Trauma-Focused Cognitive Behavioral Therapy

CONNECTICUT'S EVIDENCE-BASED
TREATMENT COORDINATING CENTER

Child Health and Development Institute

DCF CONNECTICUT

FY 2022 ANNUAL REPORT

Connecticut TF-CBT Coordinating Center

Child Health and Development Institute
270 Farmington Ave, Suite 367
Farmington, CT 06032

www.CHDI.org

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 **Christine Hauser** at **chauser@chdi.org**

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I. EXECUTIVE SUMMARY

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment for children who experience symptoms related to trauma exposure, including symptoms of post-traumatic stress disorder (PTSD), depression, and anxiety. The Connecticut 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 outpatient behavioral health treatment for children exposed to trauma. Since 2007, TF-CBT has been disseminated across the state. The Coordinating Center now supports a network of 48 TF-CBT 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 fiscal year 2022 (July 1, 2021 through June 30, 2022). This year, the ongoing COVID-19 pandemic led to persistent stress on individuals and systems resulting in workforce turnover and hiring difficulties, acute client needs, and reduced access to higher levels of care. Despite these challenges, TF-CBT services continued to produce positive results in quality and outcomes for Connecticut children and families.

KEY FINDINGS FY22:

874 children received TF-CBT

a 25% drop since the COVID-19 pandemic onset in 2020

Youth engagement in the frequency of sessions per month **(~2.3 sessions)** has improved since FY20 and approached near pre-pandemic rates **(~2.7 sessions)**

Providers surpassed all **five** quality improvement benchmarks (engagement, session frequency, available outcome data, symptom improvement, completing treatment components)

63 clinical staff were newly trained and **24** staff became credentialed in TF-CBT

Youth from diverse sociodemographic identities (race, ethnicity, sex) who received TF-CBT experienced equivalent rates of service and improved treatment outcomes (across the five benchmarks); Black children had better outcomes than other children by one measure of overall improvement.

96% Caregivers | **90%** Children reported **high satisfaction with treatment**

Children who completed TF-CBT had excellent outcomes; they reported remission in post-traumatic stress symptoms **(>66%)** and depressive symptoms **(55%)**

68% trained clinicians served at least one child with TF-CBT

KEY RECOMMENDATIONS:

- **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.
- **Gather systematic information from TF-CBT providers** to assess administrative burdens and develop strategies to improve clinical workflow and ensure all youth that receive TF-CBT services are documented.
- **Examine TF-CBT session use exceeding recommended ranges** to determine appropriate consultation guidelines and the use of briefer TF-CBT, when appropriate.

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 FY22 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 & 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 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 FY22 report is framed across access, quality, outcome, and equity goals. Summary, conclusions, and recommendations are shared to guide future work.

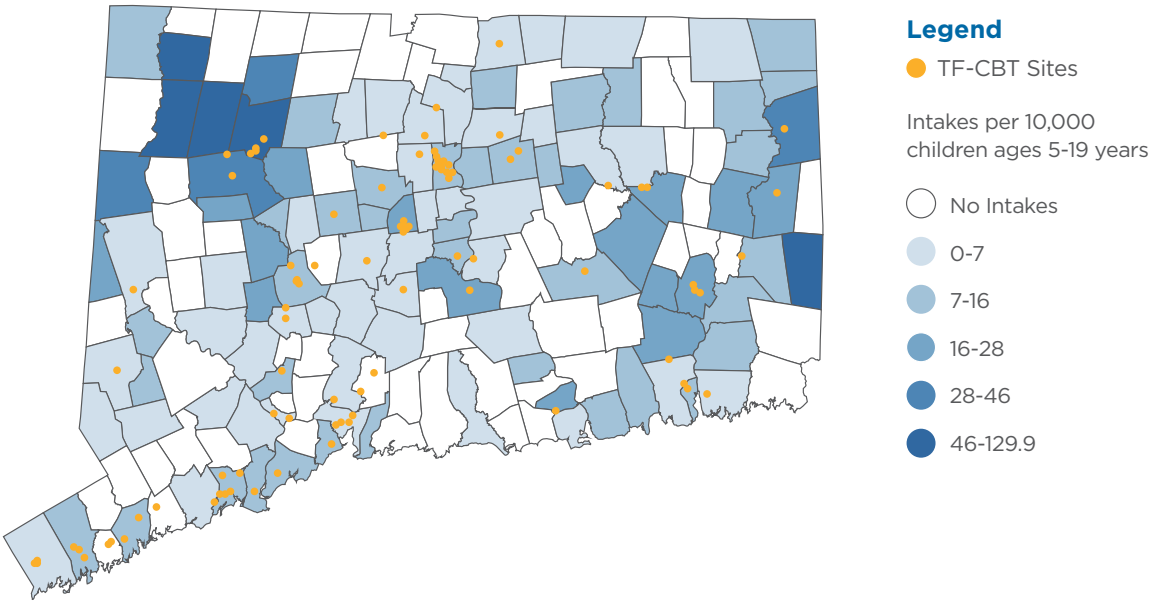
III. ACCESS TO TF-CBT IN CONNECTICUT

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

Availability Across the State

Forty-eight providers offered TF-CBT in FY22. 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 three years. Approximately 68% of clinicians (n=233) provided TF-CBT to at least one youth during the year with team sizes ranging from 2 to 25 clinicians.

Figure 1. Map of TF-CBT Providers in CT.



Clinician Training and Credentialing

Of the 343 TF-CBT clinicians, 68 (19.8%) left their teams during the year. Though attrition trends are consistent, providers reported more difficulties hiring new staff. Ongoing training and support resulted in 63[2] newly trained TF-CBT clinicians. To support access to high quality treatment, 48 clinicians attended one day booster sessions and 77 clinicians attended clinical consultation calls. As of June 30, there were 150 clinicians credentialed in TF-CBT that were active in providing services. To further enhance access to quality care, the first Advanced Clinical Training: TF-CBT with Young Children was held for 32 credentialed clinicians.

2. This number includes only clinicians trained through CHDI. 10 additional clinicians were trained in TF-CBT through an agency sponsored training, and those clinicians and their data are included in the number of clinicians providing TF-CBT and other analyses in this report.

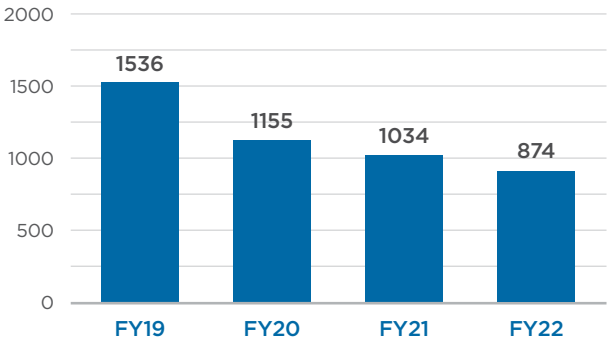
Table 1. Trends in TF-CBT Provider Network

	FY 2020	FY 2021	FY 2022	Cumulative Since 2007
TF-CBT Providers/Agencies	48	51	48	71
Newly Trained TF-CBT Clinicians	54	61	63	999
TF-CBT Clinicians Leaving	84	63	68	–
Clinicians Providing TF-CBT	253	320	343	999[3]
# Newly Credentialed/Certified	19	15	24	383

Children Receiving TF-CBT

Since 2007, 11,830 children have received TF-CBT in Connecticut. In FY22 alone, 874 children received TF-CBT, which includes 515 children who started treatment in the year. Children reported an average of 7.2 types of potentially traumatic events; caregivers reported that their children experienced ~6 types of potentially traumatic events. TF-CBT remained the most common trauma-informed EBT with quality assurance protocols used in the outpatient setting.

Figure 2. Children Served by Fiscal Year



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

Child Demographics

Table 2 provides child characteristics in TF-CBT services during FY22 with comparisons to those served in outpatient services [as reported in DCF's Provider Information Exchange (PIE) system] and the general CT population. Social and community context is highly related to service receipt and outcomes, particularly the impact of racism on inequities. Special considerations across racial and ethnic group comparisons are in this report. ***TF-CBT and general outpatient care both served higher rates of Latinx children and lower rates of White children compared to the overall CT population.*** 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 12.3 years (SD=3.4). 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 (9.3%) it was even smaller for those receiving TF-CBT (3.1%). 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 (28.0%) was more than double of those in general outpatient services (11.4%).***

Table 2. Characteristics of Children Receiving TF-CBT (n=874) with Comparisons				
	TF-CBT		OPCC[2]	CT Child Pop[4]
	N	%	%	%
Male	**285**	**32.6**	**49.0**	**51.3**
Race				
American Indian or Alaska Native	1	.1	0.4	0.4
Asian	1	.1	1.1	4.6
Black or African American	83	9.5	15.1	12.8
Native Hawaiian or Pacific Islander	1	.1	0.2	0.1
White	496	56.8	52.9	66.3
Other Race/Ethnicity (Includes Multiracial/Ethnic)	32	3.7	2.9	15.8
Did Not Disclose/Missing	260	29.7	27.4	-
Hispanic Descent or Latinx (Any Race)	**376**	**43.0**	**35.7**	**25.3**
Age (Years)				
Under 6 Years	27	3.1	9.3	30.1
6–11 Years	310	36.0	42.6	32.8
12–17 Years	524	60.9	48.1	37.1
Child Welfare Involvement During Treatment	**245**	**28.0**	**11.4**	**-**
JJ Involvement During Treatment	**13**	**1.5**	**.7**	**-**
Child Primary Language[4]				
Spanish	37	7.8	10.4	13.7
Neither Spanish nor English	1	.2	2.2	8.0

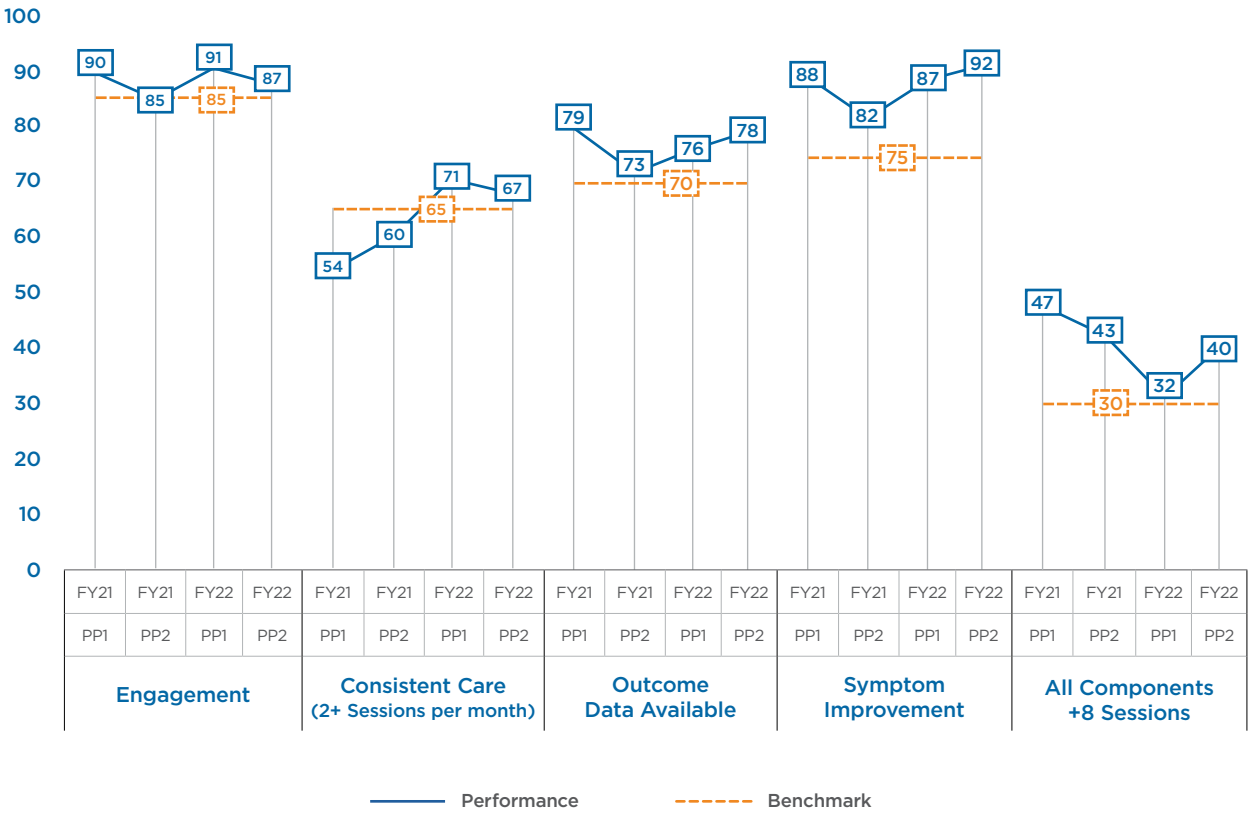
4. American Community Survey 2019 1 year estimates. Caution should be used with comparison to child demographics in OPCC and TF-CBT services. Census race categories exclude Hispanic ethnicity only for White children while TF-CBT and OPCC race categories exclude Hispanic regardless of race. Census language is only available by language spoken, not primary language. Age is percentage of children 0-17 years. We recognize there are alternate terms for describing ethnicity. This report uses "Hispanic" and "Latinx" to remain consistent with the way it is reported in the data system, which reflects the terminology in the U.S. Census.

IV. QUALITY: CONSULTATION AND CLINICAL IMPLEMENTATION

Model Implementation

Children completing TF-CBT attended an average of 21.3[5] (SD=16.9) sessions with an average episode length of 9.2 (SD=6.7) months, which is higher than conventional expectations of model completion (between 12 to 16 sessions). In FY22, over two-thirds of sessions (67.8%) were completed with the child only, 17.8% were with caregiver and child together, and 14.3% were with caregiver only. This amount of caregiver involvement during sessions (32.1%) fell just short of the statewide benchmark (33%). Nearly all children who received TF-CBT had a measure of baseline symptoms (98.6%). Of children discharged, 69.7% had at least one first and last version of a child symptom assessment (child or caregiver reporter) and 12.2% had data on caregiver symptoms.

Figure 3. QI Indicators in FY22



5. The mean was computed after removing 5 outliers with 93-134 visits.

Quality Improvement (QI) Indicators

Twice annually, CHDI reports on TF-CBT QI indicators that guide overarching implementation consultation goals. All QI indicators surpassed benchmarks in the FY22 performance periods. ***There were no significant differences in any QI indicator across race/ethnicity or sex.*** Appendix D has additional information about the QI indicators.

Satisfaction

Of all caregiver reports (n=235), approximately 96% were moderately to extremely satisfied with TF-CBT treatment, see Figure 4. Of the child satisfaction reports (n=250), approximately 91% were moderately to extremely satisfied with treatment, see Figure 5. ***There were no differences in satisfaction by race/ethnicity or sex.***

Figure 4. Caregiver Satisfaction with their Child's TF-CBT Treatment

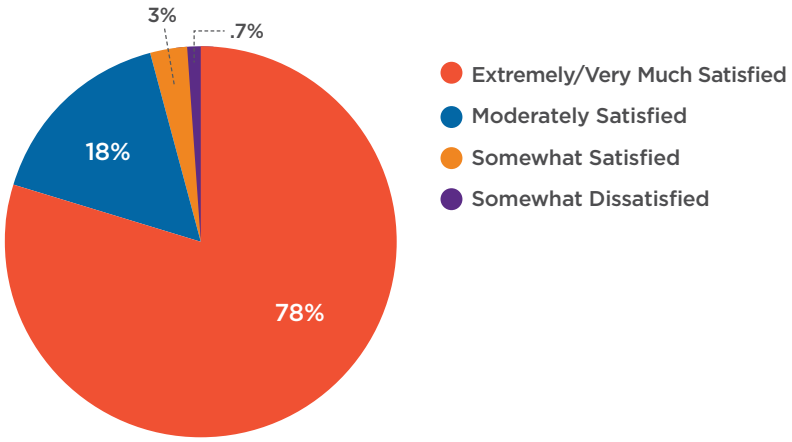
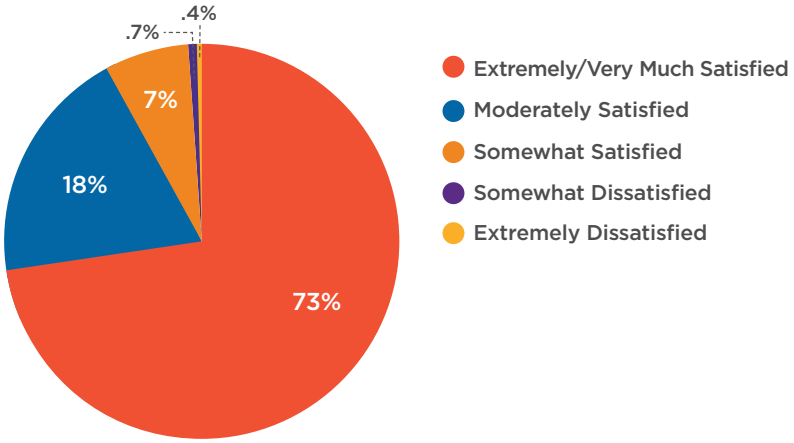


Figure 5. Child Satisfaction with their TF-CBT Treatment

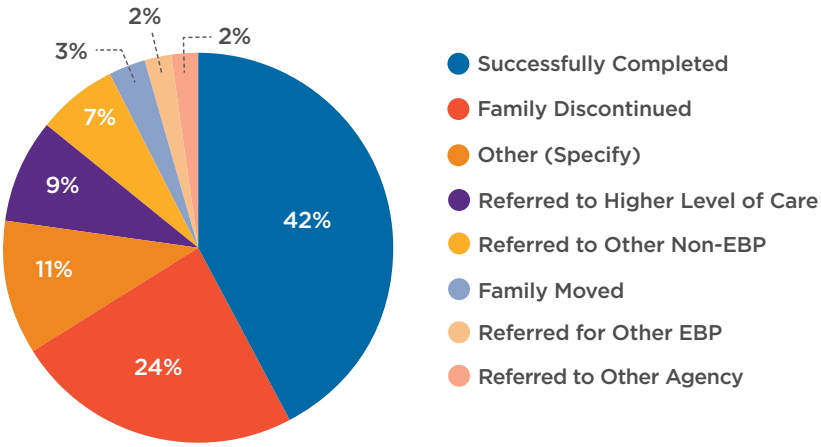


V. OUTCOMES: IMPROVEMENT FOR CHILDREN RECEIVING TF-CBT

Successful Completion

In FY22, 515 children ended their TF-CBT treatment episode with nearly half children (43%) ending treatment as "completing all EBT requirements," (see Figure 6). While family discontinuation accounted for nearly one quarter of children who did not complete TF-CBT, approximately 16% of children received either a higher level of care or other non-evidence-based practice (EBP) service. Binary logistic regression analyses were conducted to determine which factors were associated with successful discharge, see Appendix B Table B1. ***There were no significant differences in successful discharge by sex, age, race/ethnicity, or trauma exposure.***

Figure 6. Reasons for Discharge in FY22



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 FY22 to indicate clinical severity and improvement. On the CGI-S, 47.7% of clients changed from a more severe to a less severe category during the course of treatment (Figure 7). Though all sub-groups had similar baseline severity scores, ***Black youth experienced the lowest severity and the greatest improvement by discharge*** (Figure 8). Clinicians reported symptom improvement for the majority of youth (79.9%) with the CGI-I.

Figure 7. CGI-S at Start and End of TF-CBT Treatment

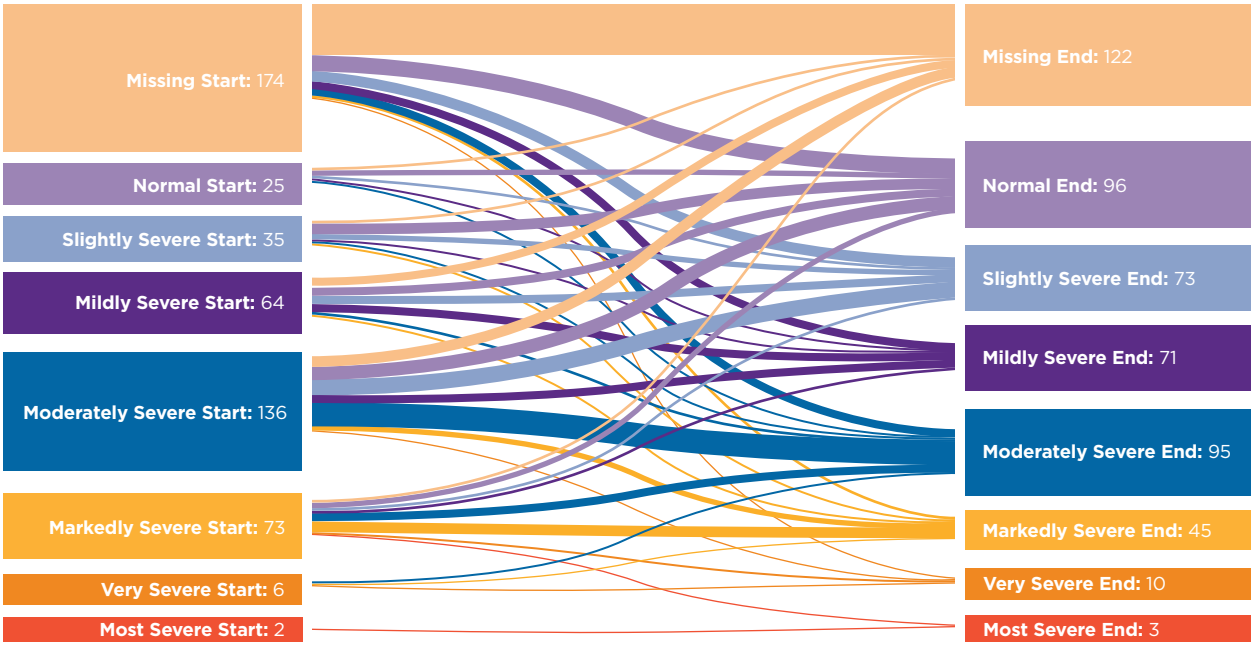
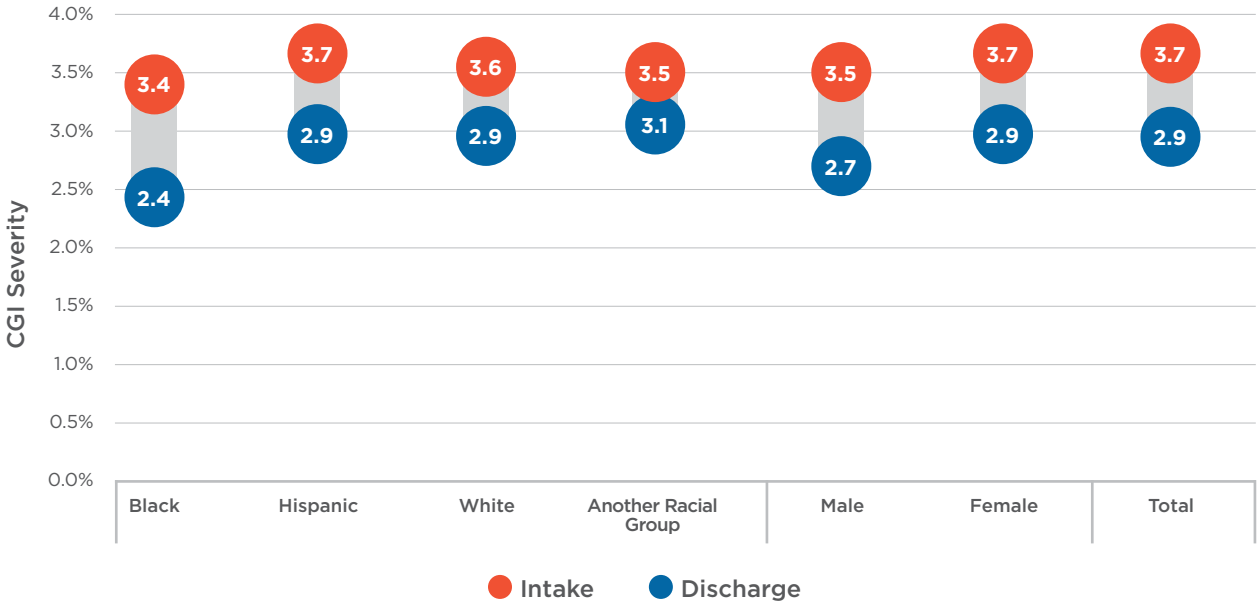


Figure 8. CGI-S Intake and Discharge Scores



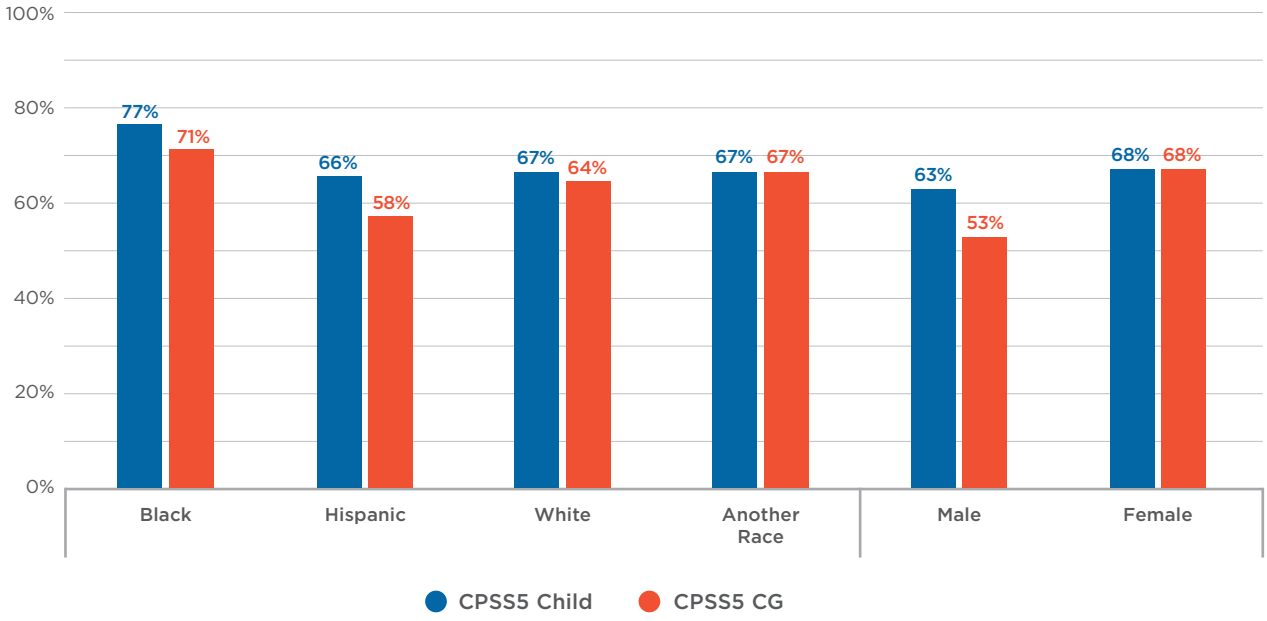
Symptom Improvement

Across all measures, ***87.5% 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 Post-traumatic 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 post-traumatic stress symptoms, the most used measures, 65.8% of all youth showed reliable improvement on child reports, and 62.1% of youth showed reliable change on caregiver reports. Figure 9 shows the rates of improvement in CPSS scores by subgroup.

Figure 9. Percentage of Children that Show Improvement in Post-traumatic Stress Symptoms



Overall Clinical Improvements across Groups

Multiple regressions were performed to explore the effect of race/ethnicity, age, and sex on change scores in post-traumatic stress symptoms, controlling for trauma exposure and successful completion (Appendix B, Table B3). Youth who successfully completed treatment or had more types of trauma exposure had greater post-traumatic stress symptom improvement. Improvement did not differ by race or ethnicity, but caregivers of female children reported greater improvement in post-traumatic symptoms, which may suggest that caregivers can more readily see/evaluate improvement in post-traumatic symptoms in their female children. Logistic regression was used to assess symptom reduction using RCI in any broadband or narrowband measure. ***No statistical differences were found in improvement rates of RCI in any measure by race and ethnicity or sex*** (Appendix B, Table B4).

VI. SUMMARY AND CONCLUSIONS

In FY22, high-quality TF-CBT services remained despite reports of workforce turnover and hiring difficulties, acute client needs, and reduced access to higher levels of care. In comparison to FY21, youth served declined by nearly 16% and the percentage of clinicians who saw at least one case dropped by nearly 8%. Since the onset of the COVID-19 pandemic, the annual number of youth served has dropped by 25%. On average, children discharged from TF-CBT attended just above 21 sessions over the course of 9 months, which exceeds the recommended range (12 to 16 sessions) but was aligned with overall outpatient service use trends. The monthly session frequency (~2.3 sessions) has improved since FY20 and approached pre-pandemic rates (~2.7 sessions). This suggests that more youth who received TF-CBT in FY22 were actively engaged in their treatment since the onset of the pandemic. Caregivers participated in an average of 32% of sessions, which is near the 33% benchmark. All other quality improvement indicators including engagement, consistent care, collection of measures, improved outcomes, and model completion surpassed benchmarks.

Nearly 20% of TF-CBT clinicians (n=343) left their positions during the year; this attrition rate has leveled off since the onset of COVID-19. Agency providers who experienced workforce turnover of clinicians, supervisors, and team leaders reported two factors that affected TF-CBT clinicians' capacity to serve youth: 1) promotions to supervisory roles with a reduced caseload, and 2) prioritization of other responsibilities as caseloads increased and more acute clients were referred to outpatient. To increase the availability of a qualified TF-CBT workforce, 63 new TF-CBT clinicians were trained, 24 TF-CBT clinicians became credentialed, and 32 credentialed clinicians participated in advanced training for TF-CBT with young children.

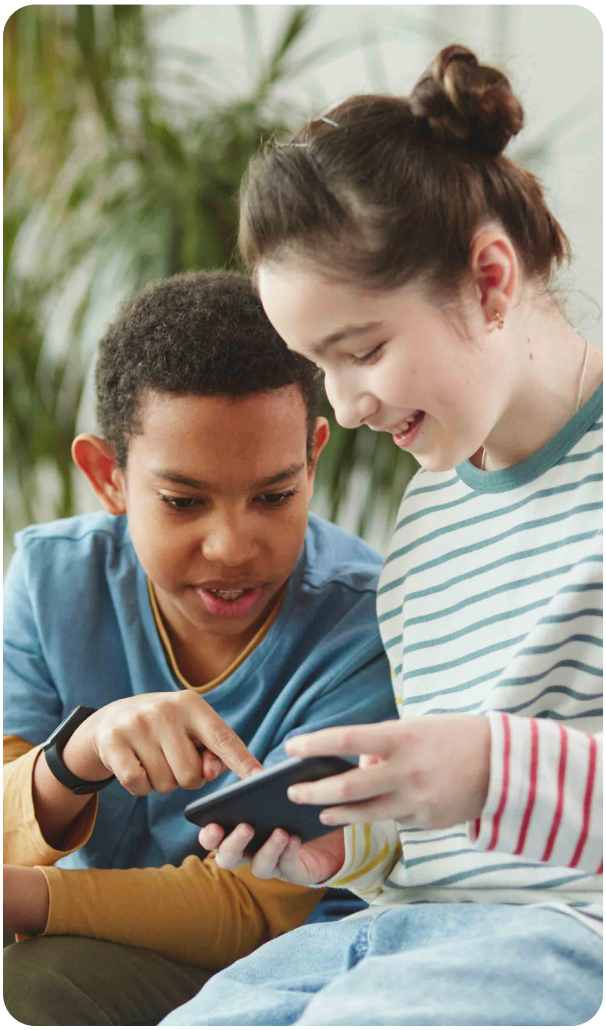
The primary reasons for discharge as reported by clinicians were successful completion (42%), family discontinued (24%) and terminating for other reasons (e.g., referred to a higher level of care or another service, model or agency). Successful discharges predicted symptom improvement and the rate of 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, 87.5% 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 showed a similar rate of improvement (79.9%) indicating that this brief measure is comparable to lengthier clinical measures.

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. Of note, Black youth experienced the greatest improvement by discharge. Compared to child outpatient services, children younger than six, male youth, and Black youth received TF-CBT services at lower rates of service, while children with child welfare involvement or who identified with Latinx origins had proportionally higher access to the TF-CBT model. Attention to these access differences during quality improvement consultation and additional trainings will help to ensure youth with trauma exposure equitably receive TF-CBT services.

Recommendations

The following recommendations are made for continued support of the TF-CBT statewide network:

- Develop and implement strategies to ensure TF-CBT new clinician statewide training maximizes available capacity through an online waitlist system that will reduce dropout rate to lower than 10%. Explore cost-sharing of agency-based trainings when there is a demand for more than 10 clinicians to be trained at a single agency at one time.
- Provide ongoing support to bilingual Spanish English clinicians implementing TF-CBT, including resources to support effective engagement and service delivery with Latinx youth.
- Utilize site visit consultations to ensure minimum TF-CBT clinician caseloads are met by establishing team-based goals supporting that at least 75% of trained clinicians serve at least one youth in TF-CBT within the SFY. Goals will be individualized based on team factors (e.g., turnover, clinician experience, staff with leadership roles, staff implementing multiple EBTs, staff coverage).
- Identify and provide training and consultation access to other trauma-informed EBPs (e.g., young children, youth involved with juvenile justice who have experienced trauma) to increase access to trauma-informed services.
- Increase child welfare, CSSD, and LYNC provider attendance at the EBP conference to highlight the availability of TF-CBT and other trauma-informed EBPs.
- Gather systematic information from TF-CBT providers to assess administrative burdens (e.g., data collection and entry) and develop resources and strategies to improve clinical workflow and ensure all youth that receive TF-CBT services are documented.
- Examine patterns of TF-CBT session use that exceed recommended ranges to determine appropriate consultation guidelines, such as the use of assessment measures to inform optimal lengths of stay and the use of briefer TF-CBT, when appropriate.
- Implement specialized consultation and resources for TF-CBT supervisors, senior leaders, and coordinators to improve and sustain their ability encourage and support clinician use of TF-CBT with fidelity to more youth amidst workforce turnover and acuity challenges.
- Expand equity-based training opportunities for TF-CBT clinicians to engage youth across social identities other than race, ethnicity, and sex (e.g., gender).
- Continue to monitor TF-CBT treatment across age, gender, and race/ethnicity for equivalent outcomes.



Conclusion

Youth served has continued to decline since the onset of the COVID-19 pandemic in 2020; however, service quality, outcomes, and equity remained strong. Efforts to recruit underserved groups into TF-CBT, particularly young children, Black youth, males, and those involved with juvenile justice who are exposed to trauma, should be prioritized. While provider workforce capacity, hiring, and retention remain central issues across the TF-CBT network, more access to trauma-informed EBPs is essential. Most children experienced improvements when they received at least some TF-CBT services, which suggests that even some sessions of a trauma-informed EBP are useful and could be prioritized, when appropriate. Expansion into other trauma-informed EBPs, including briefer options, alongside TF-CBT will support the array of trauma-informed services that Connecticut youth may access in the years to come.

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 five TF-CBT clinical trainings in July 2021, August/September 2021, November 2021, January 2022 and March/April 2022 for 63 new clinicians.
- Conducted three TF-CBT Booster trainings with 48 clinicians.
- Completed eight series of clinical consultation calls (65 total calls) for 77 clinicians.
- Held the first Advanced Clinical Training: TF-CBT with Young Children for 32 participants.
- Maintained a training record database to track training and consultation attendance of all TF-CBT providers.
- Convened the 14th annual EBP Conference virtually of 17 workshops with more than 41% meeting the cultural competency CE requirement. A total of 395 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 126 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 $454,900 in performance-based sustainment funds to agencies (41.4% of total contract funds).

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	133	-0.201	0.238	0.714	0.818 (0.513, 1.304)
Another Race Non-Hispanic	9	0.785	0.727	1.167	2.193 (0.528, 9.114)
Black Non-Hispanic	31	-0.607	0.417	2.114	0.545 (0.241, 1.235)
Sex (Male)	113	0.099	0.245	0.165	1.104 (0.683, 1.785)
Child Age	333	0.007	0.039	0.035	1.007 (0.934, 1.086)
Trauma Exposure-THS Child	333	-0.021	0.041	0.259	0.979 (0.904, 1.061)
Trauma Exposure-THS Caregiver	333	0.043	0.044	0.977	1.044 (0.958, 1.138)
Constant		-0.364	0.533	0.465	0.695

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

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=51)	Caregiver Depression	26 51%	19.69 (13.37)	13.39 (12.20)	-6.29 (13.27)	-3.39**	.474 Medium	14/26 53.8%
CPSS V Child (n=281)	Trauma Symptoms	173 61.6%	35.79 (15.16)	20.80 (16.35)	-15.00 (16.16)	-15.56**	.928 Large	115/173 66.5%
CPSS V Caregiver (n=255)		90 45.5%	30.06 (14.72	17.23 (12.71)	-12.83 (15.06)	-11.98**	.852 Large	67/90 74.4%
SMFQ Child (n=107)	Depressive Symptoms	74 69.2%	11.15 (6.26	8.23 (6.60)	-2.92 (7.76)	-3.89**	.376 Medium	41/74 55.4%
SMFQ Caregiver (n=82)		N/A	10.83 (6.84)	7.34 (5.25)	-3.49 (6.93)	-4.56**	.503 Medium	N/A
Ohio Problem Severity Child (n=200)	Severity of Internalizing/ Externalizing Behaviors	97 48.5%	25.31 (13.55)	17.99 (14.29)	-7.39 (13.14)	-7.96**	.563 Medium	53/97 54.6%
Ohio Problem Severity Caregiver (n=255)		108 42.4%	24.51 (14.40)	17.06 (13.78)	-7.43 (12.87)	-9.22**	.578 Medium	61/108 56.5%
Ohio Functioning Child (n=209)	Child's Adjustment and Functioning	49 23.4%	53.42 (12.93)	60.42 (12.29)	7.00 (13.36)	7.57**	.524 Medium	41/49 83.7%
Ohio Functioning Caregiver (n=268)		76 28.4%	51.14 (13.98)	57.32 (14.69)	6.18 (12.53)	8.08**	.493 Medium	46/76 60.5%

*p<.05 Effect sizes were derived using Cohen's D as follows: .2 = small, .5 = medium, .8 = large
**p<.001 1 extreme outlier in Ohio Problem Severity Child Change, 1 in Ohio Problem Severity Caregiver Change, and 1 for Ohio Functioning Child were set to the next highest value to reduce their biasing effect on means and statistical tests

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	-6.502	4.524	(-15.416, 2.411)	-15.438**	4.970	(-25.249, -5.627)
Trauma Exposure - THS, Child	-0.742*	0.320	(-1.372, -0.111)	-0.882*	0.379	(-1.631, -0.134)
Hispanic	-1.605	2.134	(-5.808, 2.599)	-0.648	2.367	(-5.320, 4.023)
Another Race Non-Hispanic	1.578	5.375	(-9.012, 12.167)	5.461	5.976	(-6.336, 17.258)
Black Non-Hispanic	-5.927	3.630	(-13.080, 1.225)	1.850	4.027	(-6.099, 9.799)
Sex (Male)	1.220	2.198	(-3.110, 5.550)	5.414*	2.449	(0.581, 10.248)
Child Age	0.132	0.309	(-0.477, 0.741)	0.656	0.339	(-0.012, 1.325)
Child Discharged as "Successful"	-9.493**	2.009	(-13.451, -5.536)	-4.816*	2.233	(-9.224, -0.408)
R^2	0.111			0.090		
F	4.230**			2.390*		

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

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	133	-0.304	0.287	1.123	0.738 (0.420, 1.295)
Other Non-Hispanic	9	-0.722	0.895	0.650	0.486 (0.084, 2.810)
Black Non-Hispanic	31	-0.248	0.463	0.287	0.780 (0.315, 1.933)
Sex (Male)	113	-0.323	0.299	1.169	0.724 (0.403, 1.300)
Child Age	333	-0.087	0.046	3.531	0.916 (0.837, 1.004)
Trauma Exposure - THS Child	333	-0.020	0.049	0.168	0.980 (0.890, 1.079)
Trauma Exposure - THS Caregiver	333	0.033	0.053	0.382	1.033 (0.932, 1.146)
Child Discharged as "Unsuccessful"	186	-2.606**	0.334	60.952	0.074 (0.038, 0.142)
Constant		3.665**	0.731	25.140	39.043

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

IX. APPENDIX C: RELIABLE CHANGE INDEX

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

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

Measure		Full RCI	Partial RCI
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, & Worker Versions)	10	5
	Ohio Functioning (Child, Caregiver, & 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: TF-CBT QI OVERVIEW

A complete list of the current TF-CBT 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.

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