Trauma-Focused Cognitive Behavioral Therapy

CONNECTICUT'S EVIDENCE-BASED
TREATMENT COORDINATING CENTER

CHDI® Child Health and Development Institute

DCF CONNECTICUT

FY 2023 ANNUAL REPORT

The authors retain full responsibility for all opinions and content.

CONTENTS

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 posttraumatic 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 2023 (July 1, 2022 through June 30, 2023). This year, the ongoing COVID-19 pandemic led to persistent stress on individuals and systems resulting in workforce turnover and hiring difficulties and acute client needs. Despite these challenges, TF-CBT services continued to produce positive results in quality and outcomes for Connecticut children and families.

KEY FINDINGS FY23:

874 children received TF-CBT

Youth engagement in the frequency of sessions per month **(~2.5 sessions)** has improved since FY20 and approached near pre-pandemic rates **(~2.7 sessions)**

65 clinical staff were newly trained and **21 staff** became credentialed in TF-CBT

Providers surpassed all **five quality** improvement benchmarks

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

91.7% Caregivers | **92.3%** Children
reported **high satisfaction with treatment**

Children reported remission in post-traumatic stress symptoms **(67.5%)** and depressive symptoms **(60%)**

KEY RECOMMENDATIONS:

- **Add TF-CBT penetration rates by race/ethnicity to quarterly provider outpatient reports. Use penetration rate data in site-based consultation to develop SMARTIE (Specific, Measurable, Attainable, Relevant, Time-bound, Inclusive, and Equitable) goals with agencies to increase equity in TF-CBT access for children.**

- **Expand the Coordinating Center's implementation of trauma-informed evidence-based services that complement TF-CBT, such as Attachment, Regulation and Competency (ARC) and Trauma Screening, Brief Intervention, and Referral to Treatment (T-SBIRT). This will provide a more flexible and comprehensive strategy for trauma-informed outpatient services that engage caregivers and children who are younger, male, and/or a person of color.**

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 FY23 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 FY23 report is framed across access, quality, outcome, and equity goals. Summary, conclusions, and recommendations are shared to guide future work.
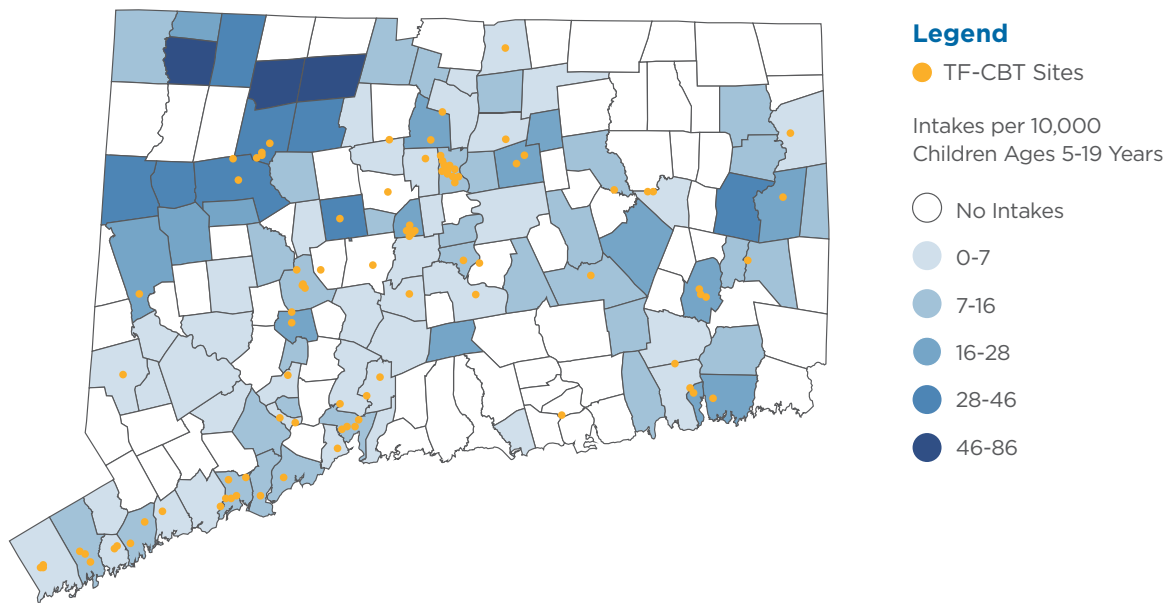
III. ACCESS TO TF-CBT IN CONNECTICUT

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 FY2023. 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 63% of clinicians (n=229) provided TF-CBT to at least one youth during the year with team sizes ranging from 1 to 31 clinicians. A searchable list of TF-CBT providers working with the Coordinating Center can be found in Connecticut's Evidence-Based Practices Directory (https://ebp.dcf.ct.gov/ebpsearch/).

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

Legend

- TF-CBT Sites

Intakes per 10,000 Children Ages 5-19 Years

- ○ No Intakes
- 0-7
- 7-16
- 16-28
- 28-46
- 46-86

Clinician Training and Credentialing

During the course of the year, 99 (27.4%) of the 361 TF-CBT clinicians left their teams. In an effort to address attrition, 65 clinicians were trained in TF-CBT. To support access to high-quality treatment, 32 clinicians attended advanced clinical training, 65 attended one-day booster sessions, and 66 attended clinical consultation calls. During the year, 146 clinicians that achieved the Connecticut TF-CBT credential provided treatment in the model.

Table 1. Trends in TF-CBT Provider Network

	FY 2020	FY 2021	FY 2022	FY 2023	Cumulative Since 2007
TF-CBT Providers/Agencies	48	51	48	48	71
Newly Trained TF-CBT Clinicians	54	61	63	65	1064**
TF-CBT Clinicians Leaving	84	63	68	99	–
Clinicians Providing TF-CBT	253	320	343	361	1071*
# Newly Credentialed/Certified	19	15	24	21	404

*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.

Children Receiving TF-CBT

Since 2007, 12,036 children have received TF-CBT in Connecticut. The number of children receiving TF-CBT during FY23 was 874, which included 543 children who started treatment in the year. Children reported an average of 7.3 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

FY19	FY20	FY21	FY22	FY23
1536	1155	1034	874	874
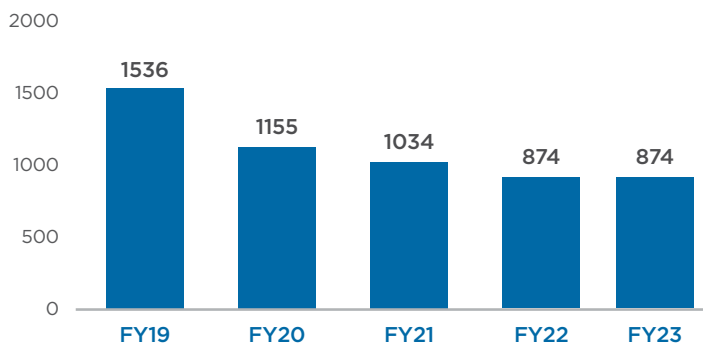
Child Demographics

Table 2 provides child characteristics in TF-CBT services during FY23 with comparisons to those served in outpatient services [as reported in DCF's Provider Information Exchange (PIE) system] and the general CT population. As shown throughout this report, indicators of access, quality, and outcomes are reported across demographic groups. Service delivery and outcomes are influenced by the social and community context. 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. ***TF-CBT (43.6%) and general outpatient care (33.1%) both served higher rates of Hispanic, Latino or Spanish (any race) children compared to the overall CT population (26.5%). Furthermore, TF-CBT (12.2%) served similar rates of black youth compared to the overall CT population (11.7%), but less than general outpatient care (15.2%).*** Similar to FY22, TF-CBT (3.2%) served fewer Spanish-speaking youth compared to general outpatient care (9.9%) and the overall CT population (13.8%). 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 (9.6%) it was even smaller for those receiving TF-CBT (1.7%).*** 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 (24.7%) was more than double that of those in general outpatient services (10.4%).***

Table 2. Characteristics of Children Receiving TF-CBT (n=874) with Comparisons[2]				
	TF-CBT		OPCC	CT Child Pop
	n	%	%	%
Male	**274**	**31.4**	**49.0**	**51.2**
Race				
American Indian or Alaska Native	*	*	0.4	0.4
Asian	*	*	1.1	4.9
Black or African American	107	12.2	15.2	11.7
Native Hawaiian or Pacific Islander	*	*	0.2	0.0
White	466	53.3	49.2	53.5
Other Race/Ethnicity (Includes Multiracial/Ethnic)	38	4.3	14.7	29.4
Did not Disclose/Missing	257	29.4	19.2	–
Hispanic, Latino, or Spanish (Any Race)	**381**	**43.6**	**33.1**	**26.5**
Age (Years)				
Under 6 Years	15	1.7	9.6	29.8
6–11 Years	301	34.4	43.1	33.2
12–17 Years	543	62.1	47.3	37
Child Welfare Involvement During Treatment	**216**	**24.7**	**10.4**	**2.9[2]**
JJ Involvement During Treatment	**16**	**1.8**	**.6**	**N/A**
Child Primary Language[2]				
Spanish	28	3.2	9.9	13.8
Neither Spanish nor English	*	*	1.7	7.8
Caregiver Speaks English (No)	**100**	**11.4**	**N/A**	**N/A**

ACCESS AND EQUITY:

874 children received TF-CBT, serving the same amount of youth from FY22

Youth receiving TF-CBT had **higher rates** of child welfare involvement compared to youth in general outpatient services.

TF-CBT **(43.6%)** and general outpatient care **(33.1%)** both served higher rates of Hispanic, Latino or Spanish (any race) children compared to the overall CT population **(26.5%)**.

2. 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 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 "Latino" to remain consistent with the way it is reported in the data system, which reflects the terminology in the U.S. Census. Used Primary Language Inside of Home for children ages 5-17 for child primary language

IV. QUALITY: CONSULTATION AND CLINICAL IMPLEMENTATION

Implementation Consultation

Model Implementation

TF-CBT was completed by children on average in 21.6[3] (SD=17.3) sessions with an episode length of 9.3 (SD=6.8) months, which exceeds the expectations of model completion (between 12 to 16 sessions). In FY23, over two-thirds of sessions (69.8%) were completed with the child only, 17.2% were with caregiver and child together, and 13.0% were with caregiver only. This amount of caregiver involvement during sessions (30.2%) fell just short of the statewide benchmark (33%). Nearly all children who received TF-CBT had a measure of baseline symptoms (95.9%). Of children discharged, 70.7% had at least one first and last version of a child symptom assessment (child or caregiver reporter) and 9.1% had data on caregiver symptoms.

Quality Improvement (QI) Indicators

CHDI reports on TF-CBT QI indicators that guide overarching implementation consultation goals. All QI indicators surpassed benchmarks in the FY23 performance periods. ***There were significant differences among youth who met the Engagement indicator with Black Non-Hispanic (71.1%) youth less likely to meet engagement compared to their Hispanic (91.5%) and White Non-Hispanic counterparts (93.8%).*** Appendix D has additional information about the definitions of the QI indicators.

Figure 3. QI Indicators in FY23
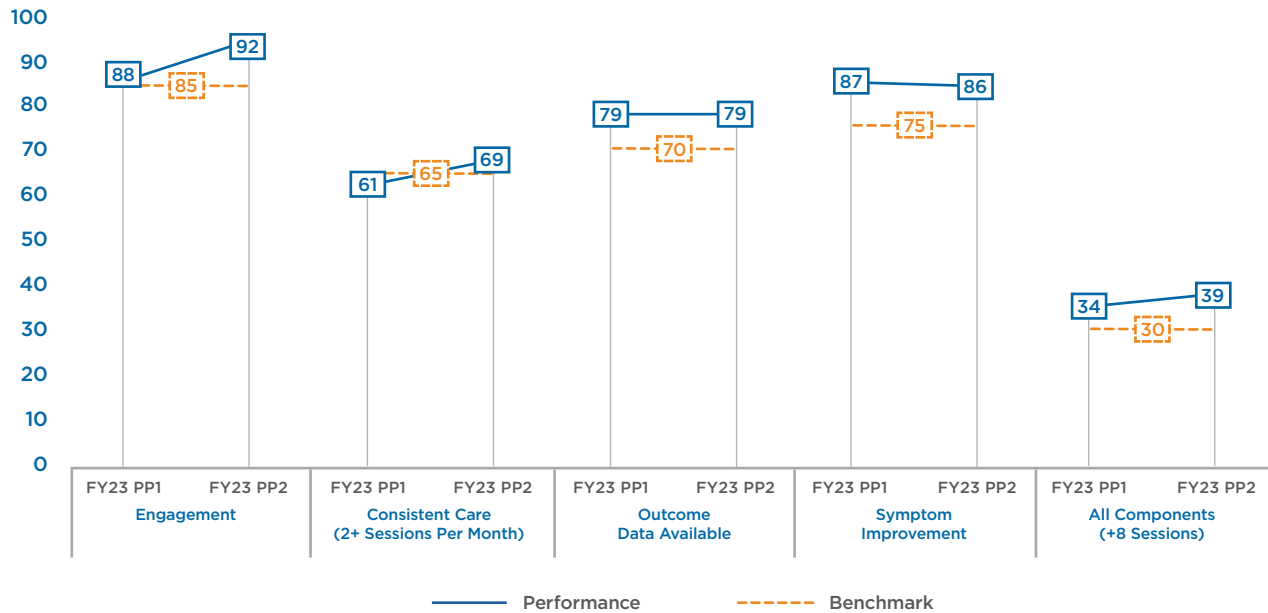
Satisfaction

Caregiver reports (n=229) continue to demonstrate consistency in satisfaction with 91.7% moderately to extremely satisfied with TF-CBT treatment. Of the child satisfaction reports (n=234), approximately 92.3% were moderately to extremely satisfied with treatment. ***There were no differences in satisfaction by race/ethnicity or sex.***

QUALITY AND EQUITY:

Rates of satisfaction with TF-CBT treatment were **similarly high**, regardless of race/ethnicity or sex.

Black Non-Hispanic youth had **lower rates** of meeting engagement criteria compared to White Non-Hispanic and Hispanic youth.
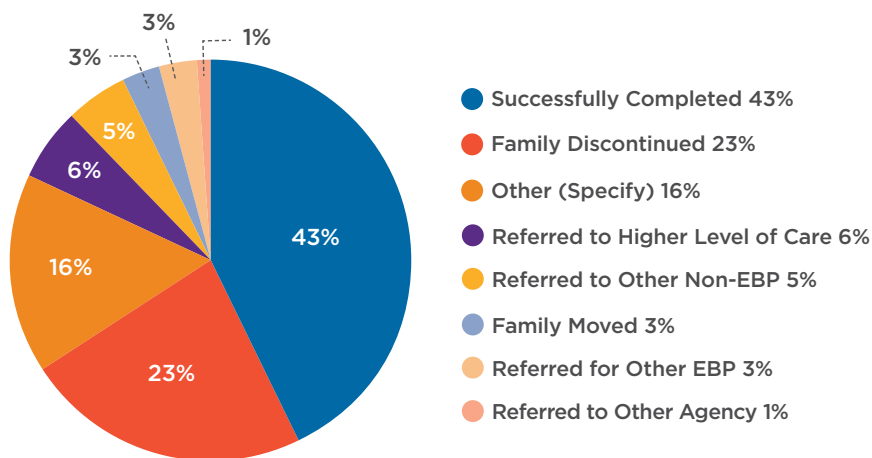
3. The mean was computed after winsorizing outliers in the data.

Successful Completion

In FY23, 488 children ended their TF-CBT treatment episode with nearly half of children (43%) ending treatment as "completing all EBT requirements," see Figure 4. While family discontinuation accounted for nearly one-quarter of children who did not complete TF-CBT, 11% of children received either a higher level of care or other non-evidence-based practice (EBP) service, a decrease from last year. *Rates of successful discharge were equivalent across sex, age, race/ethnicity, and trauma exposure* (see Appendix B Table B1).

Figure 4. Reasons for Discharge in FY23

- ● Successfully Completed 43%
- ● Family Discontinued 23%
- ● Other (Specify) 16%
- ● Referred to Higher Level of Care 6%
- ● Referred to Other Non-EBP 5%
- ● Family Moved 3%
- ● Referred for Other EBP 3%
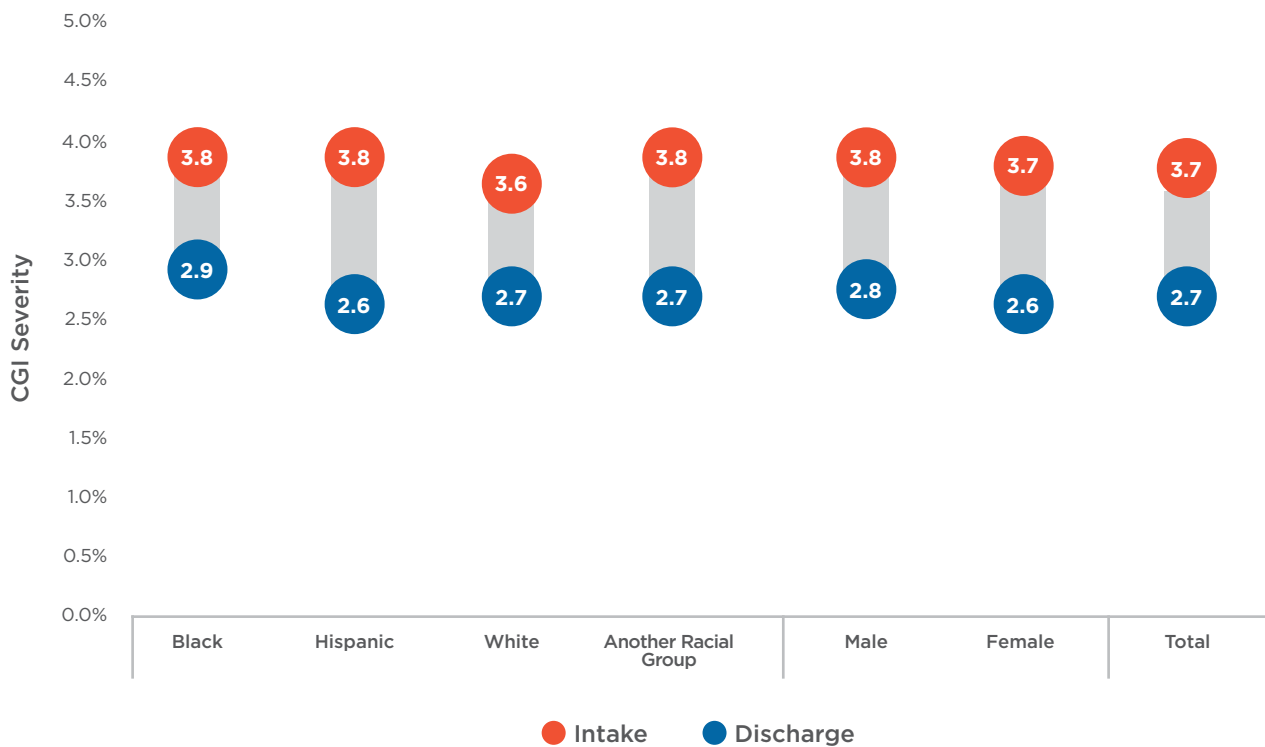- ● Referred to Other Agency 1%

Clinical Global Impressions (CGI) Scale

As a measure of clinical severity and improvement, the CGI Severity (CGI-S) and Improvement (CGI-I) scales were more frequently used in FY23. On the CGI-S, 66.1% of clients changed from a more severe to a less severe category during the course of treatment. Though all sub-groups had similar baseline severity scores, ***Hispanic youth experienced the greatest difference in severity from intake to discharge*** (Figure 5). Clinicians reported symptom improvement for the majority of youth (83.9%) with the CGI-I.

Figure 5. CGI Severity at Intake and Discharge by Subgroup

|	Black	Hispanic	White	Another Racial Group	Male	Female	Total
Intake	3.8	3.8	3.6	3.8	3.8	3.7	3.7
Discharge	2.9	2.6	2.7	2.7	2.8	2.6	2.7

● Intake   ● Discharge

Symptom Improvement

Across all measures, *86.8% 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 posttraumatic stress symptoms, the most used measures, 66.4% of all youth showed reliable improvement on child reports, and 64.8% of youth showed reliable change on caregiver reports. Figure 6 shows the rates of improvement in CPSS scores by subgroup.

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

Legend: ● CPSS5 Child ● CPSS5 CG
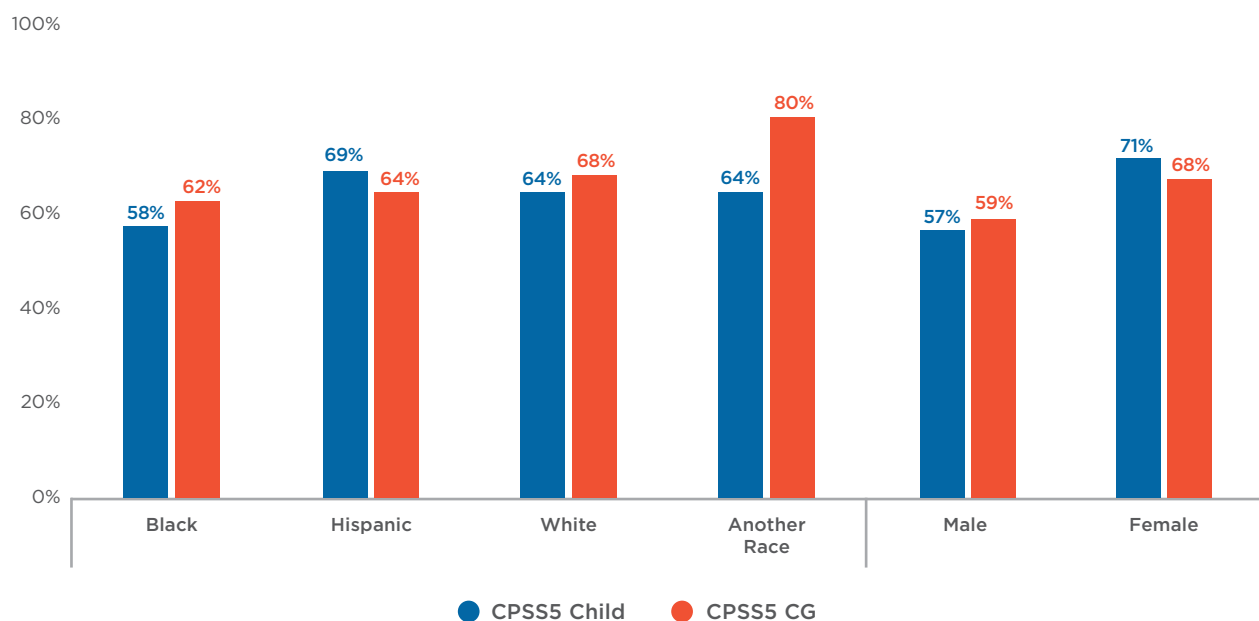
Overall Clinical Improvements Across Groups

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. Older children reported greater improvement in posttraumatic symptoms. *Youth showed equivalent posttraumatic stress symptom improvement and improvement rates of RCI in any measure regardless of race, ethnicity, and sex* (Appendix B, Table B4).

OUTCOMES AND EQUITY:

Rates of successful discharge were equivalent across sex, age, race/ethnicity, and trauma exposure.

Hispanic youth experienced the greatest improvement in CGI severity from intake to discharge compared to other youth.

Youth showed equivalent improvement rates for posttraumatic stress symptoms regardless of race, ethnicity, and sex.

VI. SUMMARY AND CONCLUSIONS

During FY23, the number of clinicians trained in TF-CBT continued to increase, with the highest number of clinicians trained since FY16. Although there were a significant number of clinicians trained, providers faced a high attrition rate with 27.4% of clinicians leaving their positions in TF-CBT during the past year. While providers were challenged by this staff turnover, the number of youth served compared to FY22 stayed the same. 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.

Children receiving TF-CBT were on average 12.5 years old, with only 1.6% being younger than six years of age. Child engagement as measured by the average sessions per month rate (~2.5 sessions/month) continues to improve and is approaching pre-2020 rates (~2.7 sessions/month). Caregiver participation decreased and fell short of the 33% benchmark. All other quality improvement indicators (engagement, consistent care, collection of measures, improved outcomes, model completion) surpassed benchmarks in FY23. With the exception of meeting the engagement QI indicator, where Black youth were statistically significantly less likely to meet engagement than their Hispanic and White counterparts, youth receiving TF-CBT experienced comparable rates of access, quality care, and improved outcomes. When compared to outpatient services for children, children younger than six, males, Black youth, and youth from other races and ethnicities received TF-CBT at lower rates, while children from Hispanic, Latino, or Spanish backgrounds had proportionally greater access to TF-CBT services.

While the work force experienced staffing challenges this did not impact the quality of care provided to youth and families. Children receiving TF-CBT treatment demonstrated positive outcomes as evidenced by the significant improvement in post-traumatic stress symptoms and problem severity. Approximately, 86.8% of children revealed significant improvement in one or more symptoms. The CGI-I indicated improvement (83.9%), which represents an increase from last year. In site-based consultation, the CGI-I has been incorporated within the consultation framework and should continue to be explored as a standard measure of overall improvement in TF-CBT.

To expand on the success of TF-CBT, the addition of other trauma-informed evidence-based practices within this initiative will increase caregiver and youth with trauma exposure engagement and access to treatment. Two such EBPs include the Attachment, Regulation and Competency (ARC) and Trauma Screening, Brief Intervention, and Referral to Treatment (T-SBIRT) models. In a shorter and more flexible treatment duration, ARC has demonstrated success with children (as young as three) and has shown reductions in not only child trauma symptoms, but also caregiver trauma and depressive symptoms as well. T-SBIRT increases youth and caregiver engagement through motivational interviewing and improved linkages to trauma-informed services, which may be particularly meaningful for Black or male youth.

Recommendations

The following recommendations will strengthen access, quality, and outcomes youth served within the TF-CBT statewide network

- Add TF-CBT penetration rates by race/ ethnicity to quarterly provider outpatient reports. Use penetration rate data in site-based consultation to develop SMARTIE (Specific, Measurable, Attainable, Relevant, Time-bound, Inclusive, and Equitable) goals with agencies to increase equity in TF-CBT access for children.

- Provide ongoing support to bilingual Spanish/English clinicians implementing TF-CBT, including resources to enhance effective engagement, maintain peer support, grow the network, and strengthen service delivery with Latinx youth.

- Establish strategies within consultation to identify potential barriers and improve TF-CBT caregiver involvement.

- Expand the Coordinating Center's implementation of trauma-informed evidence-based services that complement TF-CBT, such as Attachment, Regulation and Competency (ARC) and Trauma Screening, Brief Intervention, and Referral to Treatment (T-SBIRT). This will provide a more flexible and comprehensive strategy for trauma-informed outpatient services that engage caregivers and children who are younger, male, and/or a person of color.

- Establish strategies with agency leadership to strengthen organizational capacity and bolster internal TF-CBT team support to increase the number of youth being served and ensure those trained are familiarized with the use of the PIE database, supported in the use of assessments, staff coaching on data collection, and overall TF-CBT implementation.

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

- Establish and monitor team- based goals in site-based consultation to increase the number of clinicians serving youth to improve TF-CBT access for children and families.

- Increase child welfare, CSSD, and LYNC provider attendance at the EBP conference to highlight the availability of TF-CBT and other trauma-informed EBPs.

- Continue discussion of CGI Severity and Improvement scales within the consultation framework to continue to measure outcomes; explore using CGI as a systems-level metric to help understand treatment and outcomes not only in TF-CBT but across levels of care

- Explore culturally responsive approaches to engaging youth and families in TF-CBT, particularly youth of color with low engagement rates and identify strategies to ensure equitable access and care

- Develop strategies to identify and overcome barriers to recruitment and retention, along with access to resources for improving workforce development for clinicians and agencies delivering EBTS

- Reduce data burdens (e.g. data collection on monthly session forms) in the PIE database for TF-CBT providers to improve clinical workflow and ensure all youth that receive TF-CBT services are documented accurately and on time.

- Enhance outreach efforts to disseminate information regarding trauma-informed EBPs (e.g. TF-CBT) to increase access and expand the TF-CBT provider network across Connecticut.

Conclusion

The successful completion rate among youth receiving TF-CBT remained steady at 43%, despite longer lengths of stay. Although clinician attrition rates increased greatly from FY22 to FY23, the number of youth served remained the same with quality of care remaining high. Children who received TF-CBT experienced positive outcomes and overall satisfaction with treatment regardless of race, ethnicity, and sex. Progress in providing services equitably increased, and more efforts should focus on expanding access and engagement for youth with trauma exposure who are young (aged 6 or lower), speak Spanish, self-identify as Black, or self-identify as male. To further enhance the success of this statewide initiative, the inclusion of other trauma-informed EBPs will expand a wider array of services for youth and families in Connecticut.

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, and Credentialing

- Provided three (3) TF-CBT New Clinician trainings in August 2022, October 2022, and March 2023, with a total of 66 participants.
- Conducted three (3) TF-CBT Clinical Booster trainings in September 2022, November 2022, and June 2023, with a total of 65 participants.
- Completed three (3) series of clinical consultation calls, with 72 total calls and 66 participants.
- Held the Advanced Clinical Training: TF-CBT for 32 participants.
- Maintained a training record database to track training and consultation attendance of all TF-CBT providers.
- Convened the 15th annual EBP Conference virtually of 34 workshops with 26.5% meeting the cultural competency CE requirement. A total of 356 unique participants from community providers, DCF, CSSD and other partners attended the conference.

2. Implementation Support, Quality Improvement, and Technical Assistance

- Produced reports for two QI performance periods based on developed TF-CBT QI Indicators and Benchmarks (Appendix D).
- Provided 149 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 $380,690 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	144	-.289	0.246	1.379	.749(.463, 1.213)
Other Non-Hispanic	19	-0.516	0.51	1.024	.597(.220, 1.622)
Black Non-Hispanic	27	-.644	0.448	2.06	.525 (.218, 1.265)
Sex (Male)	104	-.017	0.255	0.004	.983 (.597, 1.619)
Child Age	321	-.021	0.04	0.269	.979 (.906, 1.059)
Trauma Exposure-THS Child	321	-0.004	0.041	0.01	.996 (.919, 1.079)
Trauma Exposure-THS Caregiver	321	-0.035	0.045	0.626	.965 (.884, 1.054)
Constant		0.461	0.560	0.678	1.586

*p<.05   As compared to White Youth
**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=31)	Caregiver Depression	9 29.0%	15.13 (13.79)	9.28 (8.46)	-4.68*	-2.83	Medium	-
							0.51	-
CPSS V Child (n=274)	Trauma Symptoms	169 62.70%	35.76 (15.49)	20.37 (15.15)	-15.25**	-16.47	Large	114/169
							0.99	67.5%
CPSS V Caregiver (n=210)		99 47.1%	29.84 (14.90)	16.11 (12.55)	-13.50**	-12.44	Large	73
							0.86	73.7%
SMFQ Child (n=76)	Depressive Symptoms	55 72.4%	11.91 (6.06)	6.99 (5.89)	-4.97**	-6.26	Medium	33
							0.72	60.0%
SMFQ Caregiver (n=60)		34 56.70%	10.12 (6.21)	7.05 (5.62)	-2.58*	-2.95	Small	15/34
							0.38	44.1%
Ohio Problem Severity Child (n=200)	Severity of Internalizing/ Externalizing Behaviors	100 50.0%	25.00 (13.52)	17.62 (13.42)	-7.09**	-8.02	Medium	60/100
							0.57	60.0%
Ohio Problem Severity Caregiver (n=251)		115 57.5%	23.81 (13.59)	15.82 (12.57)	-7.90**	-9.21	Medium	73/115
							0.58	63.5%
Ohio Functioning Child (n=207)	Child's Adjustment and Functioning	49 23.7%	53.45 (12.36)	59.34 (12.90)	5.74**	7.72	Medium	31/49
							0.54	63.3%
Ohio Functioning Caregiver (n=268)		83 31.0%	52.15 (14.11)	58.40 (13.62)	6.01**	8.26	Medium	51/83
							0.5	61.4%

**p < .001, * p < .01

Effect sizes were derived using Cohen's d as follows: .2 = small, .5 = medium, .8 = large

Some CESD-R statistics suppressed due to low n

Outliers were found and corrected for the following first scores: CESD-R, 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 (child and 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	-5.177	4.61	(-14.262,3.907)	**-12.458***	5.902	(-24.108, -0.807)
Trauma Exposure	0.131	0.305	(-0.47,0.732)	-0.09	0.412	(-0.904, 0.724)
Hispanic	-1.051	2.133	(-5.254,3.152)	1.108	2.597	(-4.019, 6.234)
Other Non-Hispanic	3.755	4.668	(-5.445,12.955)	1.326	5.686	(-9.898, 12.55)
Black Non-Hispanic	2.99	3.595	(-4.094,10.073)	1.921	4.359	(-6.683, 10.526)
Sex (Male)	1.631	2.193	(-2.69,5.952)	3.243	2.662	(-2.013, 8.499)
Child Age	**-0.662***	0.319	(-1.291,-0.034)	-0.004	0.363	(-0.721, 0.714)
Child Discharged as "Successful"	**-7.439*****	1.99	(-11.361,-3.516)	**-5.211***	2.417	(-9.983, -0.44)
R²	0.094			0.04		
F	3.311**			1.011		

*p<.05   As compared to White Females
**p<.01   Outliers were found and corrected for caregiver-reported trauma exposure and child and caregiver-reported CPSS5 change scores
***p<.001

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

Predictors	N	β	SE	Wald	eᴮ(95% CI)
Hispanic	144	0.176	0.282	0.391	1.193 (0.686, 2.073)
Other Non-Hispanic	19	-0.674	0.557	1.466	0.51 (0.171, 1.517)
Black Non-Hispanic	27	-0.027	0.478	0.003	0.974 (0.381, 2.487)
Sex (Male)	104	0.256	0.29	0.78	1.292 (0.732, 2.279)
Child Age	321	-0.016	0.046	0.118	0.984 (0.9, 1.077)
Trauma Exposure - THS Child	321	0.066	0.047	2.01	1.069 (0.975, 1.172)
Trauma Exposure - THS Caregiver	321	-0.033	0.05	0.435	0.968 (0.877, 1.067)
Child Discharged as "Unsuccessful"	180	**-1.985***	0.289	47.256	0.137 (0.078, 0.242)
Constant		**1.631***	0.664	6.032	5.109

*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.
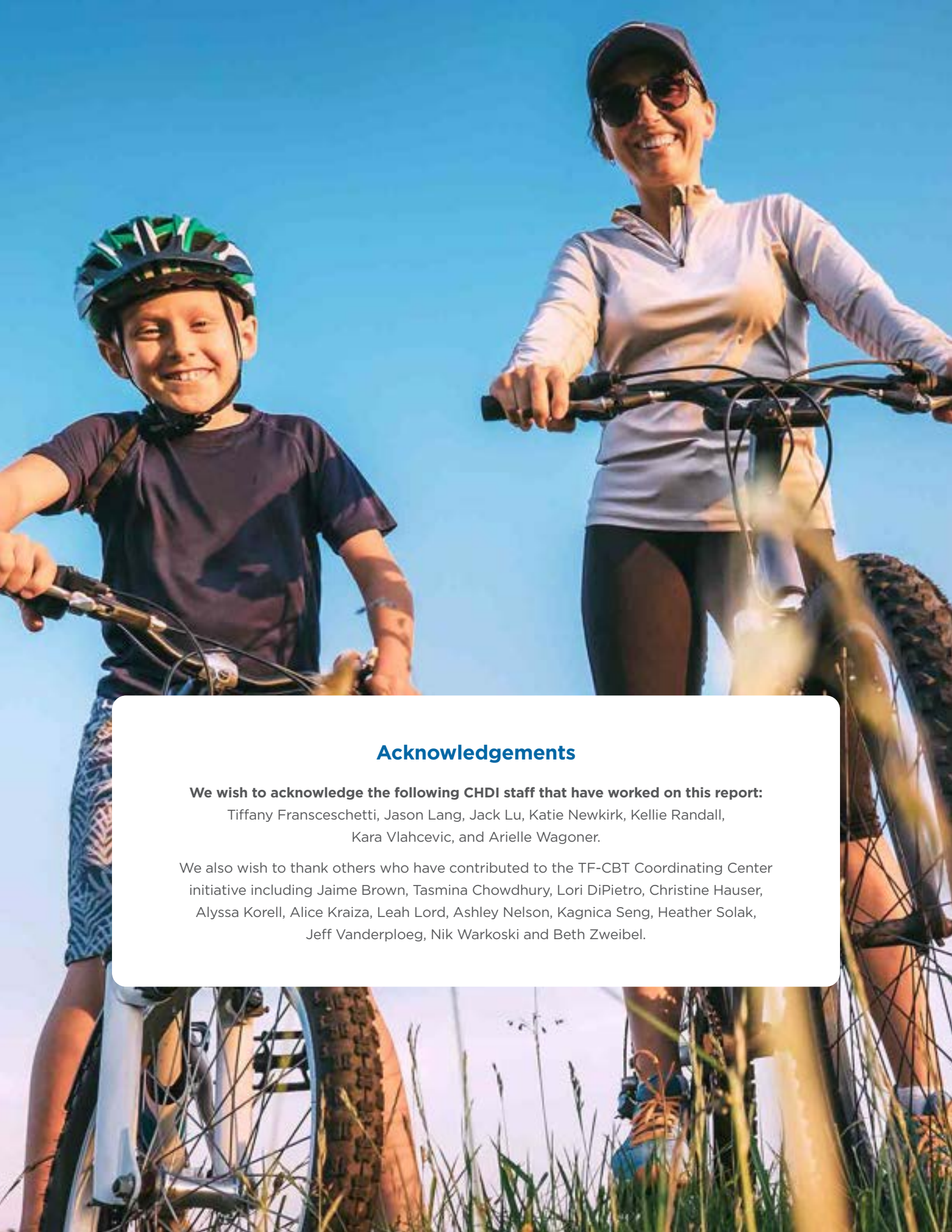
A review of available literature was conducted for the assessments included in this manual, which are used in EBP Tracker. If articles did not include an explicit RCI value, one was calculated using the equation proposed by Jacobson and Traux (1991) with the appropriate values indicated in the research. 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, 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

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 and 8 or more sessions |

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