060(.587, 1.914)
Black Non-Hispanic	86	.006	0.363	0.00	1.006(.493, 2.050)
Sex (Male)	129	-.691*	0.260	7.059	.501(.301, .834)
Child Age	382	-.041	0.054	0.584	.960(.864, 1.066)
Trauma Exposure-TEC Child	382	-0.019	0.041	0.203	.982(.905, 1.064)
Constant		2.277	0.816	7.794	9.748

*p<.05   As compared to White Females

**p<.001   Another Non-Hispanic race group removed due to no variation in successful discharge variable

Table B8. Logistic Regression Analyses for Predicting Successful Discharge from Selected Background Characteristics (BB)					
Variable	N	β	SE	Wald	eB(95%CI)
Hispanic	163	0.675	0.406	2.772	1.964(.887, 4.349)
Black Non-Hispanic	50	0.106	0.539	0.039	1.112(.387, 3.195)
Sex (Male)	155	0.057	0.365	0.024	1.058(.517, 2.165)
Child Age	368	-0.081	0.115	0.502	.922 (.736, 1.155)
Trauma Exposure-TEC Child	368	-.116	0.067	3.012	.890(.780, 1.015)
Constant		3.377	1.045	10.45	29.288

 *p<.05   As compared to White Females
**p<.001   Another Non-Hispanic race group removed due to no variation in successful discharge variable

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