Trauma-Focused Cognitive Behavioral Therapy (TF–CBT)

CONNECTICUT'S EVIDENCE-BASED
TREATMENT COORDINATING CENTER

Child Health and Development Institute

CONNECTICUT Children & Families

FISCAL YEAR 2024
ANNUAL REPORT

Connecticut TF-CBT Coordinating Center

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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).

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I. EXECUTIVE SUMMARY

The Connecticut Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Coordinating Center ("Coordinating Center") is located at the Child Health and Development Institute (CHDI). Funded by the Connecticut Department of Children and Families (DCF) and the Judicial Branch's Court Juvenile Support Services Division (CSSD), the goal of the Coordinating Center is to expand access to high-quality, evidence-based practices (EBPs) for children exposed to trauma. Since 2007, the Coordinating Center has supported TF-CBT as an evidence-based treatment for children who experience symptoms related to trauma exposure, including symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety. New in Fiscal Year 2024 (FY24, July 1, 2023 through June 30, 2024), the ARC (Attachment, Regulation, and Competency) intervention was added to increase service flexibility in addressing complex trauma from birth to young adulthood. ARC engages caregivers and addresses attachment disruptions, regulation difficulties, and competency building. **The Coordinating Center supports a network of 49 TF-CBT and 10 ARC providers throughout Connecticut** and provides training, credentialing, implementation support, site-based consultation, data collection and reporting, and ongoing quality improvement. This report summarizes the work of the Coordinating Center, highlighting the performance during FY24.

KEY FINDINGS FY24:

816 Youth received TF-CBT and **150** youth received ARC

Youth from diverse sociodemographic identities (race, ethnicity, sex) who received TF-CBT **experienced equivalent rates of high-quality service** (e.g., engagement, session frequency, available outcome data, symptom improvement, completing treatment components) and **improved treatment outcomes**

Youth completing **TF-CBT had excellent outcomes**; they reported **remission in post-traumatic stress symptoms (63.6%)** and **depressive symptoms (49.2%)**

67.5% of trained clinicians served at least one child with TF-CBT

Providers **surpassed all quality improvement** benchmarks for both TF-CBT and ARC

95% Caregivers | **90%** Youth

reported **high satisfaction with treatment**

59

Clinical staff were newly trained and **16** staff became credentialed in TF-CBT

KEY RECOMMENDATIONS:

- Improve service access by supporting teams to create goals around having at least 75% of trained clinicians serve at least one youth in TF-CBT within the SFY.
- Strengthen the integration of ARC within Connecticut's trauma-informed EBP service array by examining equitable outcomes and providing performance-based sustainability funds.
- Expand trauma screening and access to services by piloting Trauma Screening, Brief Intervention, and Referral to Treatment (T-SBIRT) with at least seven providers.

II. INTRODUCTION

The Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) model is an evidence-based treatment (EBT) for children aged 3-18 experiencing post-traumatic stress (PTS) symptoms from exposure to violence, abuse, and other forms of trauma. Since 2007, the Connecticut Department of Children and Families (DCF) has partnered with CHDI to serve as the TF-CBT Coordinating Center. Additional funding support by the Judicial Branch's Court Support Services Division (CSSD) supports access to TF-CBT services by CSSD staff. The figure below illustrates the goals and primary activities of the Coordinating Center.[1]

1. A detailed accounting of these activities during FY24 can be found in Appendix A.

TF-CBT COORDINATING CENTER GOALS AND ACTIVITIES

EQUITY

ACCESS

Increase Access to TF-CBT

Activities: Maintain a statewide network of provider agencies, train new clinicians in TF-CBT, support systems screening for trauma.

Measured by: Children receiving TF-CBT over time and across the state.

Do all groups have equal access to TF-CBT?

QUALITY

Ensure Quality of TF-CBT

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

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

Are all groups receiving high quality TF-CBT treatment?

OUTCOMES

Improve Outcomes for Children Receiving TF-CBT

Activities: Ongoing quality improvement work with agencies 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 benefitting from TF-CBT?

This FY24 report is framed across access, quality, outcome, and equity goals. As a new EBP in FY24, ARC implementation is examined across access and quality through an equity lens. Summary, conclusions, and recommendations are shared to guide future work.

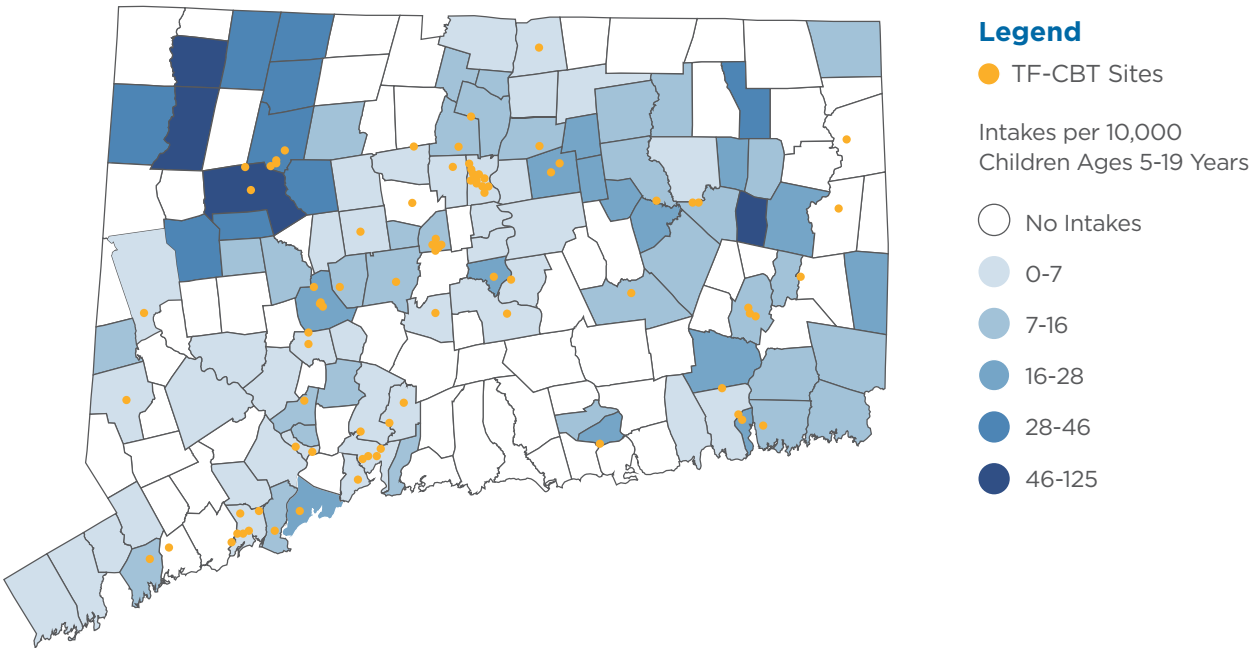
III. ACCESS TO TF-CBT AND ARC

The TF-CBT Coordinating Center aims to increase access to high-quality EBPs for youth exposed to trauma in Connecticut. This includes growing and sustaining the provider network across the state, and monitoring child characteristics to ensure access to TF-CBT and ARC.

Availability Across the State

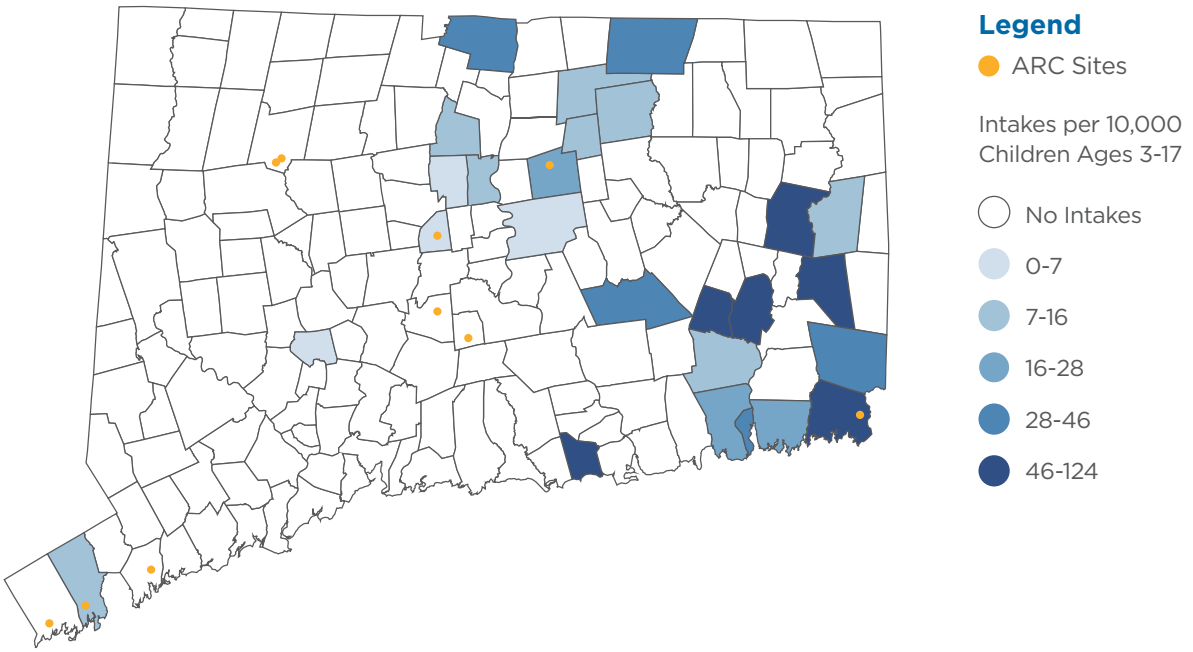
Forty-nine providers offered TF-CBT in FY2024. Figure 1 shows the location of TF-CBT sites across the state and Table 1 shows cumulative totals and trends in access over the past four years. As part of the recommendations in FY23, TF-CBT expanded its provider network in FY24 with the addition of two new clinics to provide TF-CBT interventions. Across the state, approximately 67.5% of clinicians (n=216) provided TF-CBT to at least one youth during the year with team sizes ranging from 1 to 28 clinicians.

Figure 1. Map of TF-CBT Intakes per 10,000 Children SFY 2024



Ten providers offered ARC in FY24 across Connecticut. Figure 2 shows the location of ARC sites across the state and Figure 3 shows cumulative totals and trends in access over the past six years.

Figure 2. Map of ARC Intakes per 10,000 Children SFY2024



Clinician Training and Credentialing

Of the 320 TF-CBT clinicians, 53[2] (16.6%) left their teams during the year, a decrease from FY23 (27.4%). Those agencies and supervisors who experienced attrition received ongoing training and support to enhance workforce development and sustain EBTs. During continuous training opportunities and consultation, 59 new clinicians completed TF-CBT training. To support equitable access to high quality treatment, 56 clinicians attended one day booster sessions, and 59 clinicians attended clinical consultation calls. The annual EBP conference offered additional professional development opportunities for EBP clinicians, including a presentation focused on caregiver engagement entitled Increasing Parental Collaboration in Treatment, which was attended by more than 70 participants. In addition, a workshop was attended by over 25 EBP conference attendees to enhance strategies for effective communication, collaboration and support in cross-cultural and cross-racial therapeutic practices. Ongoing support to bilingual Spanish/English clinicians implementing TF-CBT continued with 3 meetings taking place in FY24 to share resources, strategies and maintain peer support to strengthen service delivery with Latinx youth. **During the year, there were a total of 118 clinicians credentialed in TF-CBT that were active in providing treatment services.**

2. Number does not include 1 clinician that was open at 2 agencies but left one during FY24 and 1 clinician who left their agency and then returned during FY24.

Table 1. Trends in TF-CBT Provider Network					
	FY 2021	FY 2022	FY 2023	FY 2024	Cumulative Since 2007
TF-CBT Providers/Agencies	51	48	48	49	73
Newly Trained TF-CBT Clinicians	61	63	65	59	1123**
TF-CBT Clinicians Leaving	63	68	99	53[2]	—
Clinicians Providing TF-CBT	320	343	361	320	1133*
# Newly Credentialed/Certified	15	24	21	16	420

*Clinicians with open clinical roles regardless of whether they saw a child.

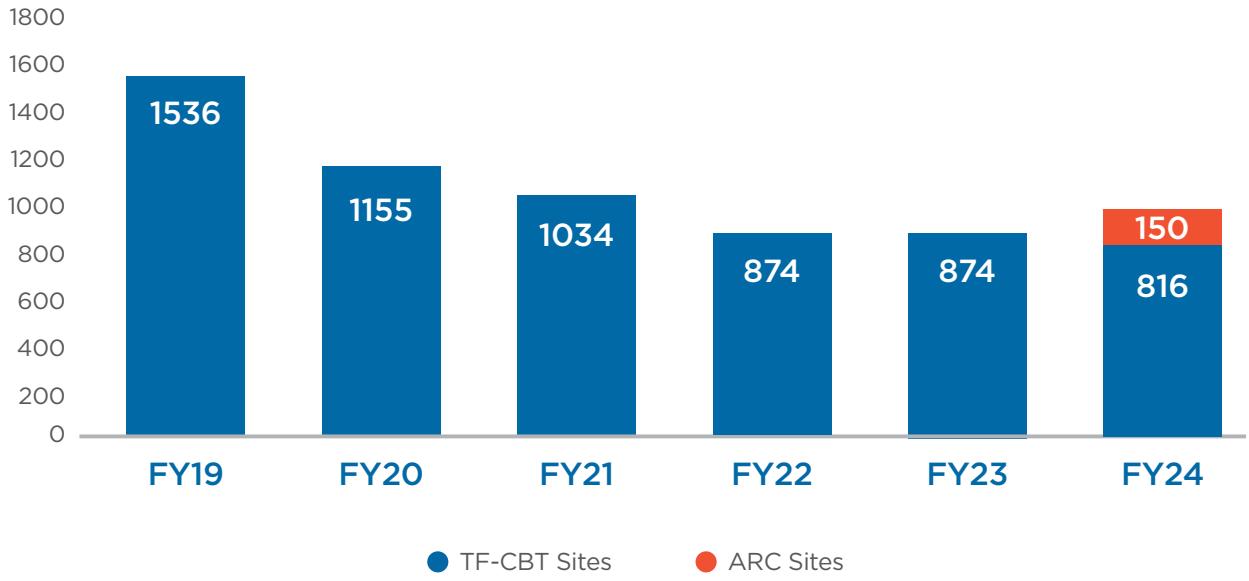
**Clinicians included from FY16 and prior were included based on training records. Includes 10 clinicians from FY22 who received training from external partners.

[2]Number does not include 1 clinician that was open at 2 agencies but left one during FY24 and 1 clinician who left their agency and then returned during FY24.

Children Receiving TF-CBT and ARC

Since 2007, 12,500 children have received TF-CBT in Connecticut. In FY24 alone, 816 children received TF-CBT, which includes 454 children who started treatment in the year. Children reported an average of 7.6 types of potentially traumatic events; caregivers reported that their children experienced ~6.2 types of potentially traumatic events. TF-CBT remained the most common trauma-informed EBT with quality assurance protocols used in the outpatient setting.

Figure 3. TF-CBT and ARC Children Served by Fiscal Year



Child Demographics

Table 2 provides child characteristics in TF-CBT services during FY24 with comparisons to those served in outpatient services [as reported in DCF's Provider Information Exchange (PIE) system] and the general CT population. Throughout this report, indicators of access, quality, and outcomes are reported by demographic groups. Social and community context is highly related to service receipt and outcomes. Racism is part of that context that research has shown leads to inequities. Recognizing this, **special consideration is given in this report to comparisons across racial and ethnic groups.** This year efforts have been directed toward those who are eligible for TF-CBT but aren't accessing services at this time. As part of the site consultation, providers were presented with TF-CBT access rates, including race/ethnicity compared to overall outpatient and equitable access. To improve the availability of Spanish-speaking TF-CBT clinicians providers received a stipend if they had an active Bilingual or Multilingual clinician on their team, and CHDI supported a regular meeting of Spanish-speaking TF-CBT clinicians. In FY24, ***TF-CBT (38.7%) and general outpatient care (34.8%) both served higher rates of Hispanic, Latino or Spanish (any race) children compared to the overall CT population(27.5%). TFCBT (16.3%) and general outpatient care (16.4%) both served higher rates of Black or African American youth than the overall CT population (11.9%)***. Similar to FY23, TF-CBT (2.7%) served fewer Spanish-speaking youth compared to general outpatient care (10%) and the overall CT population (13.4%). Accounting for nearly one in three TF-CBT youth, males were relatively underrepresented in all racial and ethnic groups compared to the outpatient and general CT population.

The average age of children who received TF-CBT is 12.5 years (SD=3.3). Children receiving TF-CBT and general outpatient services tend to be older compared to the CT population, which is consistent with mental health prevalence research showing lower rates among the youngest children. While the percentage of children in outpatient care under six was small (10%) it was even smaller for those receiving TF-CBT (2.2%). TF-CBT can be used with children as young as three, but it is used much less frequently with the youngest children.

The proportion of ***children receiving TF-CBT who had child welfare involvement (26.7%) was double that of those in general outpatient services (13.4%).***

Table 2. Characteristics of Children Receiving TF-CBT (n=816) and ARC (n=150) with Comparisons[3]

	ARC		TF-CBT		OPCC	CT Child Pop
	n	%	n	%	%	%
Sex (Male)	**67**	**44.7**	**261**	**32**	**49.0**	**51.2**
Race						
American Indian or Alaska Native	--*	--*	--*	--*	0.5	0.3
Asian	--*	--*	--*	--*	1.2	4.8
Black or African American	31	20.7	133	16.3	16.4	11.9
Native Hawaiian or Pacific Islander	--*	--*	--*	--*	0.2	0.1
White	98	65.3	446	54.7	50.8	53.4
Another Race (Includes Multiracial/Ethnic)	21	14.0	39	4.8	3	29.6
Did Not Disclose/Missing	--*	--*	196	24.0	27.9	N/A
Hispanic, Latino, or Spanish (Any Race)	**53**	**35.3**	**316**	**38.7**	**34.8**	**27.5**
Age (Years)						
Under 6 Years	39	26	18	2.2	10.0	29.9
6–11 Years	88	58.7	283	34.7	44.4	32.9
12–17 Years	23	15.3	502	61.5	45.7	37.2
Child Welfare Involvement During Treatment	**34**	**22.7**	**218**	**26.7**	**13.4**	**3.4**
JJ Involvement During Treatment	**0***	**0***	**20**	**2.5**	**1.1**	**N/A**
Child Primary Language[3]						
Spanish	N/A	N/A	22	2.7	10.0	13.4
Neither Spanish nor English	N/A	N/A	--*	--*	2.8	8.7
Caregiver Speaks English (No)	**6**	**4.0**	**80**	**9.8**	**N/A**	**N/A**

In FY24, Connecticut's TF-CBT network consisted of 49 provider agencies and one private practice. This number has remained relatively consistent over the years. In terms of individual clinicians at these agencies, there were 320 clinicians on the TF-CBT team during the year. Table 3 provides demographics on the TF-CBT clinicians.

3. American Community Survey 2021 1 year estimates. Caution should be used with comparison to OPCC and TF-CBT child demographics. Census race categories exclude Hispanic ethnicity only for White children while TF-CBT, ARC and OPCC race categories exclude Hispanic regardless of race. We recognize there are alternate terms for describing ethnicity. This report uses "Hispanic" and "Latino" to remain consistent with the way it is reported in the data system, which reflects the terminology in the U.S. Census. Census language is only available by language spoken, not primary language. Used Primary Language Inside of Home for children ages 5-17 for child primary language.
Age is percentage of children 0-17 years.

*Category numbers suppressed due to small sample size.

Table 3. Characteristics of Clinicians Providing TF-CBT (n=320)	
	%
Sex (Male)	10.3%
Race/Ethnicity	
Black or African American	11.3%
Hispanic, Latino, or Spanish (Any Race)	21.6%
White Non-Hispanic	55%
Other Race/Ethnicity Non-Hispanic	4.1%
Missing Non-Hispanic	8.1%
Languages Spoken	
Spanish	18.1%
Other	5.9%

IV. QUALITY: CONSULTATION AND CLINICAL IMPLEMENTATION

Implementation Consultation

Model Implementation

Children completing TF-CBT attended an average of 19.51 (SD=15.4) sessions.[4] The average episode length of 8.8 (SD=6.2) months, has improved from last year although it is higher than conventional expectations of model completion (between 12 to 16 sessions). In FY24, over two-thirds of sessions (70.4%) were completed with the child only, 18.9% were with caregiver and child together, and 10.7% were with caregiver only. While session rates of child and caregiver together slightly increased from last year, caregiver involvement during sessions (29.6%) fell short of statewide benchmarks (33%). TF-CBT incorporates psychoeducation and parenting skills as integral components of the treatment program. As part of TF-CBT clinical training and consultation, caregiver engagement is addressed and continues to be emphasized as professional development needs among clinicians and new supervisors of the model.

Nearly all children who received TF-CBT had a measure of baseline symptoms (97.6%). Of children discharged, 70.1% had at least one first and last version of a child symptom assessment (child or caregiver reporter) and 11.1% had data on caregiver symptoms.

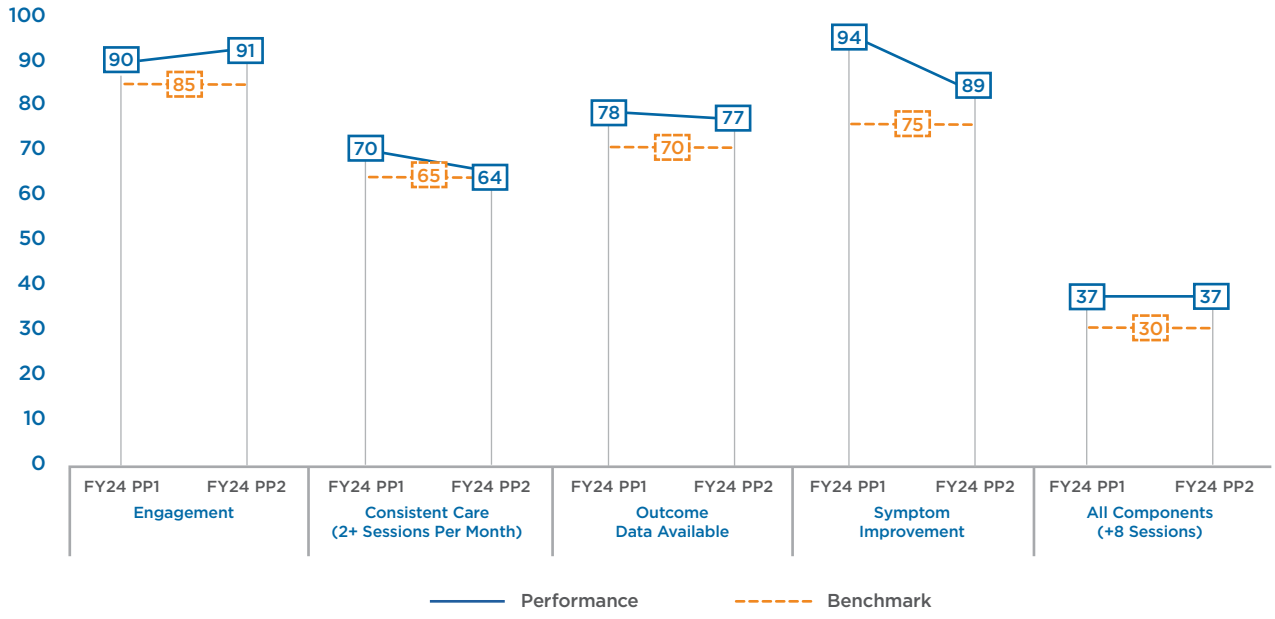
4. The mean was computed after winsorizing outliers in the data.

Quality Improvement (QI) Indicators

TF-CBT QI Indicators

Twice annually, CHDI reports on TF-CBT QI indicators that guide overarching implementation consultation goals. All QI indicators surpassed benchmarks in the FY24 performance periods except for Consistent Care in the second performance period (Figure 4). Consistent Care fell at 64% just below the benchmark of 65% in FY24 performance period 2. While TF-CBT served higher rates of Black or African American youth than the overall CT population, significant differences were found among youth who met the Model Completion indicator***. In comparison to their White Non-Hispanic counterparts (40.0%), Black Non-Hispanic youth (18.5%) were less likely to meet Model Completion.*** Appendix D has additional information about the definitions of the QI indicators. To further equity in treatment quality, clinical workshop opportunities were offered at the annual EBP Conference that allowed participants to explore how various aspects of identity (such as race, gender, and socioeconomic status) can influence the therapeutic process. Clinicians and supervisors participating in TF-CBT were also encouraged to access a TF-CBT treatment component report that can be used as a resource for identifying and supporting clinical components that are not progressing with clients to complete TF-CBT during agency team meetings and clinical supervision to improve Model Completion for all youth receiving TF-CBT.

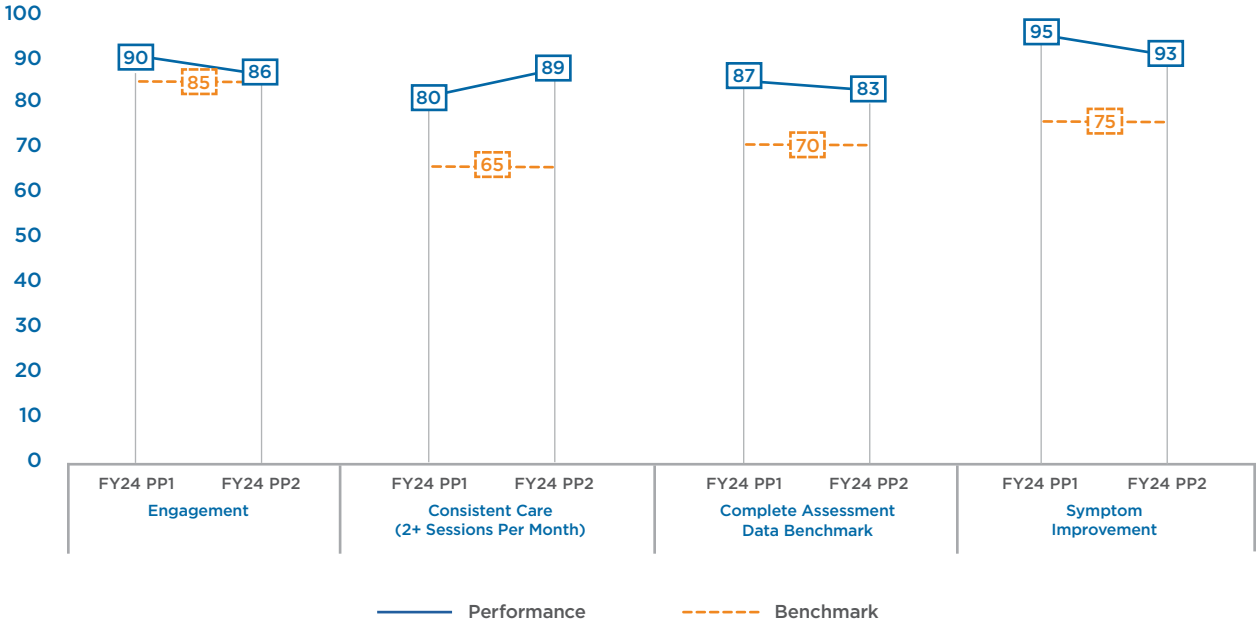
Figure 4. TF-CBT QI indicators in FY24



ARC QI Indicators

All QI indicators for ARC surpassed benchmarks in the FY24 Performance Periods (Figure 5). ***There were no significant differences in ARC QI indicators by race/ethnicity. There were significant differences among youth who met Consistent Care with Female youth (83.3%) having higher rates of meeting Consistent Care than Male youth (60.6%).***

Figure 5. ARC QI indicators in FY24



Satisfaction

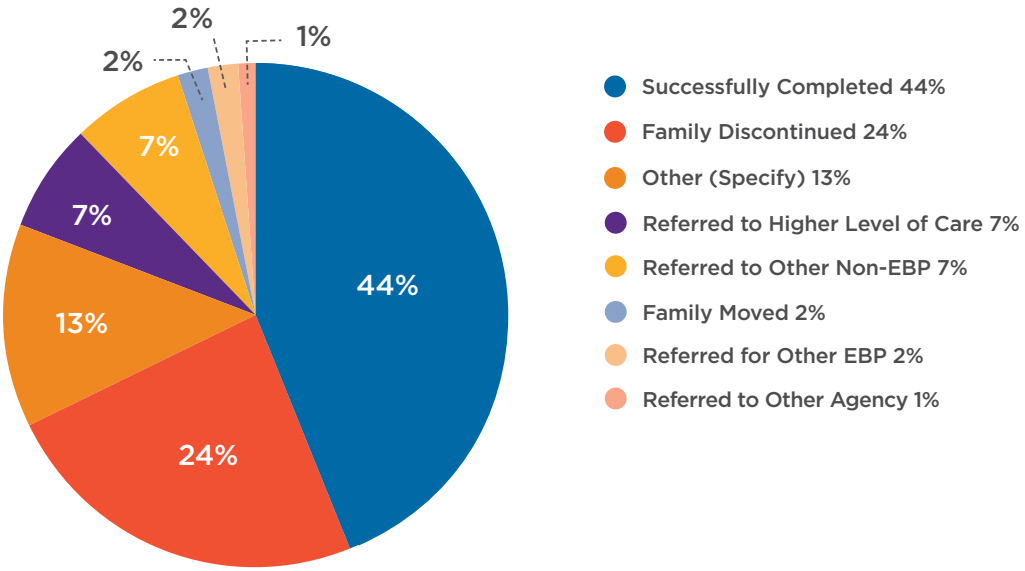
Of all caregiver reports (n=219), approximately 95.0% were moderately to extremely satisfied with TF-CBT treatment. Of the child satisfaction reports (n=226), approximately 90.3% were moderately to extremely satisfied with treatment. ***There were no differences in satisfaction by race/ethnicity or sex.***

V. OUTCOMES: IMPROVEMENT FOR CHILDREN

Successful Completion

In FY24, 461 children ended their TF-CBT treatment episode with nearly half children (44%) ending treatment as "completing all EBT requirements," a slight increase from last year, see Figure 6. While family discontinuation accounted for nearly one quarter of children who did not complete TF-CBT, approximately 14% of children received either a higher level of care or other non-evidence-based practice (EBP) service. ***Rates of successful discharge reported by clinicians were equivalent across sex, age, race/ethnicity, or trauma exposure (see Appendix B Table B1).***

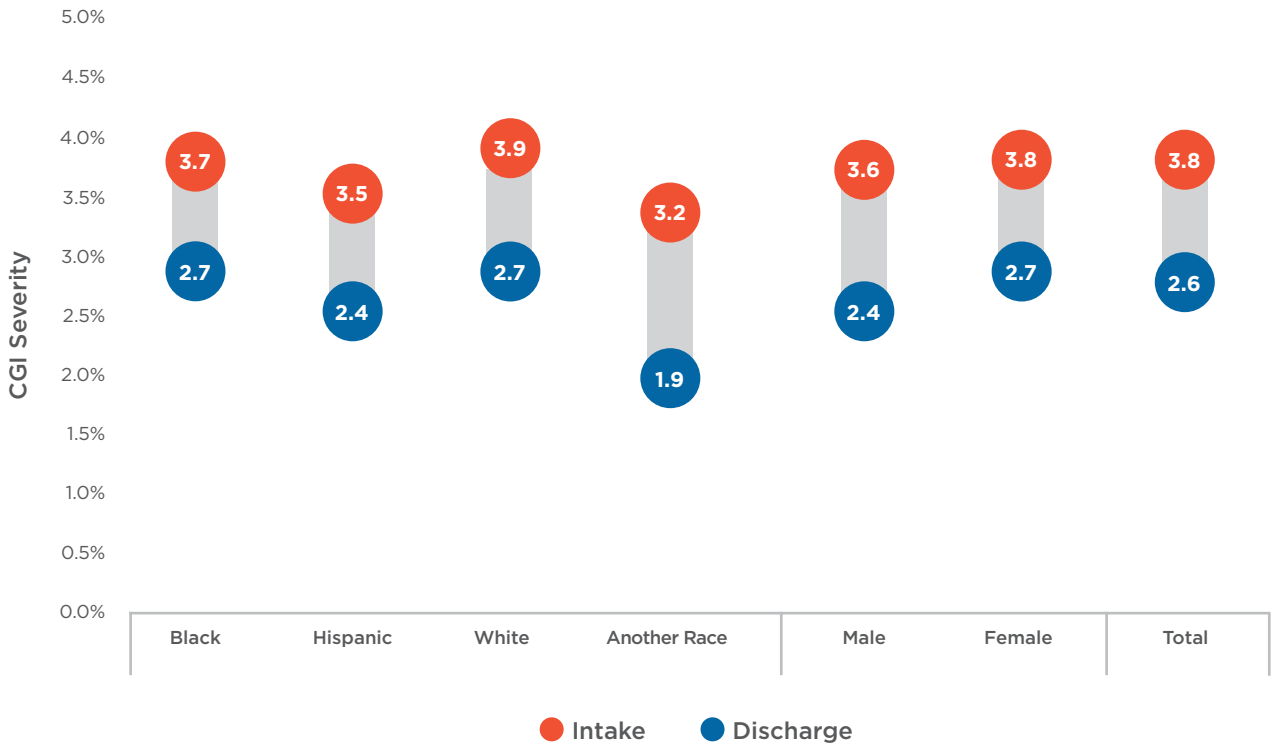
Figure 6. Reasons for Discharge in FY24



Clinical Global Impressions (CGI) Scale

The CGI Severity (CGI-S) and Improvement (CGI-I) scales were introduced in March 2021 and were increasingly used in FY24 to indicate clinical severity and improvement. On the CGI-S, 67.5% of clients changed from a more severe to a less severe category during the course of treatment. ***Youth showed equivalent rates of clinical severity improvement from Intake to Discharge regardless of race, ethnicity, and sex*** (Figure 7). Clinicians reported symptom improvement for the majority of youth (84%) with the CGI-I.

Figure 7. CGI Severity Intake and Discharge Scores by Subgroup.



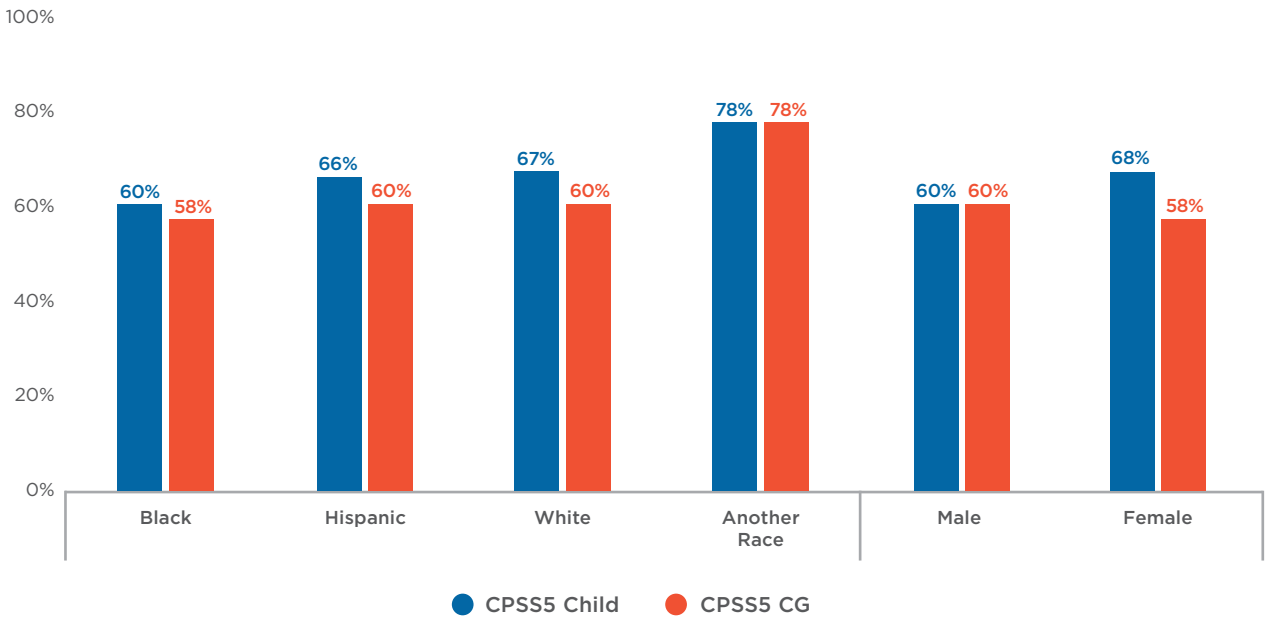
Symptom Improvement

Across all measures, ***89.5% of children showed significant reductions in one or more child symptom domains.*** Children experienced ***significant reductions in trauma, depression, and problem severity symptoms, as well as significant gains in functioning*** (Appendix B, Table B2). Caregivers also experienced significant reductions in their own depression symptoms.

Child Improvement in Posttraumatic Stress Symptoms

Change scores were calculated when children were assessed at two or more time points, and the Reliable Change Index (RCI) values determined the percentage of children who experienced reliable improvement (see Appendix C). On measures of posttraumatic stress symptoms, the most used measures, 65.7% of all youth showed reliable improvement on child reports, and 58.2% of youth showed reliable change on caregiver reports. Figure 8 shows the rates of improvement in CPSS scores by subgroup.

Figure 8. Percentage of Children that Show Improvement in Posttraumatic Stress Symptoms



Overall Clinical Improvements Across Groups

In addition to documenting the overall rates of symptom improvement, it is important to monitor if any subgroups are experiencing disproportionate outcomes. Analyses were done to look at the effect of demographics (age, race/ethnicity, sex) on both posttraumatic stress symptom improvement (change in CPSS-5 scores; (Appendix B, Table B3)) and any reliable symptom improvement (RCI; (Appendix B, Table B4)) across all measures. Analyses controlled for trauma exposure and successful completion.

Youth who successfully completed treatment had greater posttraumatic stress symptom improvement and higher rates of reliable change on any measure. ***Youth showed equivalent posttraumatic stress symptom improvement and improvement rates of RCI in any measure regardless of age, race, ethnicity, and sex*** *(Appendix B, Tables B3 & B4).*

VI. SUMMARY AND CONCLUSIONS

In FY24, high-quality TF-CBT and ARC services remained despite reports of workforce turnover, acute client needs, and reduced access to higher levels of care. While the total number of TF-CBT clinicians decreased in FY24 (320) as compared to FY23 (361), there was a higher percentage of active clinicians, those who saw at least one case, in FY24 (67.5%) than in FY23 (63%). The addition of ARC broadened the array of services in Connecticut and helped ensure more youth of color and males had access to trauma-informed EBPs.

Of the 320 TF-CBT clinicians, 16.6% of TF-CBT clinicians left their positions during the year; this attrition rate has decreased compared to FY23 (27.4%) and FY22 (20%). While agencies continue to experience the effects of workforce turnover, the slowing attrition rate is promising. To increase the availability of a qualified TF-CBT workforce, 59 new TF-CBT clinicians were trained, 56 trained clinicians attended a 1-day booster and 16 TF-CBT clinicians became credentialed in TF-CBT.

In FY24, 816 youth received TF-CBT and 150 youth received ARC. On average, children discharged from TF-CBT attended just above 19 sessions over the course of 8.8 months, which exceeds the recommended range (12 to 16 sessions) but was aligned with overall outpatient service use trends. Caregivers participated in an average of 29.6% of sessions, which fell just short of the 33% benchmark. All quality improvement indicators including engagement, collection of measures, improved outcomes, and model completion surpassed benchmarks in each performance period except for Consistent Care. Just below the benchmark of 65%, Consistent Care fell to 64% in FY24 second performance period in TF-CBT services (Figure 4).

The primary reasons for discharge as reported by clinicians were successful completion (44%), family discontinued (24%) and terminating for other (13%) reasons (e.g., referred to a higher level of care or another service, model or agency). Successful discharges predicted symptom improvement, and the rate of successful completion increased in comparison to the past three years. The majority of children who did not successfully discharge still improved by the end of treatment. Across all measures, 89.8% of children showed significant reductions in one or more child symptoms with the greatest improvements in post-traumatic stress symptoms and problem severity. The CGI-I showed a similar rate of improvement (84%) indicating that this brief measure is comparable to lengthier clinical measures.

With the exception of meeting the Model Completion QI indicator, where Black youth were statistically significantly less likely to meet Model Completion compared to their White youth counterparts, youth from diverse sociodemographic identities (race, ethnicity, sex) who received TF-CBT experienced equivalent rates of access, high-quality service (e.g. engagement, session frequency, available outcome data, symptom improvement, completing treatment components) and improved treatment outcomes. Compared to child outpatient services, children younger than six and male youth received TF-CBT services at lower rates of service, Black youth were served at the same rate as outpatient services, and children with child welfare involvement and youth or who identified with Hispanic, Latino or Spanish origins had proportionally higher access to the TF-CBT model. Attention to these access differences during quality improvement consultation and additional training will help to ensure youth with trauma exposure equitably receive TF-CBT services. Of note, youth who identified as male, Black/African American, or Multiracial/Multiethnic received ARC services at proportionally higher rates than similar youth in TF-CBT services. Though preliminary, this early trend is a positive step in broadening access to high-quality, trauma-informed EBPs in Connecticut.

Conclusion

Children who completed TF-CBT across Connecticut continue to show excellent outcomes and satisfaction with treatment. Remission in both post-traumatic stress symptoms (63.6%) and depressive symptoms (49.2%) were reported in addition to high satisfaction with treatment for caregivers (95.0%) and children (90.3%). Access and quality service have improved since FY23 and continues to remain high across sociodemographic groups. Further work will continue this fiscal year in this area, particularly ensuring that Black youth meet model completion requirements. High quality and strong outcomes have been maintained despite the average number of monthly treatment sessions decreasing and reduced caregiver participation. Furthermore, the inclusion of ARC as a complement to TF-CBT may offer even greater service flexibility for youth of all ages and their caregivers. Training opportunities in ARC and other trauma-informed EBPs will strengthen access to high-quality trauma services. A promising step will be the inclusion of a brief EBP, known as Trauma Screening, Brief Intervention, and Referral to Treatment (T-SBIRT), to help expand access through trauma screening and engagement in services across Connecticut.

Recommendations

Over the past fiscal year, work has been carried out to address the recommendations from the FY23 annual report. Recommendations met include, the continued use of site visit consultations to ensure TF-CBT quality services and equitable access, the identification and application of ARC as another trauma-informed EBP to increase access to services, and the provision of culturally responsive approaches to engaging youth and families in treatment by offering professional development opportunities to the network as well as providing ongoing support to the bilingual Spanish/English TF-CBT network.

The following recommendations from FY24 will continue to strengthen access, quality, and outcomes for youth served within the TF-CBT statewide network:

- TF-CBT continues to be an effective treatment for youth experiencing trauma, showing strong outcomes and rates of success across various demographic groups. Continue to monitor outcomes across age, gender, and race/ethnicity to better understand equitable access to TF-CBT.
- Improve service access by establishing team-based goals supporting that at least 75% of trained clinicians serve at least one youth in TF-CBT within the SFY.
- Support agency leadership efforts to strengthen internal team support to increase youth being served, provide guidance to increase engagement, support use of measures, provide staff coaching on data collection and overall TF-CBT implementation.
- Increase advanced training opportunities within the TF-CBT network to strengthen access and high-quality care
- Strengthen the integration of ARC within Connecticut's trauma-informed EBP service array by examining equitable outcomes and providing performance-based sustainability funds.
- The inclusion of ARC as a complementary model to TF-CBT can help broaden access to trauma-based services across Connecticut, particularly for youth aged 0 through 21. Monitor and support the quality of ARC data collection; accurate data is needed to further understand its effectiveness and use.
- Expand strategies that will increase caregiver involvement, including the introduction of T-SBIRT interventions with at least 7 providers, which will enable caregivers to understand the scope of trauma exposure, identify the need for trauma treatment, and improve engagement into services.

VII. APPENDIX A: ACTIVITIES AND DELIVERABLES

The Coordinating Center has worked to support the TF-CBT implementation goals through the following activities.

1. Training, Consultation, & Credentialing

- Provided three TF-CBT clinical trainings in August 2023, November/December 2023, and March 2024 for 59 new clinicians.
- Conducted three TF-CBT Booster trainings with 56 clinicians.
- Completed 6 series of clinical consultation calls (72 total calls) for 58 clinicians.
- Maintained a training record database to track training and consultation attendance of all TF-CBT providers.
- Convened the 16th annual EBP Conference virtually of 34 workshops with 61.8% meeting the cultural competency CE requirement. A total of 410 unique participants from community providers, DCF, CSSD and other partners attended the conference.

2. Implementation Support, Quality Improvement, & Technical Assistance

- Produced reports for two QI performance periods based on developed TF-CBT QI Indicators and Benchmarks (Appendix D).
- Provided 106 virtual implementation consultation site visits.
- Convened three Coordinator meetings focusing on sharing implementation and successful meeting strategies.
- Convened three meetings for bilingual TF-CBT clinicians.
- Provided monthly data dashboards, quarterly QI benchmarks reports, quarterly RBA, and annual reports.

3. Data Systems

- Maintained a public directory site that provides a searchable, public listing of TF-CBT providers through EBP Tracker (https://ebp.dcf.ct.gov/ebpsearch/).
- Monitored, maintained, and provided technical assistance for online data entry for all TF-CBT providers in PIE.
- 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 $453,745.77 in performance-based sustainment funds to agencies.

VIII. APPENDIX B: REGRESSION TABLES

Table B1. Logistic Regression Analyses for Predicting Successful Clinical Discharge From Selected Background Characteristics.

Predictors	*N*	β	*SE*	*Wald*	e^B*(95% CI)*
Hispanic	114	-0.226	0.263	0.737	0.798 (0.476,1.336)
Other Non-Hispanic	10	0.365	0.673	0.293	1.44 (0.385,5.387)
Black Non-Hispanic	42	-0.719	0.384	3.509	0.487 (0.23,1.034)
Sex (Male)	106	-0.260	0.251	1.073	0.771 (0.471,1.261)
Child Age	297	-0.016	0.042	0.150	0.984 (0.905,1.069)
Trauma Exposure-THS Child	297	-0.037	0.040	0.834	0.964 (0.89,1.043)
Trauma Exposure-THS Caregiver	297	-0.068	0.048	2.034	0.934 (0.85,1.026)
Constant		1.049	0.580	3.265	2.854

*p<.05 As compared to White Females

**p<.001 Outliers were found and corrected for caregiver and child reported trauma exposure

Table B2. Descriptives and Change Scores for All Assessment Measures

Assessment Name	Construct	Above Cutoff	Initial Mean (S.D.)	Last Mean (S.D.)	Change Score	T-Score	Effect Size (Cohen's d)	Remission
CESD-R (n=43)	Caregiver Depression	20 46.5%	16.57 (11.36)	8.78 (7.54)	-6.93**	-3.90	Medium	15/20
							0.59	75%
CPSS V Child (n=268)	Trauma Symptoms	151 56.3%	34.05 (15.52)	20.2 (15.31)	-13.65**	-14.11	Large	96/151
							0.86	63.6%
CPSS V Caregiver (n=201)		73 36.3%	27.07 (14.81)	15.01 (11.67)	-11.81**	-11.85	Large	59/73
							0.84	80.8%
SMFQ Child (n=90)	Depressive Symptoms	65 72.2%	11.74 (6.53)	9.17 (7.13)	-2.56*	-3.09	Small	32/65
							0.33	49.2%
SMFQ Caregiver (n=55)		39 70.9%	8.58 (5.78)	6.00 (5.46)	-2.76**	-3.77	Medium	21/39
							0.51	53.8%
Ohio Problem Severity Child (n=195)	Severity of Internalizing/ Externalizing Behaviors	78 40.0%	23.5 (13.47)	16.39 (11.36)	-6.71**	-8.28	Medium	43/78
							0.59	55.1%
Ohio Problem Severity Caregiver (n=235)		87 37.0%	20.77 (13.14)	13.17 (10.13)	-7.20**	-9.73	Medium	57/87
							0.64	65.5%
Ohio Functioning Child (n=199)	Child's Adjustment and Functioning	36 18.1%	54.92 (11.61)	60.44 (11.52)	5.24**	6.42	Medium	26/36
							0.46	72.2%
Ohio Functioning Caregiver (n=246)		62 25.2%	52.64 (13.31)	59.21 (13.62)	6.50**	8.38	Medium	35/62
							0.53	56.5%

**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: CESD-R, SMFQ (caregiver), Ohio PS (child and caregiver), Ohio Functioning (child and caregiver)

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

Outliers were found and corrected for the following change scores: CESD-R, CPSS 5 (child and caregiver), SMFQ Caregiver, Ohio PS (child and caregiver), Ohio Functioning (child and caregiver)

Table B3. Multiple Regression Analyses of Selected Demographic Variables on Change in Outcome Scores.

Predictors	Change in CPSS 5 Child			Change in CPSS 5 Caregiver		
	β	*SE*	*95% CI*	β	*SE*	*95% CI*
Constant	-8.464	5.076	(-18.471, 1.543)	-8.217	6.465	(-20.987, 4.554)
Trauma Exposure	-0.477	0.349	(-1.165, 0.210)	-0.822	0.451	(-1.712, 0.068)
Hispanic	1.807	3.026	(-4.158, 7.772)	-1.651	3.255	(-8.081, 4.779)
Black Non-Hispanic	3.376	2.907	(-2.355, 9.106)	5.008	4.170	(-3.229, 13.245)
Sex (Male)	4.002	2.861	(-1.638, 9.642)	3.253	2.937	(-2.549, 9.056)
Child Age	0.150	0.364	(-0.569, 0.868)	0.208	0.380	(-0.543, 0.959)
Child Discharged as "Successful"	**-9.317*****	2.106	(-13.469, -5.164)	-4.203	2.374	(-8.892, 0.486)
R^2	0.113			0.054		
F	4.68***			1.642		

*p<.05 As compared to White Females
**p<.01 Another race/ethnicity non-Hispanic group removed due to low n
***p<.001 Outliers were found and corrected for child and caregiver-reported trauma exposure and CPSS change scores

Table B4. Logistic Regression Analyses for Predicting any Child Symptom RCI from Selected Background Characteristics.

Predictors	*N*	β	*SE*	*Wald*	e^B*(95% CI)*
Hispanic	114	-0.347	0.320	1.181	0.706 (0.377, 1.322)
Other Non-Hispanic	10	-0.290	0.831	0.122	0.748 (0.147, 3.817)
Black Non-Hispanic	42	0.091	0.430	0.045	1.095 (0.472, 2.542)
Sex (Male)	103	0.408	0.303	1.823	1.504 (0.832, 2.722)
Child Age	297	0.036	0.051	0.506	1.037 (0.939, 1.145)
Trauma Exposure - THS Child	297	0.048	0.048	1.023	1.049 (0.956, 1.152)
Trauma Exposure - THS Caregiver	297	-0.067	0.057	1.394	0.935 (0.837, 1.045)
Child Discharged as "Unsuccessful"	156	-2.46***	0.335	53.86	0.085 (0.044, 0.165)
Constant		1.878*	0.695	7.309	6.541

*p<.05 As compared to White Females
**p<.01 Outliers were found and corrected for caregiver-reported trauma exposure
***p<.001

IX. APPENDIX C: RELIABLE CHANGE INDEX

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

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

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

X. APPENDIX D: QI OVERVIEW

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

QI Indicators	Benchmark	QI Description
Engagement	85% of closed episodes	Percentage of closed episodes with four or more clinical sessions attended. Starting SFY21 the benchmark for this indicator changed from 55% to 85%.
Outcome Data Available/Measures	70% of closed and engaged episodes	Percentage of closed and engaged treatment episodes with at least one measure available at two different time points for any measure of child or caregiver symptoms.
Symptom Improvement/ Improved Outcomes	75% of closed and engaged episodes with measures available	Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change (symptom improvement only) on any measure. Includes any measure of child or caregiver symptoms.
Consistent Care	65% of closed and engaged episodes	Percentage of closed and engaged treatment episodes with an average of two or more treatment episodes per month. Calculated by dividing the LOS by number of visits.
All Components/ Model Completion	30% of closed and engaged episodes	Percentage of closed and engaged treatment episodes that fully complete the model. Model completion definitions are: TF-CBT: completion of all required child treatment components and 8 or more sessions

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