Cognitive Behavioral Intervention for Trauma in Schools

CONNECTICUT'S EVIDENCE-BASED TREATMENT COORDINATING CENTER

Child Health and Development Institute

DCF CONNECTICUT

FY 2022 ANNUAL REPORT

Connecticut CBITS/BB 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 **Alice Kraiza** at **akraiza@chdi.org**

The authors retain full responsibility for all opinions and content.

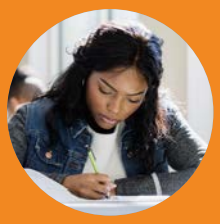
CONTENTS

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 33 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) 2022 (July 1, 2021 through June 30, 2022).

KEY FINDINGS OF FY22:



1,749 students were screened for trauma exposure and associated symptoms.

830 students received CBITS or BB across **105 CBITS** and **74 BB** groups.

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.

96 schools and **10** other community-based organizations offered CBITS and/or BB.

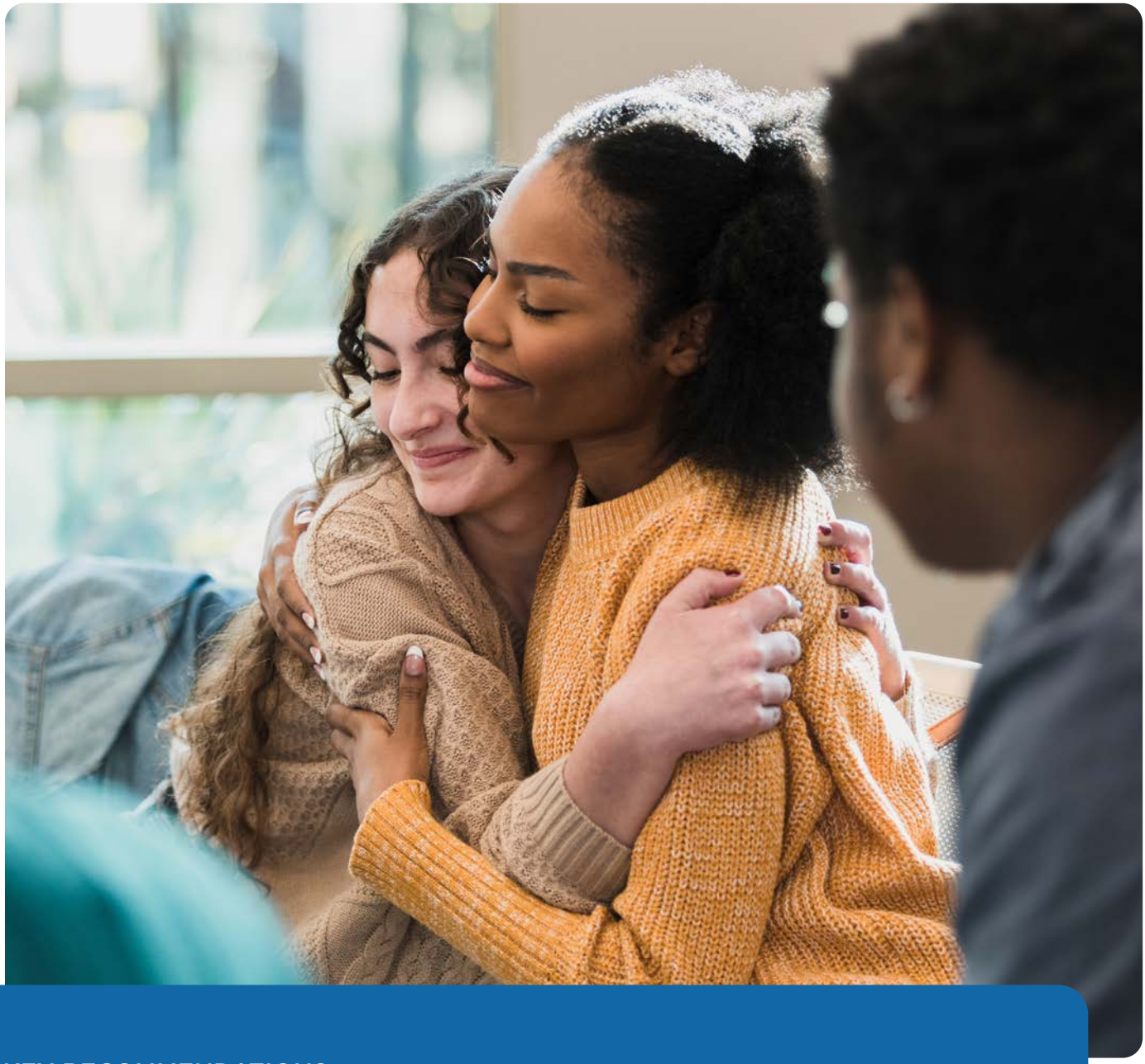
High satisfaction with CBITS/BB treatment among children **(82%)** and caregivers **(91%)**.

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

57 new clinicians were trained in CBITS and **39** new clinicians in BB.

Most youth receiving CBITS and BB experienced reliable PTSD symptom reduction (**69.7%** and **62.3%**, respectively).

Youth receiving CBITS experienced equivalent trauma symptom improvements across all racial, ethnic, and sex subgroups. For BB, Hispanic and Black youth experienced the greatest improvement in trauma symptoms.



KEY RECOMMENDATIONS:

- **Establish** simplified and streamlined implementation guidelines for screening, consenting, data entry, and enrollment protocols to improve access to CBITS/BB services, particularly for Hispanic youth.
- **Expand** the use of CBITS/BB in community-based settings that are ideal for short-term, group-based treatment formats, such as extended day treatment, intensive outpatient, and partial hospitalization programs.
- **Provide** specialized consultation and training opportunities for providers who work with young children to ensure quality treatment and additional resources are available to improve outcomes, particularly for White youth and youth of Another Race who receive BB services.

II. INTRODUCTION

The 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 FY22, the network consisted of 32 school districts and 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 FY22 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 benefitting from CBITS/BB?

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

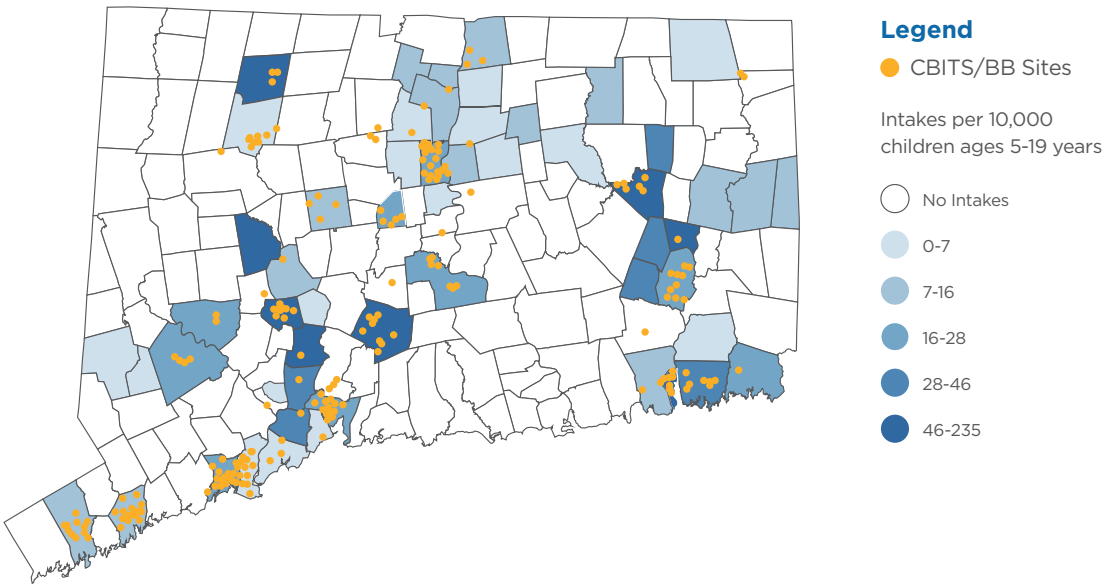
III. ACCESS TO CBITS/BB IN CONNECTICUT

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 FY22, CBITS was implemented at 58 schools and 10 community-based settings across 29 different providers; BB was implemented at 47 schools and 5 community-based settings across 23 different providers. A total of 105 CBITS and 74 BB groups were held in FY22.

Figure 1. Map of CBITS/BB Sites and Children Served



In FY22, 57 CBITS and 39 BB clinicians were trained, while 18 CBITS and 11 BB clinicians achieved certification. Tables 1 and 2 show details about CBITS and BB teams.

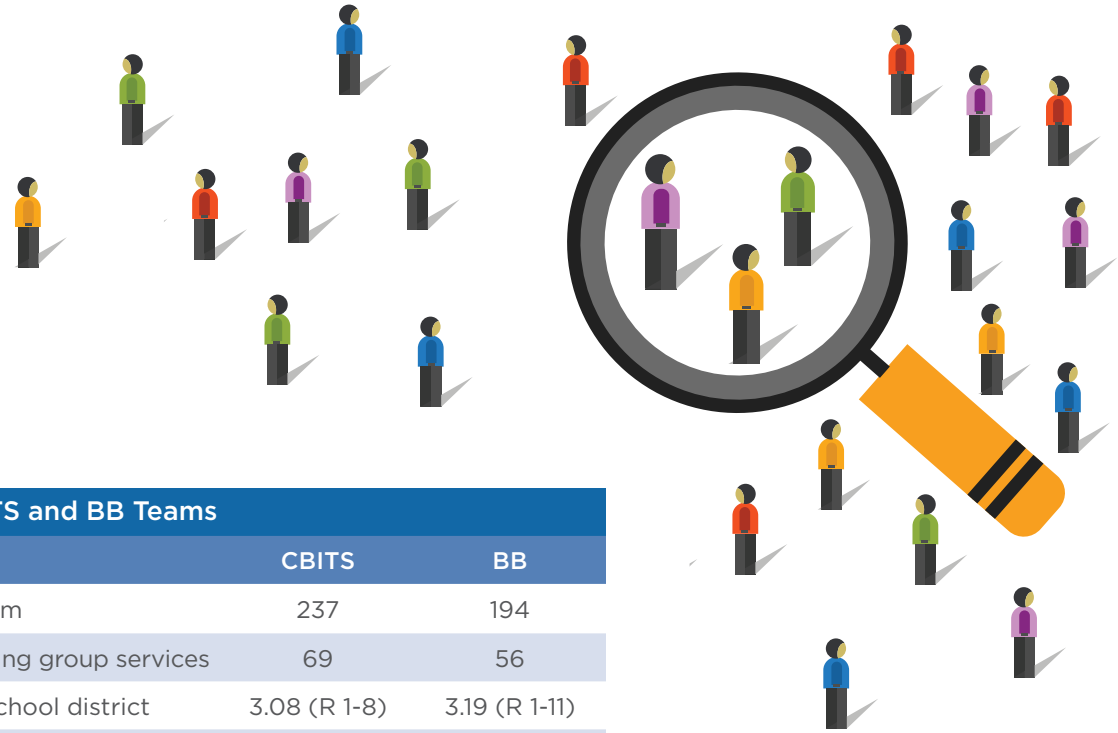


Table 1. FY22 CBITS and BB Teams		
	CBITS	BB
# of clinicians on team	237	194
# of clinicians providing group services	69	56
Average team size-school district	3.08 (R 1-8)	3.19 (R 1-11)
Average team size-community based	2.00 (R 1-5)	2.75 (R 1-5)

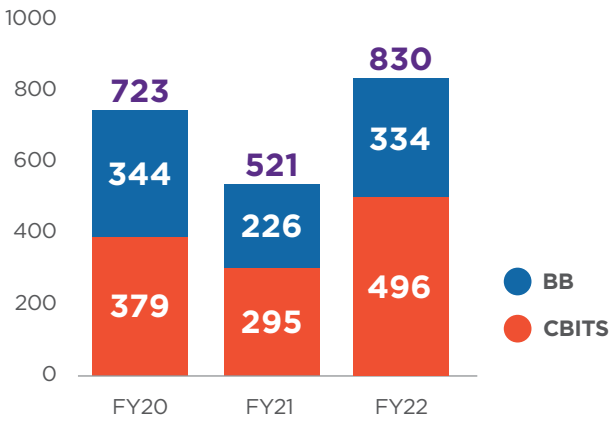
Table 2. Trends in CBITS/BB Provider Network				
	FY 2020	FY 2021	FY 2022	Cumulative Since 2015
Schools				
CBITS	47	43	**58**	194*
BB	55	35	**47**	
School Districts				
CBITS	18	16	**26**	36*
BB	18	17	**20**	
Community-Based Settings**				
CBITS	6	3	**10**	18*
BB	5	4	**5**	
Newly Trained Clinicians				
CBITS	69	49	**57**	580*
BB	47	42	**39**	
# Newly Certified				
CBITS	0	1	**6**	44*
BB	0	2	**4**	
Clinicians Providing Treatment				
CBITS	59	50	**69**	310*
BB	60	43	**56**	

*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 Receiving CBITS/BB

In FY22, 1,749 children were screened for trauma exposure and traumatic stress and 964 were eligible to participate in a group; 496 children received CBITS and 334 children received BB during the year. Children reported an average of 7.5 (CBITS) and 5.6 (BB) of 18 types of traumatic exposures. Figure 2 shows the number of children who have received CBITS and BB since FY20. To date, 2,507 children have received CBITS since 2015 and 1,499 children have received BB since 2017 (4,006 total children served).

Figure 2. Children Served Since FY20



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. The average age of youth who received CBITS is 13.3 years (SD=2.19), and 8.8 years for youth who received BB (SD=1.55). In general, 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=496) and BB (n=334) with comparisons						
	CBITS		BB		CT Schools[i]	CT Pop[ii]
	N	%	N	%	%	%
Sex (Male)	**171**	**35.3**	**159**	**48.0**	**51.5**	**51.3**
Race						
American Indian or Alaska Native	5	1.0	3	0.9	0.3	0.4
Asian	6	1.2	6	1.8	5.1	4.6
Black or African American	122	24.6	82	24.6	12.6	12.8
Native Hawaiian or Pacific Islander	3	0.6	1	0.3	0.1	0.1
White	299	60.3	205	61.4	48.6	66.3
Another Racial Group	61	12.3	37	11.4	4.3	15.8
Hispanic Origin	223	45.0	163	48.8	29.0	25.3
Age (Years)						
Under 6 years	1	0.2	18	5.4	N/A	30.1
6–11 years	110	22.2	314	94	N/A	32.8
12–17 years	374	75.4	2	0.6	N/A	37.1
18 and older	11	2.2	0	0.0	N/A	N/A
Grade						
Elementary	48	9.7	325	97.3	43.3	N/A
Middle	246	49.6	9	2.7	23.3	N/A
High	202	40.7	0	0.0	33.4	N/A
Child Welfare Involvement During Treatment	**43**	**8.7**	**40**	**12.0**	**N/A**	**2.9[iii]**
Juvenile Justice Involvement During Treatment	**2**	**0.4**	**1**	**0.3**	**N/A**	**N/A**
Child Primary Language						
Spanish	16	5.0	8	5.3	N/A	13.7
Neither Spanish nor English	1	0.3	1	0.7	N/A	8.0
Caregiver Speaks English (No)	**45**	**11.4**	**35**	**16.0**	**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.

IV. QUALITY: CLINICAL IMPLEMENTATION AND IMPROVEMENT

Treatment Dose and Duration

A total of 74 BB and 105 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 9.4 (SD=1.1) group and 1.5 (SD=1.0) individual sessions over an average of 2.8 months. Youth receiving BB completed 9.6 (SD=0.8) group and 2.1 (SD=1.2) individual sessions over an average of 2.7 months.

Quality Improvement Indicators

In FY22, nearly all children receiving CBITS/BB had a baseline assessment (98% CBITS; 97% BB) and most had both baseline and post-group assessment data available (76% CBITS; 73% BB). Quality improvement (QI) indicators demonstrate progress across the statewide initiative during the fiscal year. All QI indicators demonstrated improvement and were above the benchmark by the end of the year for both models except for symptom improvement for youth receiving BB (see Appendix D for additional QI Indicators information).

Figure 3. FY22 QI Indicators

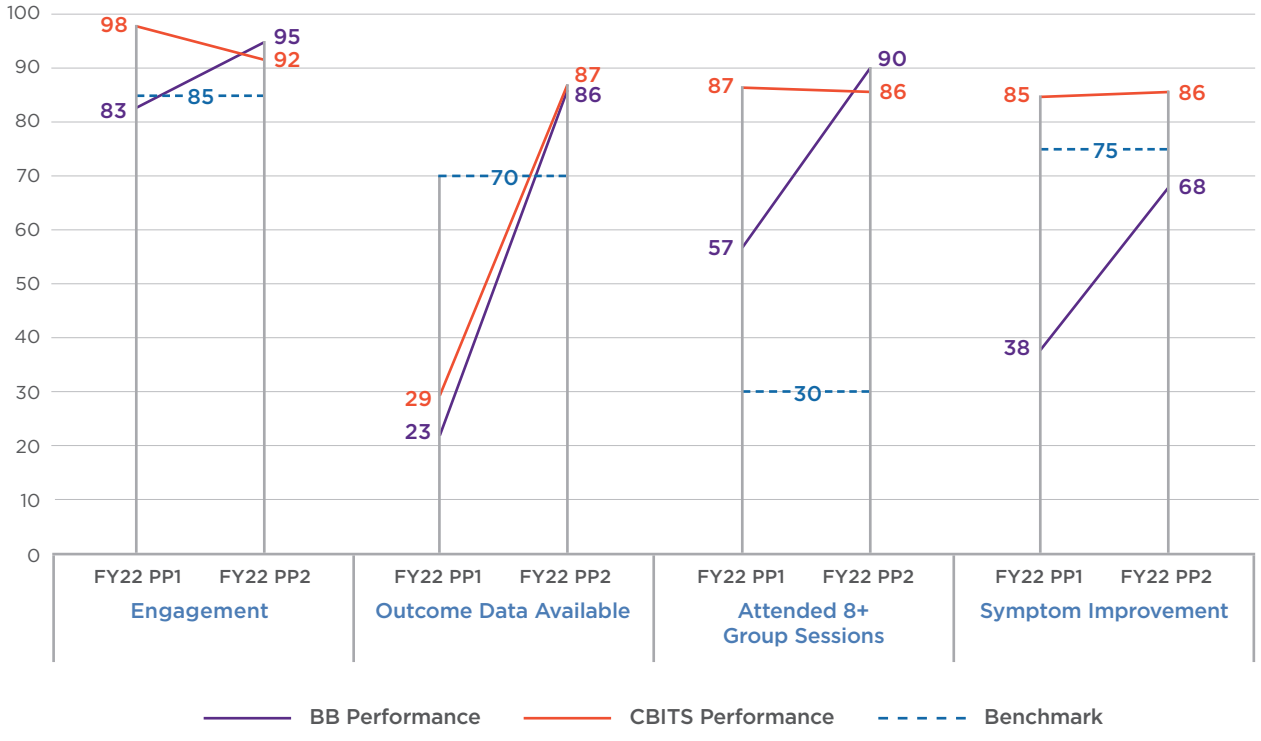
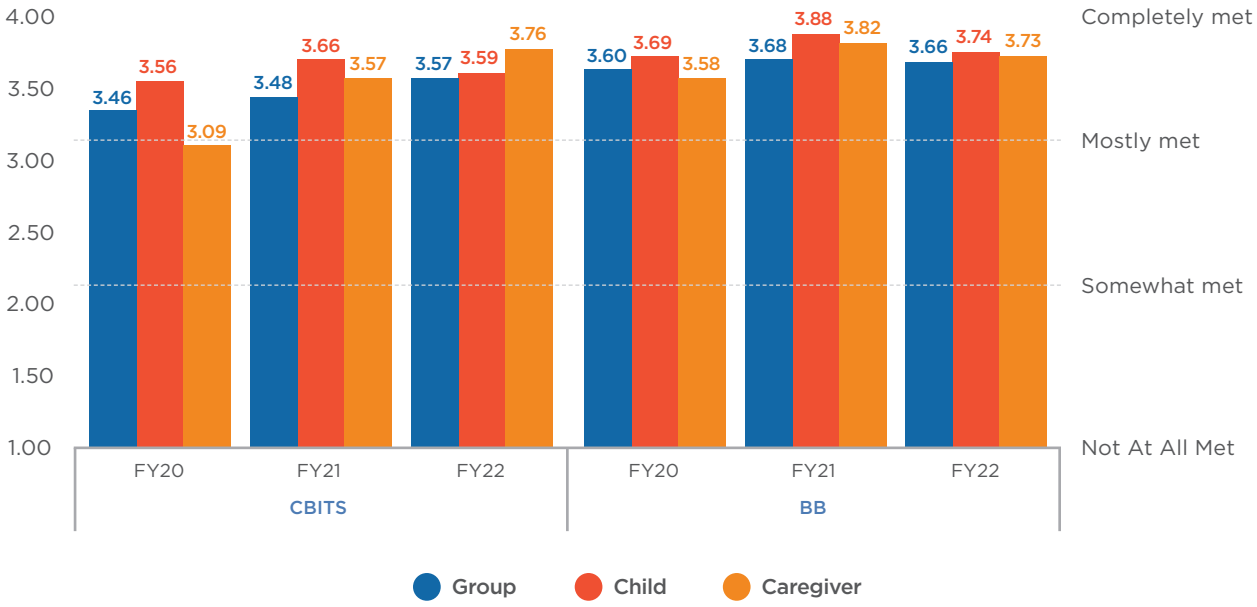


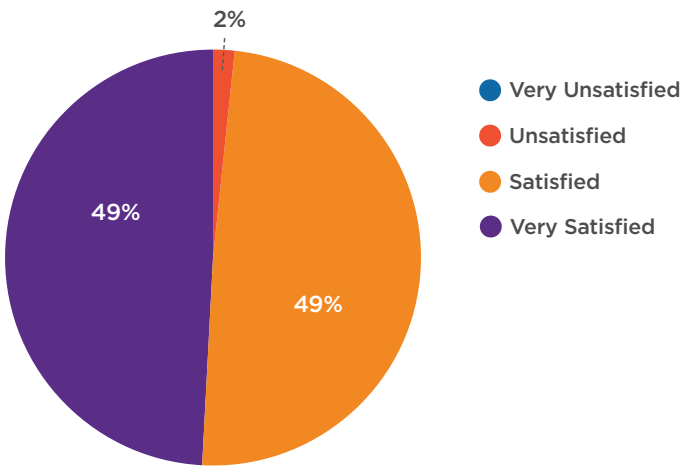
Figure 4. Group, Child, and Caregiver Session Objectives-Average Ratings Over Time



Satisfaction

In FY22, 165 children completed Ohio Satisfaction assessments about their CBITS/BB group, see Figure 5. Ninety one percent of 23 caregivers completed reported being moderately or extremely satisfied with treatment.

Figure 5. CBITS/BB Child Treatment Satisfaction



V. OUTCOMES: IMPROVEMENT FOR CHILDREN RECEIVING CBITS/BB

Discharge Reason

In FY22, 536 children in CBITS and 356 children in BB completed their treatment episode. More than 70% of children successfully completed treatment, see Figure 6 and 7.

Figure 6. Reasons for Discharge in FY22 (CBITS)

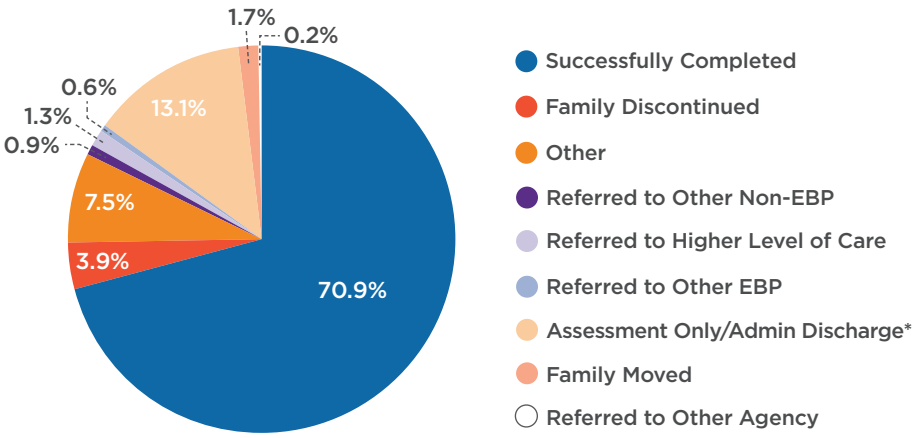
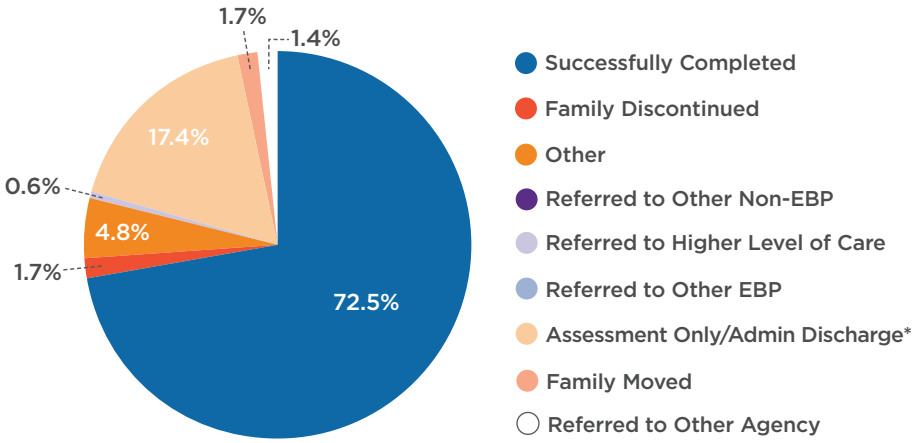


Figure 7. Reasons for Discharge in FY22 (BB)



*Note: "Assessment Only" refers to no treatment needed since the client was deemed inappropriate for EBT services after the initial intake assessment. "Admin Discharge" is a CHDI-level discharge.

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-I, clinicians reported symptom improvement for 83.9% of youth receiving CBITS (n=240) and 90.5% of youth receiving BB (n=199). On the CGI-S, 62.6% of youth receiving CBITS (n=203) and 60.5% of children who received BB (n=129) 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 8. CGI Severity at Start and End of CBITS Treatment

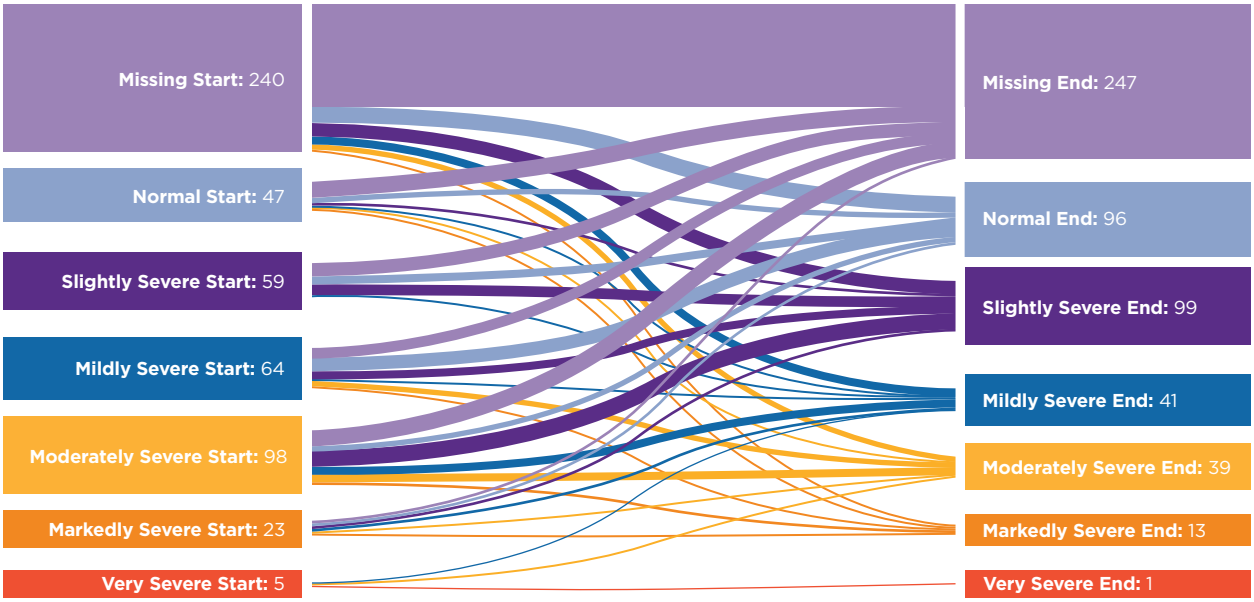
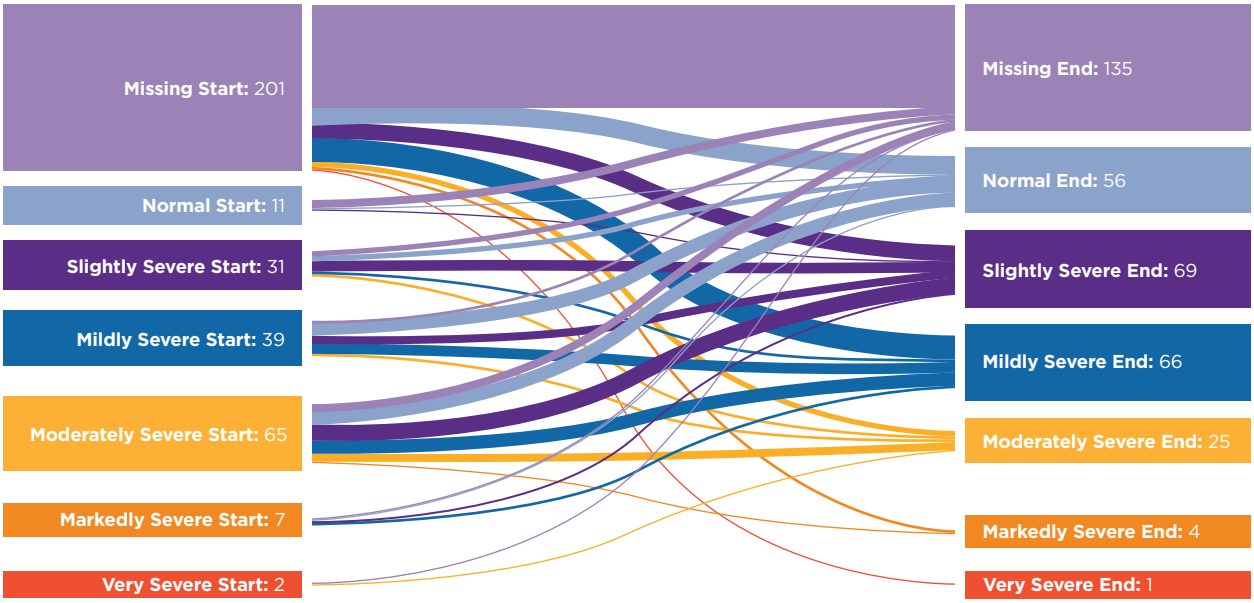


Figure 9. CGI Severity at Start and End of BB Treatment



Symptom Improvement

Children consistently experienced significant 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.

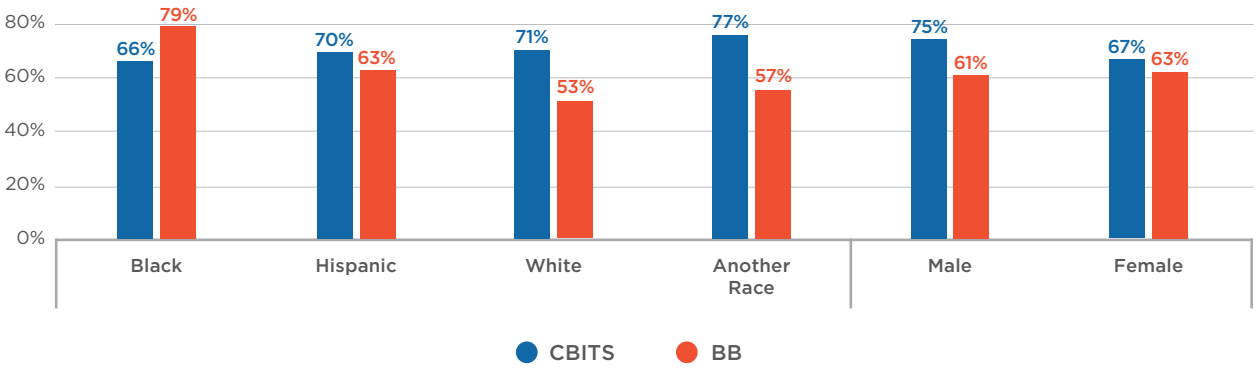
Overall Clinical Improvements Across Groups

Multiple regressions were performed to explore the effect of race, age, and sex on change scores, controlling for trauma exposure and successful completion (Appendix B, Tables B3 and B4). Youth receiving CBITS ***experienced equivalent trauma symptom improvements all racial, ethnic, and sex subgroups. For BB, Hispanic and Black youth experienced the greatest improvement in trauma symptoms.*** Logistic regressions were used to assess impacts on symptom reduction in any measure (Appendix B, Tables B5 and B6). In both CBITS and BB, ***youth who did not receive a "successful" reason for discharge (i.e., unsuccessful discharge) were less likely to experience symptom improvement.*** In CBITS only, ***children with Hispanic descent were about half as likely as white children to experience a successful discharge*** (Appendix B, Tables B7 and B8).

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 (69.7% CBITS, 62.3% BB) showed improvement in post-traumatic stress symptoms. Figure 10 shows the rates of improvement by subgroup.

Figure 10. Percentage of Children that Show Reliable Improvements in Posttraumatic Stress Symptoms



VI. SUMMARY AND RECOMMENDATIONS

In FY22, network providers screened over 1,700 youth for trauma exposure and served 830 youth in CBITS or BB. FY22 represents the second-highest year of CBITS/BB use since 2014. Though service use was high, less than a third of all trained clinicians provided CBITS/BB. While this has increased since 2021, it remains lower than pre-COVID rates in SFY19 (CBITS, 50%; BB, 58%). The quality of services was consistently high for both treatment models, youth completed approximately 95% of group sessions in less than three (3) months, and the average session ratings were marked as nearly "Completely met" by clinicians. By year's end, all but one of the Quality Improvement (QI) indicators surpassed benchmarks; the QI symptom improvement for youth receiving BB fell short by seven (7) points. Finally, nearly all youth (98%) reported satisfaction or high satisfaction with services.

Most youth receiving CBITS (71%) and BB (73%) had successfully completed the group by the end of treatment. Approximately two-thirds of youth had clinically meaningful reductions in post-traumatic stress symptoms in both CBITS and BB treatment models, 69.7% and 62.3% respectively. According to the CGI, overall improvements by the end of treatment were high for both models (CBITS, 83.9%; BB, 90.5%).

Child characteristics and service experiences 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. There were no service quality differences among youth receiving CBITS/BB across racial, ethnic, and sex sub-groups. Regarding outcomes, youth receiving CBITS experienced equivalent symptom improvement outcomes across racial, ethnic, and sex sub-groups. Though similar to BB services, Hispanic and Black youth experienced the greatest improvements in trauma symptoms.

Despite these strong outcomes for youth across racial/ethnic groups, youth who received a reason for discharge other than "successful" were less likely to experience symptom improvement at rates similar to those who were successfully discharged from services. While understandable given that these youth typically did not complete services, it is noteworthy that for every two White youth who received a successful discharge, only one Hispanic youth received the same status in CBITS services. Since overall outcomes remained equitable for Hispanic youth in CBITS, examining factors that led to only assessments or youth with administrative discharges should remain a priority to address barriers that impact service access.

Recommendations

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

- Maintain hybrid clinical training format options for new and existing CBITS/BB providers.
- Utilize site visit consultations to establish CBITS/BB team-based goals that support at least 35% of trained clinicians provide at least one group during the year.
- Utilize site visit consultations to examine factors that affect youth who experience administrative discharges or who receive only an assessment to increase engagement and completion rates.
- Expand CBITS and BB services into additional community-based settings, particularly in intermediate care settings, such as extended day treatment, intensive outpatient, and partial hospitalization programs.
- Incorporate CBITS/BB services as one component within a broader array of comprehensive school-based mental health services, such as a Multi-Tiered System of Support. [4]
- Expand training and implementation opportunities to improve youth of color engagement and service completion, which may include more investment in the CBITS Racial Trauma Module to improve completion rates for Hispanic youth.
- Increase caregiver input and follow-up about their satisfaction with CBITS/BB services.
- Provide specialized consultation and training opportunities for providers who work with young children to ensure quality treatment and additional resources are available (e.g., Gizmo's Pawesome Guide to Mental Health[5]) to improve outcomes, particularly for White youth and youth of Another Race who receive BB services.
- Streamline screening, consenting, enrollment, and data entry protocol guidelines for providers.
- Sustain CBITS and BB site-based trainers in statewide training opportunities.

4. Hoover, S., Bracey, J., Lever, N., Lang, J., & Vanderploeg, J. (2018). Health students and thriving schools: A comprehensive approach for addressing students' trauma and mental health needs. Retrieved from https://www.gizmo4mentalhealth.org/wp-content/uploads/2021/09/impact_final10_1_18.pdf
5. United Way of Connecticut. (2017). Gizmo 4 mental health. Retrieved from https://www.gizmo4mentalhealth.org/about/over time: A longitudinal, multi-level qualitative study. *School Mental Health*, 13, 201–212.

Conclusion

CBITS and BB are vital trauma-informed behavioral health services for Connecticut youth, particularly in school settings. Recognizing that CBITS/BB providers screened and treated a high number of youths in FY22, more attention to barriers that affect service delivery should be prioritized, such as youth who only received an initial assessment or were administratively discharged before treatment completion. Since CBITS and BB services are expandable to non-school, community-based settings, the group-based models may be of particular interest to providers interested in providing high-quality care and outcomes for more youth.

VII. APPENDIX A: ACTIVITIES AND DELIVERABLES

In FY22, the Coordinating Center has supported CBITS/BB implementation goals through the following activities.

1. Training, Consultation, & Credentialing

- Coordinated three CBITS and three BB statewide new clinician trainings, one BB internal training, and one CBITS Bridgeport-specific training for 57 CBITS and 39 BB staff.
- Coordinated CBITS Booster training for 61 clinical staff and BB Booster trainings for 40 clinical staff.
- Coordinated seven CBITS clinical consultation call groups with 84 total calls for 59 clinical staff.
- Coordinated seven BB clinical consultation call groups with 84 total calls for 54 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 14th annual EBP and Best Practice conference in virtual format series 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

- Conducted 127 site visits and 95 non-clinical consultation calls (virtual or telephonic).
- Onboarded 4 new provider teams; Bridgeport Public Schools, Community Health and Wellness Center of Greater Torrington, CT Junior Republic, and Klingberg Family Centers.
- 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@uchc.edu.
- 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 $358,538.80 (41.6% of total contract funds) in performance-based sustainment funds to agencies.

VIII. APPENDIX B: REGRESSION TABLES

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

Assessment Name	Construct	Above Clinical Cutoff	Initial Score Mean	Last Score Mean	Effect Size	Remission
CPSS 5 Child (n=363)	Post-traumatic stress symptoms	65.3%	38.6	24.94	Large** 0.94	49.4%
Ohio Problem Severity Child (n=341)	Severity of internalizing/ externalizing behaviors	52.8%	27.76	20.14	Med/Large** 0.67	45.0%
Ohio Problem Severity Caregiver (n=43)		30.2%	20.58	13.63	Medium** 0.63	61.5%
Ohio Functioning Child (n=341)	Child's adjustment and functioning	25.5%	51.74	55.35	Small** 0.32	56.3%
Ohio Functioning Caregiver (n=43)		20.9%	50.77	57	Med/Large** 0.65	66.7%

*t-score for score change significant at p<.05
**t-score for score change significant at p<.001
Effect sizes were derived using Cohen's D as follows: .2 = small, .5 = medium, .8 = large

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

Assessment Name	Construct	Above Clinical Cutoff	Initial Score Mean	Last Score Mean	Effect Size	Remission
CPSS 5 Child (n=239)	Post-traumatic stress symptoms	52.3%	32.46	21.72	Large** 0.78	60.0%
Ohio Problem Severity Child (n=73)	Severity of internalizing/ externalizing behaviors	47.9%	27.04	15.92	Large** 0.85	68.6%
Ohio Problem Severity Caregiver (n=26)		50.0%	25.96	18.27	Medium* 0.62	53.8%
Ohio Functioning Child (n=73)	Child's adjustment and functioning	16.4%	55.45	61.22	Medium** 0.51	91.7%
Ohio Functioning Caregiver (n=26)		23.1%	51.38	54.92	Sm/Med* 0.36	50.0%

*t-score for score change significant at p<.05
**t-score for score change significant at p<.001
Effect sizes were derived using Cohen's D as follows: .2 = small, .5 = medium, .8 = large

Table B3. Multiple regression analyses of selected demographic variables on child CPSS5 change scores (CBITS)

Variable	β	*SE*	*95%CI*
Constant	-15.023	5.364	(-25.574, -4.472)
Trauma Exposure-TEC Child	-0.058	0.237	(0.523, 0.408)
Child Discharged "Unsuccessful"	-0.301	1.868	(-3.976, 3.373)
Hispanic	-2.364	1.852	(-6.007, 1.280)
Other Non-Hispanic	0.269	4.152	(-7.898, 8.435)
Black Non-Hispanic	-1.045	2.231	(-5.433, 3.344)
Sex (Male)	-1.415	1.650	(-4.660, 1.830)
Child Age	0.273	0.355	(-0.425, 0.970)
R^2	-0.011		
F	0.476		

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

Table B4. Multiple regression analyses of selected demographic variables on child CPSS5 change scores (BB)

Variable	β	*SE*	*95%CI*
Constant	2.165	5.103	(-7.890, 12.220)
Trauma Exposure-TEC Child	-0.570	0.326	(-1.212, 0.073)
Child Discharged "Unsuccessful"	0.545	2.152	(-3.695, 4.786)
Hispanic	-4.638*	2.124	(-8.822, -0.453)
Other Non-Hispanic	0.813	4.519	(-8.091, 9.717)
Black Non-Hispanic	-6.350*	2.711	(-11.692, -1.008)
Sex (Male)	-0.858	1.799	(-4.403, 2.686)
Child Age	-0.734	0.497	(-1.713, 0.246)
R^2	0.030		
F	1.900		

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

Table B5. Logistic regression analyses for predicting if there was partial or reliable change on any measure (CBITS)					
Variable	*N*	*β*	*SE*	*Wald*	*eB(95%CI)*
Hispanic	219	0.276	0.290	0.908	1.318 (0.747, 2.326)
Other Non-Hispanic	18	1.284	0.912	1.983	3.611 (0.605, 21.561)
Black Non-Hispanic	101	0.124	0.339	0.135	1.133 (0.583, 2.202)
Sex (Male)	169	0.011	0.258	0.002	1.012 (0.610, 1.678)
Child Age	479	0.086	0.056	2.332	1.090 (0.976, 1.217)
Trauma Exposure-TEC Child	479	-0.021	0.037	0.340	0.979 (0.911, 1.052)
Child Discharged "Unsuccessful"	109	-3.617**	0.344	110.569	0.027 (0.014, 0.053)
Constant		0.305	0.792	0.148	1.356

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

Table B6. Logistic regression analyses for predicting if there was partial or reliable change on any measure (BB)					
Variable	*N*	*β*	*SE*	*Wald*	*eB(95%CI)*
Hispanic	160	-0.019	0.292	0.004	0.981 (0.553, 1.741)
Other Non-Hispanic	14	-0.882	0.688	1.645	0.414 (0.108, 1.593)
Black Non-Hispanic	58	0.049	0.386	0.016	1.050 (0.493, 2.236)
Sex (Male)	158	-0.139	0.249	0.311	0.870 (0.534, 1.418)
Child Discharged "Unsuccessful"	69	-2.663**	0.424	39.366	0.070 (0.030, 0.160)
Child Age	326	-0.026	0.069	0.140	0.975 (0.851, 1.116)
Trauma Exposure-TEC Child	326	0.056	0.047	1.461	1.058 (0.966, 1.159)
Constant		0.486	0.700	0.482	1.626

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

Table B7. Logistic regression analyses for predicting successful discharge from selected background characteristics (CBITS)

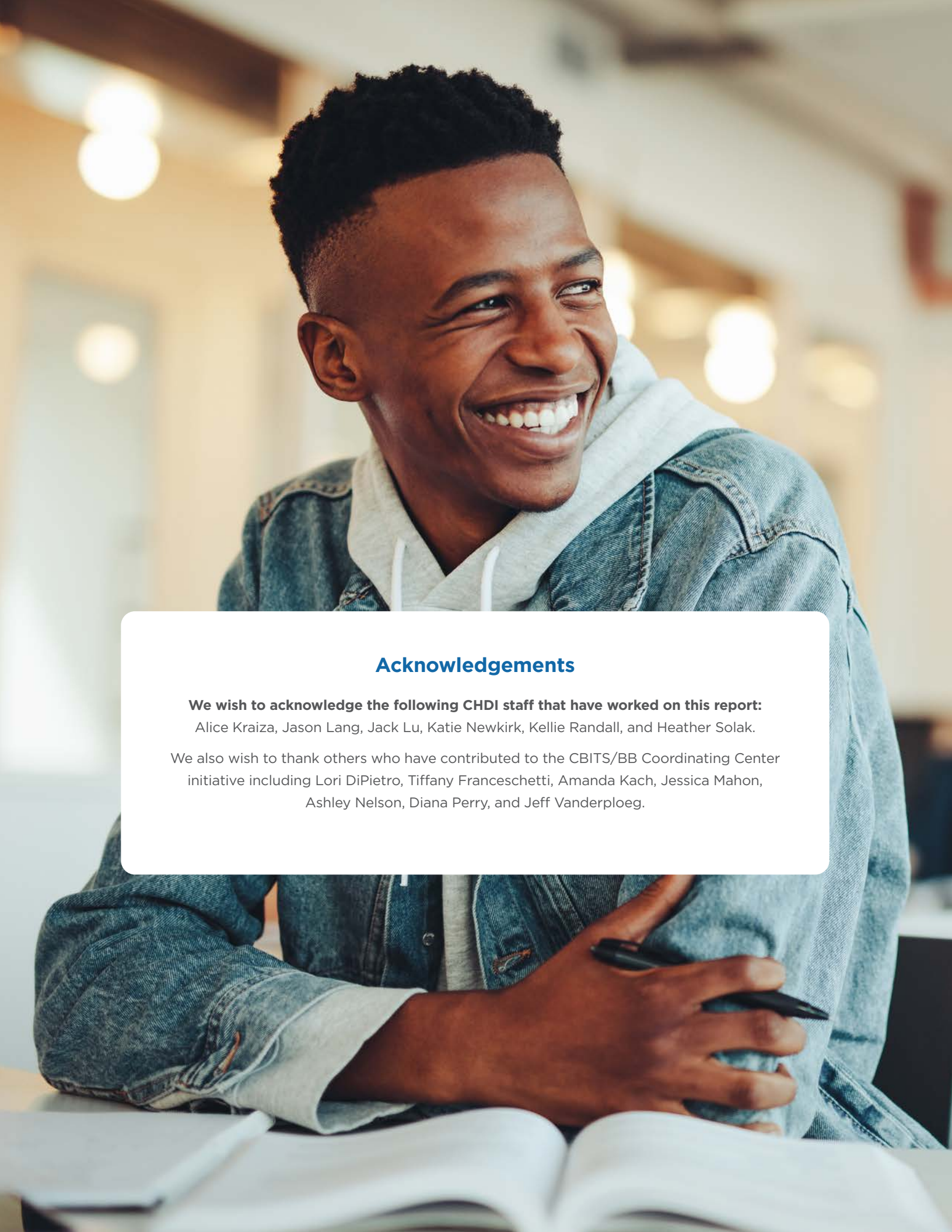
Variable	*N*	*β*	*SE*	*Wald*	*eB(95%CI)*
Hispanic	219	-0.651*	0.272	5.722	0.522 (0.306, 0.889)
Other Non-Hispanic	18	1.164	1.056	1.216	3.203 (0.405, 25.353)
Black Non-Hispanic	101	-0.239	0.335	0.510	0.787 (0.408, 1.518)
Sex (Male)	169	0.356	0.243	2.151	1.428 (0.887, 1.030)
Child Age	479	-0.069	0.050	1.881	0.934 (0.847, 1.030)
Trauma Exposure-TEC Child	479	-0.030	0.033	0.836	0.970 (0.909, 1.035)
Constant		2.605	0.736	12.512	13.532

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

Table B8. Logistic regression analyses for predicting successful discharge from selected background characteristics (BB)

Variable	*N*	*β*	*SE*	*Wald*	*eB(95%CI)*
Hispanic	160	0.442	0.336	1.724	1.555 (0.804, 3.007)
Other Non-Hispanic	14	-0.544	0.623	0.761	0.581 (0.171, 1.969)
Black Non-Hispanic	58	-0.502	0.386	1.693	0.605 (0.284, 1.289)
Sex (Male)	158	-0.010	0.283	0.001	0.990 (0.569, 1.724)
Child Age	326	0.121	0.073	2.768	1.129 (0.979, 1.303)
Trauma Exposure-TEC Child	326	-0.013	0.051	0.068	0.987 (0.893, 1.091)
Constant		0.293	0.726	0.162	1.340

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



Acknowledgements

We wish to acknowledge the following CHDI staff that have worked on this report:
Alice Kraiza, Jason Lang, Jack Lu, Katie Newkirk, Kellie Randall, and Heather Solak.

We also wish to thank others who have contributed to the CBITS/BB Coordinating Center initiative including Lori DiPietro, Tiffany Franceschetti, Amanda Kach, Jessica Mahon, Ashley Nelson, Diana Perry, and Jeff Vanderploeg.

Child Health and Development Institute

CBITS/BB FY 2022 Annual Report

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