2023 Annual Progress Report

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Site: University of Missouri-St. Louis
Principal Investigator: Joel Epstein
Project Title: Project CONTACT
(Community Operations Network for Treatment After Childhood Trauma)

Introduction

This report provides an overview of the progress made during the second year of Project CONTACT. It lists the project's three primary goals as articulated in the original application and under each goal provides:

a) Description of any changes from the original application
b) Relevant data
c) Key accomplishments
d) Difficulties and problems encountered along with planned actions to overcome these barriers
e) Analysis of Goal Achievement

Goal 1: Establish an active network of community partners to serve as novel referral hubs for children and families who have recently experienced trauma

Goal 1 Objectives:

- By the end of the project's second month, 100% of our community partners will identify a specific staff member to serve on Project CONTACT's Referral Network Team (RNT)
- At least 50% of project partners will attend the RNT biweekly meetings
- Using principles of Community-Informed Participatory Research, by the project's third quarter, the RNT's members will create a tool to monitor their efficacy and productivity
- On quarterly assessments, starting in Year 2, at least 80% of RNT participants will rate their efficacy and productivity on the aforementioned tool as "very good" or higher

Changes from Original Application

Early in the project, we received permission from our GPO to modify our goals around community partners. Initial efforts to form a Referral Network Team were unfruitful and partnering agencies expressed reluctance to commit significant time to the project. They were, however, generally enthusiastic about our program and indicated a willingness to provide referrals. Consequently, our efforts switched from attempting to coordinate meetings with all our partners to a strategy of more individualized outreach.

Relevant Data

Our revised strategy of engaging community partners has allowed us to dramatically expand our list of agencies who have agreed to serve as referring partners. At the end of last year, we had 12, and this year we have 44. Please see Table 1 for a list of these organizations. In addition to individual phone calls and emails, we have also conducted formal meetings and trainings with our community partners. Please see Table 2 for list of these activities. In total our outreach efforts allowed us to make over 1,200 individual contacts during this grant year.

Key Accomplishments

In addition to conducting the aforementioned phone calls and meetings, we implemented two additional activities this year that were designed to increase community partner engagement with our project.

First, we finalized our website and installed analytics software on the server to allow us to identify how the site was being used. We have found that having the site is not only helping spread the word about our program, but it is facilitating referrals as well. Anecdotally, we have had several individuals (both within our agency and outside as well) mention that they have accessed our website. Additionally, via the contact form on the site, we have had several individuals and community partners reach out to us to get families referred to treatment. Finally, to be conservative in measuring the impact of our site, we are only tracking new users. So far, we have had over 550 unique individuals use our site.

The second significant innovation designed to increase community partner engagement that we adopted this year was the distribution of monthly newsletters. We adopted a formal structure for these communications that included:

a) An introductory note
b) A message about our therapeutic intervention
c) Notable numbers about our project
d) Updates on trainings our agency is providing
e) A brief feedback survey
f) A community partner spotlight

We currently have almost 100 individuals subscribed to our mailing list and every month we have between 30-50 of those actually open our newsletter.

Difficulties, Problems, and Planned Actions to Overcome Barriers

Almost without fail, whenever we present our program to community partners, they respond enthusiastically, pledging to provide us with countless referrals. And while it is heartening to know that we are offering a much-needed service, it is also rather disappointing that this initial excitement is rarely followed with sizeable numbers of referrals. What we have found, however, is that during the week or so following a meeting with a community partner, we typically receive a referral or two. Consequently, we will continue to schedule follow-up meetings with our community partners to keep our project top-of-mind.

Two of our community partners, Legal Services of Eastern Missouri and the Washington University Trauma Response Program (WU-TRP), have taken advantage of our offer to set up their staff as users in our Patient Portal. We keep their accounts stocked with referral forms and this allows them to make referrals at their convenience. The WU-TRP relationship is of particular note because they have a relationship with St. Louis Children's Hospital to receive all referrals for children who have experienced trauma. However, WU-TRP only has a single clinician who has been trained in the Child and Family Traumatic Stress Intervention (CFTSI; the modality we employ for Project CONTACT). Consequently, they have agreed to send all their overflow to us. And while this is definitely a positive development for our project, in practice we have seen that they are also sending us referrals that are not appropriate for our particular project. Because we

want to maintain a positive relationship with our partners, we do our best to accommodate these families with other services within our agency. Nevertheless, it does take time and resources to handle these referrals. We attempt to gently remind the WU-TRP staff about what makes for a successful referral to our program.

Last year, our consultants encouraged us to adopt a Customer Relationship Management (CRM) software to help us track the interactions we have with our community partners. Consequently, we adopted the CIVIcrm platform. The advantage of using this platform was that it was free and compatible with our existing website. Although the program has been somewhat helpful in tracking our activities, it does have some limitations. Notably, it is not fully compatible with our university's web server. Consequently, we are not able to send and track emails from the system. Therefore, we have adopted a separate service (MailChimp) to handle communications with our community partners. But this requires effort to synchronize the two systems and the result is that we know we are not capturing all of the interaction data as efficiently as we could. Our agency has been auditioning alternative systems for use on our other grant-funded programs. During the coming year, we hope to explore whether switching CRM systems will help us more readily track activities with our community partners.

Analysis of Goal Achievement

Because we have changed the way we are interacting with our community partners, we cannot directly assess how well we achieved our goals as they were stated in our original application. However, the underlying intent was, and continues to be, to engage key community stakeholders and encourage them to make referrals to our project. We have considerably increased the numbers of agencies in the St. Louis Metropolitan area who we consider community partners and we have made efforts to implement practices that keep these groups engaged.

Goal 2: Increase the number of children in the St. Louis metropolitan area who have access to and engage in treatment after experiencing trauma

Goal 2 Objectives:

- By the end of year one, our eight project partners will refer a total of 80 families for treatment and the CASGSL forensic unit will refer an additional 60
- 75% of referred clients will engage in at least two sessions of treatment
- Project partners will increase their referrals by 10% during project years two through five
- Compared to CASGSL's baseline and then each subsequent year thereafter, we will have 10% more families engaging in treatment
- Compared to CASGSL's baseline and then each subsequent year thereafter, we will have 10% more families graduating from treatment
- Throughout the duration of the project, the percentage of graduations and drop-outs will be equivalent across gender, race, and family SES

<u>Changes from Original Application</u>

We have made no substantive changes to our operations as compared to what we had articulated in our original application. Our internal Forensic Team provided the vast majority of referrals, though that was anticipated given the changes we articulated in the previous section. We

anticipate receiving additional referrals from our community partners in the upcoming quarters. It is important to note, however, that some of our community partners – such as the St. Louis Metropolitan Police Department – refer families to us through our Forensic Team.

Relevant Data & Key Accomplishments

This second year of the project let us build off the strengths established during the first year. Notably, we have established a cohesive team that consists of individuals from multiple departments in our agency. We all share a common vision for helping referred families and work together to help provide services. Our processes and procedures are firmly in place and although everyone understands their role on the project, we all are willing to help each other when difficulties arise.

Key Outcomes: Treatment Flow

Despite our agency's overall long-term wait list being at approximately five months, we are pleased that the processes and procedures we have in place for Project CONTACT are allowing families to enter treatment much more quickly. In fact, at the end of our second year, we are averaging just under ten days between initial referral and a family's first meeting with one of our Family Engagement Specialists (FES), and then just less than two weeks until the first meeting with their clinician. Because CFTSI is a brief therapeutic model, families are averaging around six weeks from between their first and last clinical appointment. These data are summarized in the table below. It is important to note that delays are largely due to families' availability, and not staffing issues on our end.

Average Days from Assignment to FES meeting:	9.76
Average Days from FES to 1st clinical appointment:	13.11
Average Days from 1st to last appointment:	43.20
Average Days from Last Appointment to 2nd FES:	19.44

Key Outcomes: Referrals

Throughout the duration of the first two years of this project, we have received a total of 246 referrals. ***Table 3*** provides a detailed view of the source and disposition of those referrals. There are a few notable take-aways.

- A majority of our referrals come from our internal Forensic Team (82%)
- Most of the referrals from the forensic team (69.8%) made it to their initial FES session. The most common reasons for these referrals not making their initial FES session include: inability for families to schedule in time for CFTSI and families no longer interested in participating in therapy.
- Only about a quarter (27.67%) of all interviews of individuals over seven years old conducted by our Forensic Team resulted in referrals to Project CONTACT. Having noticed this trend a quarter way through our second year, we modified the Forensic Team's database to help capture reasons why referrals weren't being made. ***Table 4*** provides an interesting insight to this issue. Caregivers not being interested, children being too young, and children already in treatment were the most common reasons for referrals not being

made. Based on these data, we have contacted our NCTSN Category II partner (Yale University; the developer of the CFTSI model) and expressed an interest in being trained in their younger child adaptation of the model. Unfortunately, they are not quite ready to provide training yet, but indicated that it may happen during this current grant year.

- We had considerably more referrals from community partners during our second year than our first; an indication that our outreach efforts are being successful.
- The percentage of total clinical intakes conducted that led to referrals to Project CONTACT was remarkably low (9.13%). As with our investigation with our Forensic Team, we conducted a follow-up with our Intake Team. Please see **Table 5** for details. This revealed that a considerable number of intakes were conducted with families that might have been appropriate for Project CONTACT, but were never scheduled. The most common reason for this was that the Intake Team was never able to re-establish contact with the family after the initial phone call. That being said, there were still some cases that fell through the cracks. Consequently, we explored the idea of purchasing a HIPAA-compliant CRM software to help aid the Intake Team's processes. Although we identified an ideal platform, because both members of the team indicated that they were not going to be at our agency for much longer, their manager decided to wait to implement a new system until new hires were made. As a result of discussing these issues, during the last quarter we made a rather significant change to our overall workflow. Now, all potential referrals coming to our internal Intake Team are handed directly to our FES staff for follow-up and scheduling. It is our hope that this modification to our processes will improve the likelihood of enrolling referred families into our program.

Key Outcomes: Demographics

Please see ***Table 6*** for a summary of the demographics of the 175 families who we were able to engage in our program. Girls were more than twice as likely to be represented than boys. Teens were just over twice as likely to be represented than either pre-teens or tweens. Approximately 54% of our families identified as African American and about 27% identified as white. Women (specifically mothers) were the most commonly seen caregivers. In fact, less than 10% of all caregivers participating in treatment identified as males. A majority of families reported a household income between $50-99K. Please see **Table 6a** for a breakdown of the St. Louis Metropolitan area's demographics. A comparison of these two tables makes it abundantly clear that our program is serving a significantly greater proportion of minorities than would be expected by our area's demographics.

Key Outcomes: Graduations

Please see ***Table 7*** for a summary of Project CONTACT's graduation rates. Several things are notable in these data:

- We have discharged a total of 158 families; 17 are currently in treatment; 10 are awaiting treatment for a total of 185 entering the program during our first two years (seven quarters, given that no enrollments were made during Y1Q1).
- A majority (53.8%) of individuals entering the program graduate
- Of those who graduate, over half (52.94%) are referred for additional trauma therapy; some (16.47%) are referred for non-trauma related therapy; and not quite one-third (30.59%) do not require any additional treatment.
- A sizable number of families never engage in treatment (31) after being referred or drop out prior to graduation (30)

Table 8 shows our clients' graduation rates by demographic classification. There were no significant differences in percentage of individuals graduating by race, gender, age, or Hispanic heritage. Similarly, there were no significant differences in graduation rates based on the congruence between the client and clinician's racial identity. However, there were differences in graduation rates based on the congruence between the client and clinician's gender, with less than expected not graduating when the congruence was different, and more than expected graduating when the congruence was the same. This finding may be due to the very low number of male clinicians we have in our program.

Difficulties, Problems, and Planned Actions to Overcome Barriers

Throughout the course of this grant, one of our primary challenges has been staff attrition. Our Manager of Forensic Services has left the agency and yet to be replaced. Two of our Forensic Team's Family Advocates have left the agency. Although we have hired one replacement, she is still in training and not actively working on Project CONTACT. We have had three Family Engagement Specialists come and go. Although we currently have two individuals in this role, one has temporarily stepped back from her duties, and it is unclear whether she will continue. Finally, we have had six clinicians leave the project and another announce her upcoming departure; leaving us with a total of 6.5 Clinician FTEs. Ideally, to be fully staffed, we would have a total of 8.5 Clinician FTEs.

Another issue we encountered this year was the unexpected burden experienced by our Intake Team. One member is in school full-time and has had to reduce her days working at our agency. So, even though referrals to our program have not been as frequent as what we would have hoped, our Intake Team has still struggled to maintain a timely schedule of reaching out to new referrals. Consequently, we made a marked change in operations with our project this year: now, all referrals to our Intake Team that may be appropriate for Project CONTACT are going directly to our Family Engagement Specialists. Although this had helped decrease some of the burden on our Intake Team, it has led to additional burden on our FES. Nevertheless, the change does seem to improve the efficiency with which new referrals are scheduled.

We are currently at a critical staffing level. There are currently no plans to hire a replacement for our Manager of Forensic Services; we are unsure if we will be able to hire a replacement for our Family Engagement Specialist; and although we will be hiring new clinicians, they will not be immediately trained in the CFTSI model. We will carry on as best we can, though in all likelihood the consequences of these staffing challenges will be that we will no longer be able to tell our community partners that we do not have a wait-list for services – a key selling point that has previously driven enthusiasm for our program.

Analysis of Goal Achievement

Referrals to our program have not followed the pattern we had initially anticipated in our original application. In fact, we are receiving dramatically more referrals from our internal Forensic Team than from our Community Partners. It is important to note, however, that many of our partners do not make referrals through our Intake team, but through our Forensic Team (e.g., law enforcement). Consequently, some of our efforts to promote our program may actually be increasing referrals, but are funneled through our Forensic Team. Nevertheless, we are seeing that our outreach efforts are also helping to increase the number

of referrals made to our Intake Team (during Year One, we had 11, whereas there were 33 during Year Two). Finally, as we continue our promotion efforts with our Community Partners, we hope to decrease the number of inappropriate referrals (e.g., families who do not qualify for the CFTSI model).

Once families enter our program, we are doing an excellent job providing care; on average they have 3.78 sessions with our clinicians, and our graduation rates are comparable to published studies of the CFTSI model. Additionally, we are not observing any differential graduation rates based on family's demographics.

Goal 3: Improve the mental health functioning of children and families who have experienced trauma and participate in treatment

Goal 3 Objectives:

- 75% of children who participate in treatment will report significantly improved post-therapy scores on key outcomes including metrics of PTSD, Resiliency, Connectedness, and Self-Efficacy, as compared to their scores at the beginning of treatment
- 75% of children will sustain the aforementioned treatment gains through a six-month follow-up
- At the six-month follow-up period, as compared to status at post-therapy, 75% of caregivers who participate in treatment will report that their children's grades, school absences, school discipline reports, and criminal justice involvement are maintained or improved
- Following therapy, clients and caregivers will report satisfaction with treatment at the 75th percentile or higher
- Throughout the duration of the project, therapeutic outcomes will be equivalent across children's race, gender, age, SES, and referral source

Changes from Original Application

We are largely following the evaluation plan as articulated in the original application. However, there are some key changes, made largely in order to ensure our operations are in congruence with Yale's specifications of the CFTSI model. Some of these changes only affect the CFTSI process (e.g., ensuring we're using the same in-therapy assessment measures, collection of adult trauma experiences); others impact our Project CONTACT operations (e.g., changing our post-therapy follow-up period from six months to three months). All other outcome metrics remain the same as what were proposed in the grant application and what we have been using since the beginning of the project.

Relevant Data & Key Accomplishments

Please see ***Table 9*** for an overview of our primary outcome measures and their relationships with key demographic variables. The table shows that very few demographic variables were associated with pre/post change scores on outcomes. These variables were then used as between-subjects factors in subsequent analyses.

Caregiver's Ratings of Child Symptomatology

A repeated measures (pre/post therapy) general linear model analysis of caregiver's ratings of their children's trauma symptoms (CPSS: caregiver) was not significant, $F(1,53) = 3.264$, $p=.076$, $\eta^2 =.058$. However, because the aforementioned analyses indicated that demographic variables did impact scores on this outcome, we conducted follow-up analyses.

There was both a significant main effect, $F(1,52) = 8.497$, $p=.005$, $\eta^2 =.140$ and a significant interaction effect for Hispanic Heritage, $F(1,52) = 5.061$, $p=.029$, $\eta^2 =.089$. Examination of the means (**Table 10)** indicated that caregivers of Hispanic Heritage indicated significantly more reduction in their child's symptomatology than those who were not Hispanic.

Similarly, there was both a significant main effect, $F(1,51) = 4.851$, $p=.032$, $\eta^2 =.087$ and a significant interaction effect for Racial Identity (split into three categories; White, African-American, Other), $F(1,51) = 3.809$, $p=.029$, $\eta^2 =.130$. Examination of the means (**Table 11)** indicated that caregivers identifying as either White or Other indicated significantly more reduction in their child's symptomatology than those who identified as African American (of whom actually indicates slight but non-significant increases in symptomatology).

Children's Ratings of Their Own Trauma Symptomatology

A repeated measures (pre/post therapy) general linear model analysis of children's ratings of their own trauma symptoms (CPSS: child) was significant, $F(1,50) = 13.294$, $p<.001$, $\eta^2 =.210$. Analyses of means (**Table 12**) demonstrated significant pre- to post-treatment reductions in symptomatology. As previously mentioned, there were no significant effects of demographic variables on children's ratings of their own symptomatology. However, in light of the findings presented above regarding caregivers' ratings, we went ahead and ran outcomes by race (please see **Table 12a**). The results of this analysis demonstrated that all children, regardless of racial identity, reported improvements in trauma symptomatology over the course of treatment.

Caregiver's Ratings of Child Resiliency

A repeated measures (pre/post therapy) general linear model analysis of caregiver's ratings of their children's resiliency symptoms (Resiliency: caregiver) was significant, $F(1,53) = 5.207$, $p=.027$, $\eta^2 =.089$. However, because the aforementioned analyses indicated that demographic variables impacted scores on this outcome, we conducted a follow-up analysis.

There was both a significant main effect, $F(1,52) = 10.466$, $p=.002$, $\eta^2 =.168$ and a significant interaction effect for Hispanic Heritage, $F(1,52) = 4.886$, $p=.031$, $\eta^2 =.086$. Examination of the means (**Table 13)** indicated that caregivers of Hispanic Heritage indicated significantly greater increases in their child's resiliency than those who were not Hispanic.

Children's Ratings of Their Own Resiliency

A repeated measures (pre/post therapy) general linear model analysis of children's ratings of their own resiliency (Resiliency: child) was significant, $F(1,51) = 4.033$, $p = .050$, $\eta^2 =.073$. Analyses of means (**Table 14**) demonstrated significant pre- to post-treatment increases in

resiliency. As previously mentioned, there were no significant effects of demographic variables on children's ratings of their own symptomatology, consequently no further analyses were conducted.

Children's Ratings of Their Own Self-Efficacy

A repeated measures (pre/post therapy) general linear model analysis of children's ratings of their own self-efficacy (Efficacy; for children older than 12) was significant, $F(1,25) = 13.917$, $p < .001$, $\eta^2 = .358$. However, because the aforementioned analyses indicated that demographic variables impacted scores on this outcome, we conducted a follow-up analysis.

There was a significant main effect, $F(1,24) = 10.348$, $p=.004$, $\eta^2 = .301$ but not a significant interaction effect for Age, $F(1,24) = 0.270$, $p = .608$, $\eta^2 = .011$. Examination of the means (**Table 15)** indicated that although both tweens and teens had improvements in their efficacy scores, tweens generally scored higher than teens.

Addition of Follow-up Data

For all of the aforementioned analyses, we also ran them with three time points (baseline, post-therapy, follow-up). However, because we have yet to have a significant number of follow-up interviews conducted (n=24), none of these were significant. It is our hope that in the coming year, we will have additional cases that will allow us to conduct a more complex time-series analytic strategy.

Correlation of Satisfaction to Outcomes

At their last session with our Family Engagement Specialists, we collect ratings of satisfaction with services for both caregivers and child clients. Our participants are generally quite pleased with their experiences at our agency.

Satisfaction	Mean	SD	Count
Caregiver (max = 33)	24.02	7.47	52
Child: (max = 50)	43.51	7.38	50

We observed no correlations between satisfaction scores and change scores on any of our outcome measures. Similarly, the correlation between the caregiver's satisfaction scores and the children's satisfaction scores was non-significant.

Congruence of Caregiver/Child Ratings

Caregivers and child clients complete both the trauma symptom and resiliency measures. We hypothesized that the difference between caregiver and child scores on these measures would be greater at baseline and decrease after treatment. Formal analyses, however, revealed that there were no significant differences in the congruence between caregiver and child scores over time.

Service Utilization Variables

We conducted analyses to examine whether those who graduated had differential rates of service utilization than those who did not. There were no significant differences in the number of

cancellations between the two groups, however there were significant differences in the number of no-shows, $F(1,156) = 8.504$, $p = .004$, $\eta^2 = .052$; with those graduating having half the rate of no-shows than those who did not graduate (.41 vs .85). As one might expect, those who graduated attended significantly more sessions than those who did not; $F(1,156) = 342.362$, $p < .001$, $\eta^2 = .687$; 5.73 sessions vs. 1.52 sessions.

Difficulties, Problems, and Planned Actions to Overcome Barriers

We have encountered remarkably few difficulties in collecting the data necessary to evaluate the project's success. Having our FES serve as the point-of-contact for families as they complete our pre- and post-therapy assessments has not only decreased the burden on our clinicians, but improved our completion rate. That being said, there is still room for improvement in terms of collecting both end-of-therapy and follow-up assessments. Although we have been very successful in ensuring that we enter baseline and discharge NOMs for all our clients, the proportion of individuals who we are able to successfully interview at discharge is much lower than we would like. Referring back to ***Table 7,*** it is reasonable to expect that 46% of our census will not participate in the interview for the NOMs because they drop out of therapy prematurely or otherwise do not complete our program. However, there are a number of individuals who graduate that have not been willing to return to complete the NOMs. As indicated in last year's annual report, we have been making an effort to set the expectation for families early on in their treatment that we hope they'll participate in end-of-treatment assessments, not all of them have been willing to do so. We will continue monitoring our ability to capture these data and, as appropriate, examine any trends that may predict success or failure.

Analysis of Goal Achievement

We are pleased to see that measures of post-traumatic growth (e.g., resiliency and self-efficacy) revealed improvements over the course of treatment and that children rated their trauma symptoms as less severe. However, caregiver ratings of child symptomatology did not improve. This was largely due to caregivers identifying as African American reporting increases in child symptomatology. This is a perplexing finding - particularly because a similar pattern was not seen in the children themselves in which all reported improvement regardless of racial identity. We ran a couple of additional analyses, which although did not turn out to be statistically significant, showed some trends that may help explain some of our findings: a) caregiver ratings of childhood symptomatology are nearly identical when analyzing by either race or SES; b) caregivers with lower SES reported higher rates of experiencing trauma themselves. These findings warrant continued discussion among our team in the coming year.

During this reporting period, in an effort to maintain fidelity to Yale's specifications for the CFTSI model, we reduced the follow-up duration from six to three months. Nevertheless, we have yet to collect adequate numbers of follow-up assessments to conduct meaningful analyses. We are finding that many families are simply unable or unwilling to participate in these follow-up sessions - particularly in light of the fact that they often no longer in treatment. Over the course of the coming year, we will make efforts to set the expectation with caregivers that we would like them to return for these sessions. However, we anticipate by the end of the next reporting period, we will have sufficient numbers to report on these outcomes. Finally, despite families general reluctance to participate in follow-up sessions, we are observing that both caregivers and children alike are generally quite pleased with the services they receive.

Table 1: List of Community Partners

A Red Circle
Affton School District
Behavioral Health Response
Beyond Housing
BJC Victims of Violence
Burns Recovered - Midwest Children's Burn Camp
Cardinal Glennon - Fostering Healthy Children
CASA of St. Louis
CHADS Coalition for Mental Health
Child Protection Program
City Courts
Crime Victim Center
Crisis Aid International
Handle with Care (MHB)
Healthy Blue Missouri
Herbert Hoover Boys & Girls Club of St. Louis Inc.
Kids in the Middle
Legal Services of Eastern Missouri
Lutheran Family & Children Services of Missouri
Missouri Children's Division
National Alliance on Mental Illness (NAMI)
Parkway School District
Preferred Family Healthcare
Regional Intake Coordinators
Safe Connections
Saint Martha's
SLMPD Sex Crimes, Child Abuse, and Domestic Violence Department
SSM Health
St. Francis Community Services
St. Louis Children's Hospital
St. Louis City Family Violence Council
St. Louis Public Schools District
St. Louis Regional Intake Coordinators
St. Vincent Home for Children
The Covering House
The Spot
Twenty-Second Judicial Circuit Court
University City Schools
United 4 Children
Vision for Children at Risk
Vitendo 4 Africa
Washington University Trauma Response Program
Women's Safe House

Table 2: Community Partner Activities

Date	Quarter	Organization	# Reached
10/4/22	1	SLPS High School Counselors	27
10/12/22	1	Crisis Aid - referral training	4
10/10/22	1	Saint Martha's Hall - Site Visit	3
10/12/22	1	Crisis Aid International	4
10/26/22	1	Herbert Hoover Boys & Girls Club of St. Louis Inc.	2
10/28/22	1	Barnett, Heather; Kids in the Middle	1
10/28/22	1	Legal Services of Eastern Missouri	1
11/18/22	1	St. Louis Children's Hospital	1
12/2/22	1	Miller, Joe; U-City Schools	1
12/8/22	1	Preferred Family Healthcare	2
12/14/22	1	The Spot	4
12/15/22	1	Behavioral Health Response	4
1/15/23	2	January Newsletter	54
2/28/23	2	February Newsletter	56
3/31/23	2	March Newsletter	58
3/31/23	2	website Traffic	109
4/1/23	3	Child Safety and Wellbeing Fair	30
4/21/23	3	CASGSL Open House	65
5/18/23	3	Afton School District Referral Training	17
5/23/23	3	Crime Victim Center Referral Training	14
6/7/23	3	Presentation to City Family Violence Council Meeting	22
6/22/23	3	Presentation to CASGSL Didactics	6
4/30/23	3	April Newsletter	30
6/30/23	3	June Newsletter	34
quarterly	3	New Website Visitors	343
7/25/23	4	special emailing to regional intake coordinators	70
7/24/23	4	brochure mailing to CHADS	1
9/27/23	4	Parkway School District's Care Coordinators	9
quarterly	4	New Website Visitors	130
7/11/23	4	July newsletter opens	30
8/8/23	4	August Newsletter Opens	34
9/30/23	4	September newsletter Opens	37
Total			1203

Table 3: Referral Data

Referrals to the Program	Y1Q2 1/22-3/22	Y1Q3 4/22-6/22	Y1Q4 7/22-9/22	Y2Q1 10/22-12/22	Y2Q2 01/23 - 03/23	Y2Q3 04/23 - 06/23	Y2Q4 07/23 - 09/23	TOTAL
Forensic Referrals making first FES appt.	34	24	11	15	25	12	20	141
% of Forensic Referrals making 1st appt	80.95	80.00	47.83%	75.00%	83.33%	46.15%	64.52%	69.80%
Forensic Referrals that didn't make it to first FES	8	6	12	5	5	14	5	55
% of Forensic Referrals not making 1st appt	19.05%	20.00	52.17%	25.00%	16.67%	53.85%	16.13%	27.23%
Forensic Referrals Pending	0	0	0	0	0	0	6	6
% of Forensic Referrals pending	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	19.35%	0.82%
Total Forensic Referrals	42	30	23	20	30	26	31	202
Percent of all Referrals coming from Forensics	91.30%	88.24%	88.46%	68.97%	81.08%	86.67%	70.45%	82.11%
# of Forensic Interviews (age > 7)	132	120	112	98	61	122	85	730
% of Forensic Interviews -> referral	31.82%	25.00%	20.54%	20.41%	49.18%	21.31%	36.47%	27.67%
# of Community Referrals making to first FES	4	4	3	6	7	4	6	34
% of Community Referrals making 1st appt	100.00	100.00	100.00	66.67%	100.00%	100.00%	46.15%	77.27%
Community Referrals that didn't make it to FES	0	0	0	3	0	0	3	6
% of Community Referrals not making 1st appt	0.00%	0.00%	0.00%	33.33%	0.00%	0.00%	23.08%	13.64%
Community Referrals Pending	0	0	0	0	0	0	4	4
% of Community Referrals Pending	0%	0%	0%	0%	0%	0%	0%	0.83%
Total Community Referrals	4	4	3	9	7	4	13	44
Percent of all referrals coming from Community	8.70%	11.76%	11.54%	31.03%	18.92%	13.33%	29.55%	17.89%
# of Clinical Intakes	78	68	73	63	69	71	60	482
% of Clinical Intakes -> referral	5.13%	5.88%	4.11%	9.52%	10.14%	5.63%	10.00%	9.13%
Total Referrals	46	34	26	29	37	30	44	246
Total Referrals Making to 1st FES appt	38	28	14	21	32	16	36	185
Percentage of referrals making to 1st appt	82.61%	82.35%	53.85%	72.41%	86.49%	53.33%	81.82%	75.20%
Total Completed Treatment	10	29	27	17	22	33	20	158

Table 4: Offering of CFTSI to Families Having Forensic Interviews

CFTSI Offered to Family by Family Advocate? (02/02/2023 - 09/27/2023)			
didn't offer - already in treatment	34	101	48.56%
didn't offer - child not with Legal Guardian at interview	12		
didn't offer - not in St. Louis City or County	10		
didn't offer - too much time elapsed since original trauma	0		
didn't offer - too young	45		
offered and accepted	67	67	32.21%
offered but declined - caregiver not interested	28	40	19.23%
offered but declined - child not interested	9		
offered but declined - will be seeking services elsewhere	3		
missing	104	104	

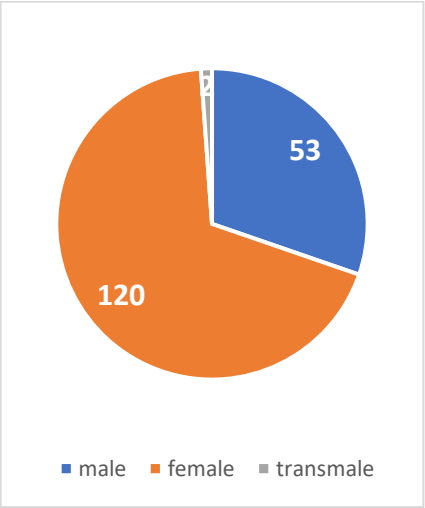
total	312
asked	208

Table 5: Referrals from Internal Intake Team

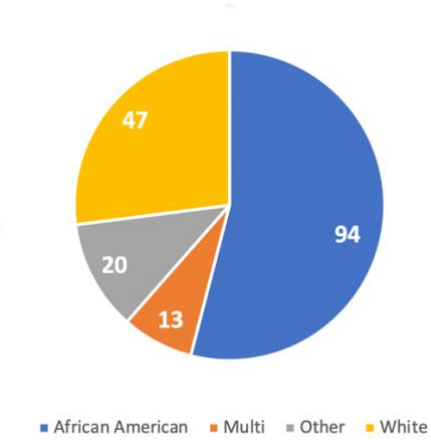
	Y1Q2	Y1Q3	Y1Q4	Y2Q1	Y2Q2	Y2Q3	Totals
Appropriate for CFTSI, and made FES appointment	3	4	3	6	5	3	24
Appropriate for CFTSI, but never made FES appointment	2	4	6	11	5	4	32
Appropriate for CFTSI, but made alternate referral	1	3	0	0	2	1	7
Not Appropriate for CFTSI	1	0	1	1	8	3	14
Totals	7	11	10	18	20	11	77

Table 6: Client Demographics

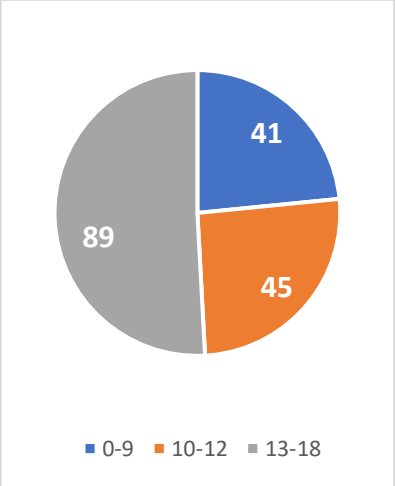
Gender



Client's Race



Client's Age



Primary Caregiver

Mother	121
Father	13
Aunt	9
Grandmother	9
Not Specified	6
Foster Mother	4
Other	4
Sister	3
Stepfather	3
Stepmother	2
Mentor	1

Caregivers in Household

Two opposite gender	74
Single woman	74
Other	8
Single man	4
Two women	8
Unspecified	7

Family Income

$0-$9,999	28
$10,000-$14,999	14
$15,000-$19,999	6
$20,000-$29,999	21
$30,000-$49,999	28
$50,000-$99,999	39
$100,000 or more	23
Unknown	16

Table 6a: Demographics of St. Louis Metro Area:

Race (alone or in combination):

- White: 78.5%
- Black: 18.8%
- Asian: 3.7%
- American Indian and Alaska Native: 2.0%
- Native Hawaiian and Other Pacific Islander: less than 0.5%
- Some Other Race: 4.7%

Ethnicity:

- Hispanic or Latino: 3.4% (of any race)
- Mexican: 2.1%
- Other Hispanic or Latino: 1.1% (not Mexican, Puerto Rican, Cuban)
- Puerto Rican and Cuban less than 0.5%
- Not Hispanic or Latino: 96.6%

Table 7: Graduation and Referrals

Deemed inappropriate for CFTSI	4	73	5.48%	46.20%
Never engaged in treatment	31		42.47%	
Dropped out prior to CFTSI graduation	30		41.10%	
Transferred prior to CFTSI completion	8		10.96%	
Graduated - Further Trauma Tx Recommended	45	85	52.94%	53.80%
Graduated - Further Non-Trauma Tx Recommended	14		16.47%	
Graduated - No Additional Tx Recommended	26		30.59%	
total discharged	**158**			

clients currently in treatment	17
clients awaiting entry into program	10
Total Clients in Program	185

Never contacted after referral	61
Total referrals	**246**

Average Days from Assignment to FES meeting:	9.76
Average Days from FES to 1st clinical appointment:	13.11
Average Days from 1st to last appointment:	43.20
Average Days from Last Appointment to 2nd FES:	19.44

Table 8: Graduation by Demographic Categories

	Graduation Status By Racial Identity			
	White	African American	Other	Total
Not Graduated	15	47	11	73
Graduated	27	38	20	85
Total	42	85	31	158

	Graduation Status By Gender Identity			
	Female	Male	Transmale	Total
Not Graduated	50	23	0	73
Graduated	58	25	2	85
Total	108	48	2	158

	Graduation Status By Age			
	Pre-teen	Tween	Teen	Total
Not Graduated	19	15	39	73
Graduated	21	24	40	85
Total	40	39	79	158

	Graduation Status By Hispanic Heritage		
	Not Hispanic	Hispanic	Total
Not Graduated	65	8	73
Graduated	73	12	85
Total	138	20	158

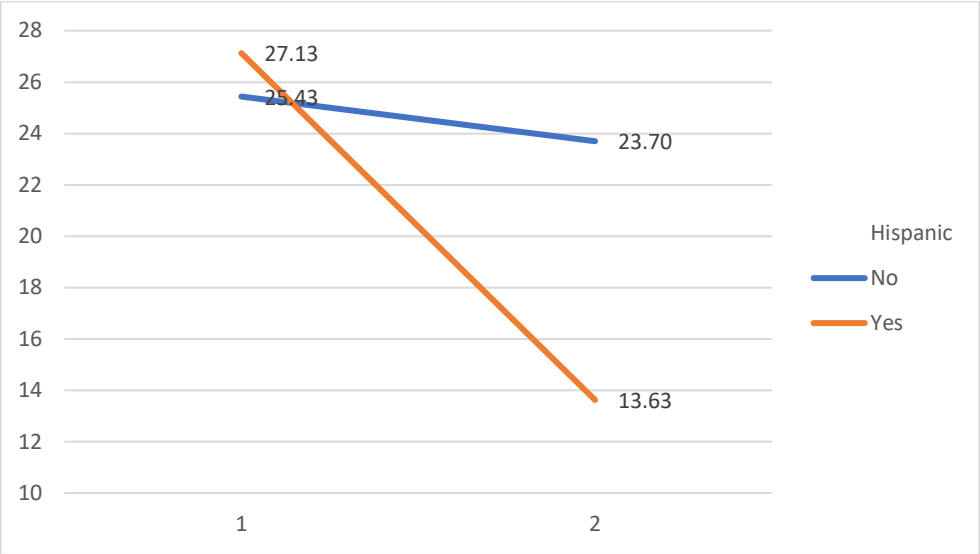
	Graduation Status By Gender Congruence		
	No	Yes	Total
Not Graduated	33	40	73
Graduated	21	64	85
Total	54	104	158

	Graduation Status By Racial Congruence		
	No	Yes	Total
Not Graduated	53	20	73
Graduated	56	29	85
Total	109	49	158

Table 9: Treatment Outcomes

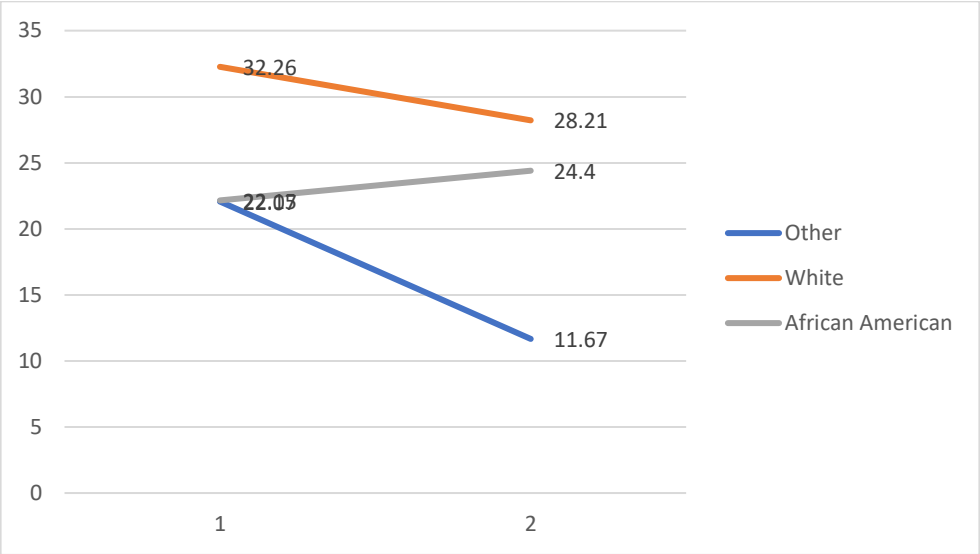
	CPSS: Caregiver	CPSS: Child	Resiliency: Caregiver	Resiliency: Child	child self-efficacy
Age	X	X	X	X	F(1,27)=9.559, p=.005
Race	F(1,51) = 3.809, p=.029	X	X	X	X
Gender	X	X	X	X	X
Hispanic	F(1,52) = 5.061, p = .029	X	F(1,52) = 4.886, p = .031	X	F(1,27) = 6.076, p = .020
Congruence Race	X	X	X	X	X
Congruence Gender	X	X	X	X	X

Table 10: Caregiver's Ratings of Child Symptomatology by Hispanic Heritage



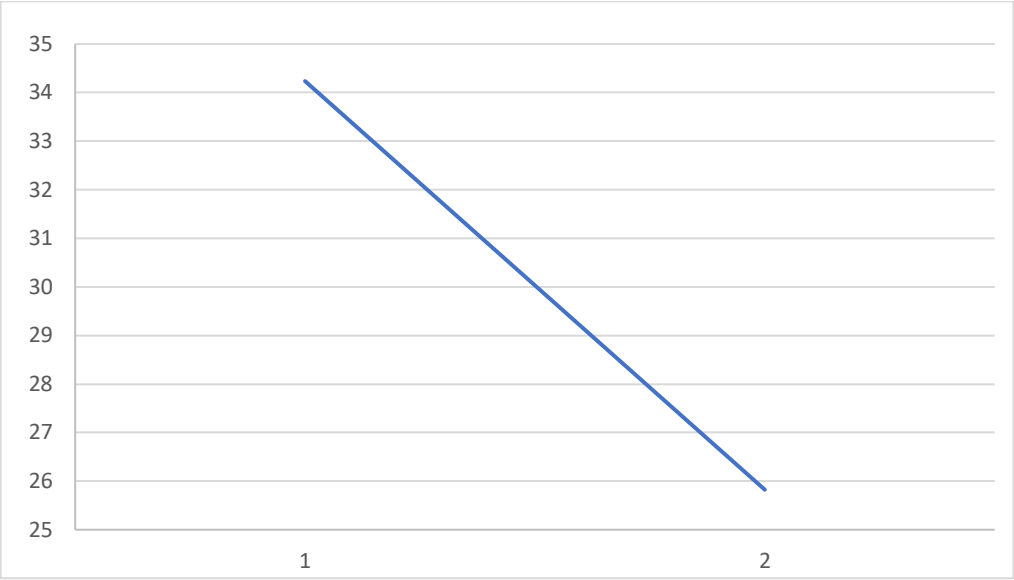
Hispanic		Mean
No	Pre	25.435
	Post	23.696
Yes	Pre	27.125
	Post	13.625

Table 11: Caregiver's Ratings of Child Symptomatology by Racial Identity



Racial Identity		Mean
Other	Pre	22.067
	Post	11.667
White	Pre	32.263
	Post	28.211
African American	Pre	22.150
	Post	24.400

Table 12: Child's Ratings of Their Own Symptomatology



	Mean	SD
CPSS Child Total Score at Baseline	34.24	16.997
CPSS Child Total Score at Post-Therapy	25.82	17.720

Table 12a: Child's Ratings of Their Own Symptomatology – by Race

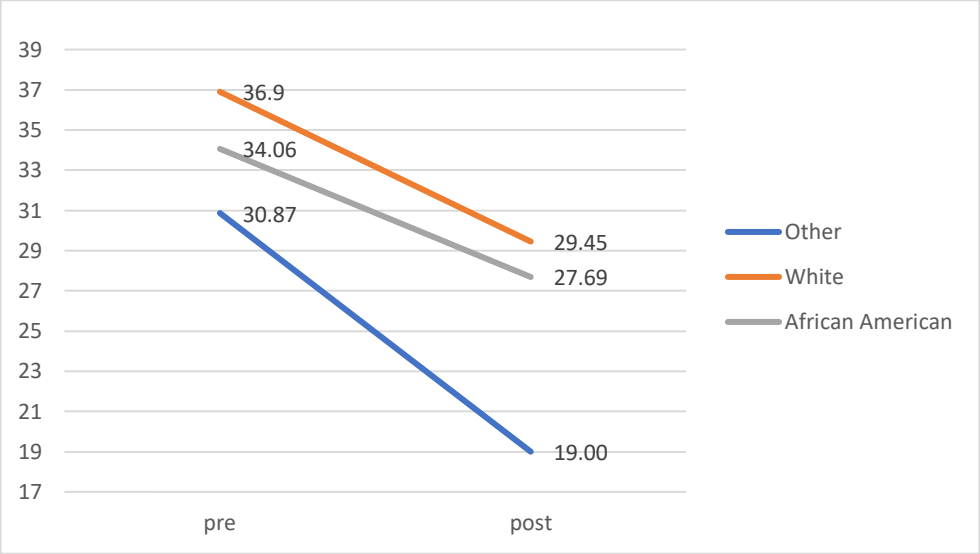
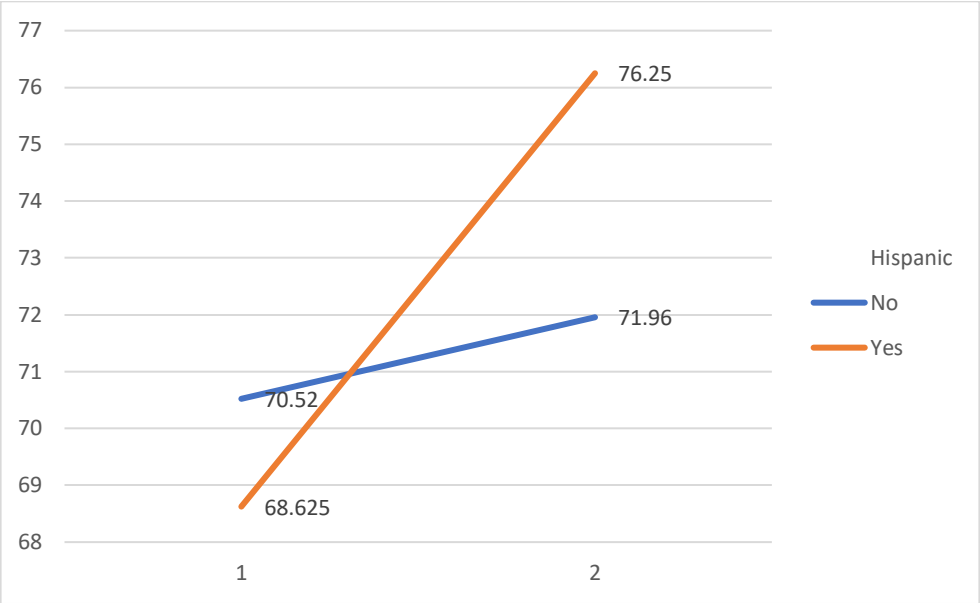


Table 13: Caregiver's Ratings of Child Resiliency



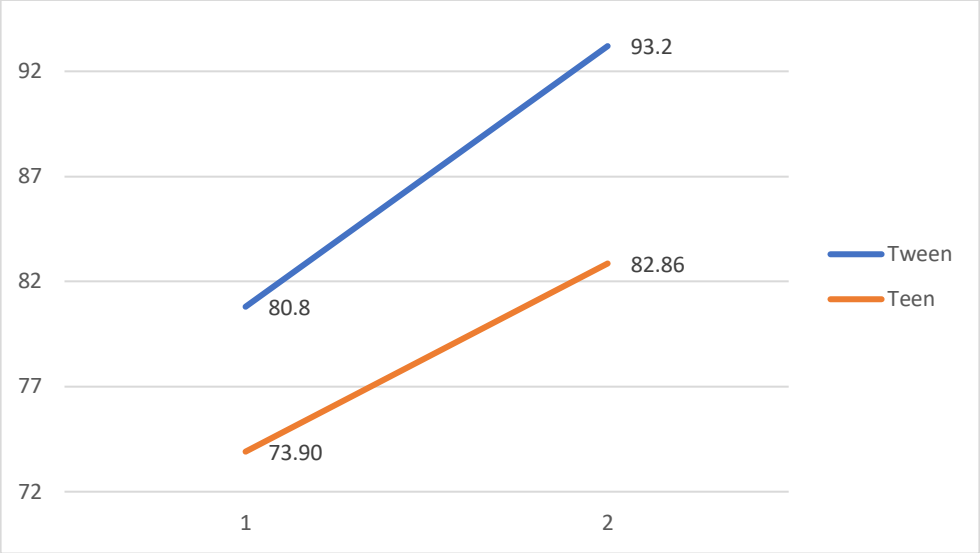
Hispanic		Mean
No	Pre	70.522
	Post	71.957
Yes	Pre	68.625
	Post	76.250

Table 14: Children's Ratings of Their Own Resiliency

Descriptive Statistics

	Mean	SD
Resiliency Child Total Score at Baseline	69.17	10.943
Resiliency Child Total Score at Post-Therapy	72.58	10.414

Table 15: Children's Ratings of Their Own Self-Efficacy



Age Group		Mean
Tween	Pre	80.800
	Post	93.200
Teen	Pre	73.905
	Post	82.857