



**MOBILE CRISIS
INTERVENTION SERVICES**

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MOBILE CRISIS INTERVENTION SERVICES

Performance Improvement Center (PIC)

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Fiscal Year 2021 Annual Report

A Note on the Impact of COVID-19

Due to COVID-19, schools were closed and stay-at-home orders were put in place for the non-essential workforce in Connecticut in mid-March 2020. The pandemic continued throughout this year, though many restrictions were lifted during the last few months of FY2021. As part of the essential workforce, Mobile Crisis remained operational throughout the pandemic, with clinicians providing in-person responses whenever it was safe to do so, and offering telephone or video “telehealth” options when an in-person response could not safely occur. During FY2021, telephone and video “telehealth” responses became less common but are occasionally still used when necessary. Within this report, both video and in-person responses are reflected as ‘mobile’ responses. Due largely to schools utilizing varying degrees of remote vs. in-person learning, there has been a significant decrease in both call and episode volume for Mobile Crisis. These numbers have increased throughout the year as schools returned to full-time in-person learning and other restrictions were lifted; however they have still not reached pre-pandemic levels. Volume decrease as well as other factors associated with COVID-19, including challenges with data collection, should be noted when reviewing this report.

Mobile Crisis Intervention Services (Mobile Crisis) is a mobile intervention for children and adolescents experiencing a behavioral or mental health need or crisis. Mobile Crisis is funded by the Connecticut Department of Children and Families (DCF) and is accessed by calling 2-1-1. The statewide Mobile Crisis network is comprised of over 150 trained mental health professionals who can respond in-person within 45 minutes when a child is experiencing an emotional or behavioral crisis. The purposes of the program are to serve children in their homes, schools, and communities; reduce the number of visits to hospital emergency rooms; and divert children from high-end interventions (such as hospitalization or arrest) if a lower level of care is a safe and effective alternative. Mobile Crisis is implemented by six primary contractors, most of whom have satellite offices or subcontracted agencies. A total of 14 Mobile Crisis sites collectively provide coverage for every town and city in Connecticut.

The Mobile Crisis Performance Improvement Center (PIC) is housed at the Child Health and Development Institute (CHDI) and was established to support the implementation of a best practice model of Mobile Crisis services for children and families. Since August 2009, the PIC has provided data analysis, reporting, and quality improvement; standardized workforce development; and standardized practice development. The PIC is responsible for submitting monthly, quarterly, and annual reports that summarize findings on key indicators of Mobile Crisis service access, quality, and outcomes, and to take a lead role on quality improvement activities. DCF also charges the PIC with taking the lead on practice development and outcomes evaluation.

The FY2021 Annual Report summarizes results from Mobile Crisis data entered into the Provider Information Exchange (PIE), DCF’s web-based data entry system, as well as other activities and results relevant to Mobile Crisis implementation. **This year, even amidst the challenges of COVID-19, Mobile Crisis continued to demonstrate strong results in service access, quality, outcomes, and workforce development.** Achievement of positive results is due to strong collaborations among various partners including DCF, Mobile Crisis providers, the PIC and its subcontractors, the CT Clearinghouse at Wheeler Clinic, 211-United Way, the Connecticut Behavioral Health Partnership (CT BHP) and Beacon Health Options, Data Silo Solutions, family members and advocates, and other partners and stakeholders.

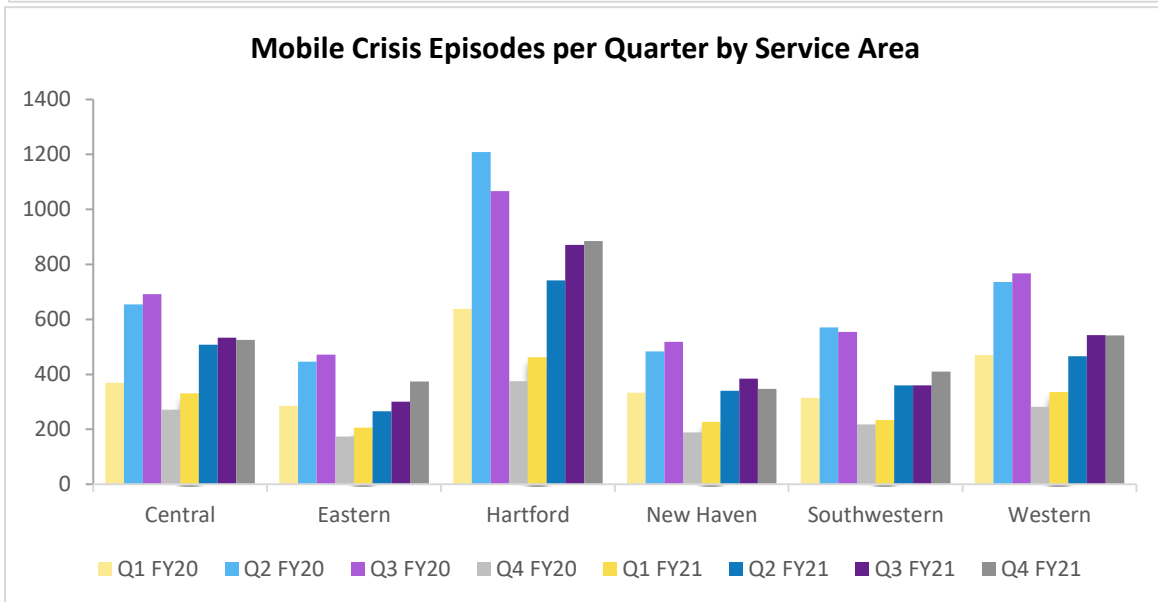
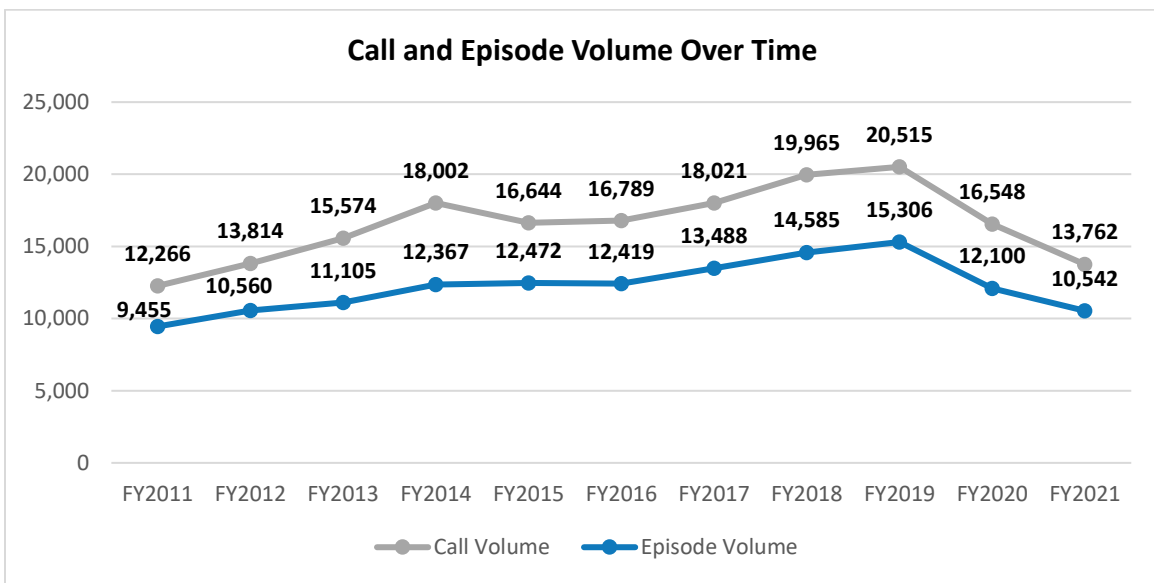
This report reviews data and activities from Fiscal Year 2021 (FY2021; July 1, 2020 to June 30, 2021), and when appropriate, includes comparisons to previous years. The report is organized according to the following sections:

- Call and Episode Volume

- Characteristics of Children and Families Served
- Performance Measures and Quality Improvement
- Standardized Workforce Development and Technical Assistance
- Collaboration among Mobile Crisis Intervention Services Partners
- Model Development and Promotion
- Goals for Fiscal Year 2022

Call and Episode Volume

In FY2021, there were 13,762 calls to 2-1-1 requesting crisis intervention, which is a 16.8% lower call volume than FY2020 (16,548 calls). Due to the impact of the COVID-19 pandemic, this is the lowest call volume since FY2011 (see below). Of the 13,792 calls this year, 10,542 resulted in opened episodes of care with Mobile Crisis Intervention Services providers, a 12.9% decrease from FY2020 (12,100). Figure 4 provides a quarter-by-quarter look at the trends in volume for each region since the beginning of FY2020. There was a sharp decline in episodes from FY2020 Q3 to FY2020 Q4, with the impact of COVID-19 beginning in March 2020. In quarters that follow, there has been a gradual increase in episode volume, though volume still remains lower than volume during the same time periods prior to the start of the pandemic.



Characteristics of Children and Families Served

Demographic Characteristics

For all Mobile Crisis episodes, data were entered into PIE to capture demographic characteristics, case characteristics, and clinical functioning characteristics of the youth and families that were served.

*Sex*¹: Among all Mobile Crisis episodes of care, 54.7% were for females and 45.3% were for males. This is somewhat of a departure from previous years, as males have typically made up a slight majority of children served.

Age: The highest percentage of children served by Mobile Crisis were 13 to 15 years old (36.7%) and 9 to 12 years old (29.7%). An additional 23.0% of children were 16 years old or older and the remaining 10.6% of children were 8 years old or younger.

Ethnic Background: Most episodes (61.3%) were for children who identified as having a non-Hispanic² ethnicity. An additional 12.6% of episodes served children who did not disclose their ethnicity. Of the 26.4% of episodes serving children from a Hispanic ethnic background, most reported their ethnicity as “Other Hispanic/Latino” (16.0%) or “Puerto Rican” (9.0%).

Racial Background: The PIE data system allows for more than one race to be selected. In FY2021, the majority (54.3%) of Mobile Crisis episodes were for children who reported “White” as their racial background, 16.7% for those who reported “Black/African-American”, and 2.5% for those who reported another race. 4.0% of episodes were for a child who selected more than one race, and 22.3% of episodes did not report racial background.

Health Insurance Status: **For most Mobile Crisis episodes, children were covered by public insurance sources** including Husky A (57.3%) and Husky B (1.4%). Private insurance coverage was reported for 32.0% of episodes and 1.4% of episodes this year served children who had no insurance coverage, which is slightly lower than FY2020 (2.1%).

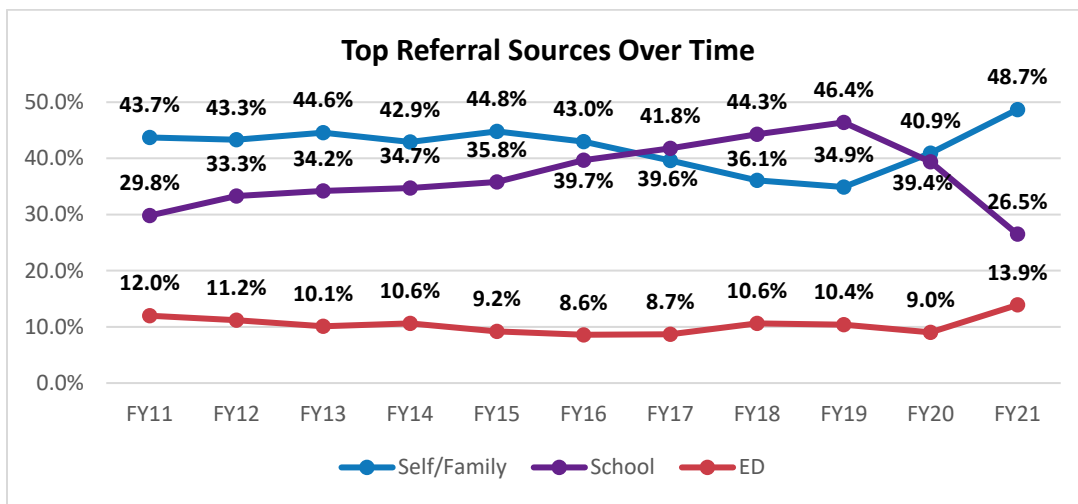
Temporary Assistance for Needy Families (TANF) eligibility: Statewide, **38.4% of Mobile Crisis episodes served children who were eligible for TANF**, among those who answered the question. Across all 14 Mobile Crisis sites, the percentages of episodes serving TANF eligible families ranged from 23.0% (CFGC: Norwalk) to 49.2% (Wheeler: Meriden). It should be noted that TANF eligibility is reported as “unable to determine” for 59.6% of episodes.

Case Characteristics

Referral Source: **Most children were referred by self or family members (48.7%), schools (26.5%), or emergency departments (13.9%)**. Though schools had become the most common referral source between FY17 and FY19, self or family comprised the largest percentage of referrals to Mobile Crisis in FY2020 and FY2021. This change was the result of school closures for the last 3-4 months of FY2020 due to COVID-19, implementation of remote learning by many schools for a large part of FY2021, and the continued strict visitor policies by many schools.

¹ Sex assigned at birth

² We recognize there are other preferred terms for describing ethnicity. This report uses “Hispanic” and “Latino” to remain consistent with the way it is collected in the data system, which reflects the terminology in the 2010 U.S. Census.



Mean Mobile/Office Visits: In FY2021, the average Mobile Crisis episode included 1.8 sessions (by site, the average number of sessions ranged from 1.1 to 2.6). The majority of sessions were mobile, in which the provider traveled to the child; however, a handful of follow-ups were office visits. Among non-mobile episodes, most were phone contact, with a very small number of visits occurring in the provider’s office. The average number of in-office sessions was 0.05 sessions (by site, the average number of in-office sessions ranged from 0.0 to 0.73). In comparison, there was an average 0.07 in-office sessions per episode of care statewide in FY2020. Consistent with the Mobile Crisis model and practice standards, all 14 Mobile Crisis provider sites had a higher average number of mobile sessions per episode than office sessions.

Length of Stay (LOS): In FY2021, the median LOS was 14.0 days, and the mean LOS was 18.1 days among discharged episodes of care coded as *stabilization plus follow-up*. The FY2021 mean LOS is similar to FY2020, reflecting a lower mean LOS than in previous years (ranging from 20.3 days to 24.5 days since FY2011). In FY2021, Mobile Crisis providers continued to manage LOS and ensure that data on start and end dates were accurately entered into PIE. Among episodes classified as *stabilization plus follow-up*, **3.3% exceeded a 45-day LOS (coming in under the benchmark of 5% of episodes exceeding 45 days)**. This percentage is lower than rates in FY2020 (4.5%), and represents a continued decrease from FY2016 (10.0%). In FY2021, the median LOS for episodes coded as “Face-to-Face” was 4.0 days, and for “Phone Only” episodes the median LOS was less than 1 day.

Clinical and Functional Characteristics at Intake

Primary Presenting Problems: The six most common primary presenting problems at intake were **Harm/Risk of Harm to Self (29.3%); Disruptive Behavior (24.5%); Depression (17.3%); Anxiety (7.4%); Family Conflict (5.4%); and Harm/Risk of Harm to Others (4.1%)**. All other presenting problems combined accounted for 12.0% of referrals. These percentages are fairly similar to prior years.

Diagnosis: The five most common primary diagnoses at intake in FY2021 were Depressive Disorder (35.8%); Adjustment Disorder (14.0%); Conduct Disorders (13.3%); Anxiety Disorder (12.5%); Trauma Disorders (9.9%); and Attention Deficit/Hyperactivity Disorder (7.4%).

Trauma exposure: Statewide, **59.6% of children served by Mobile Crisis reported exposure to one or more traumatic events**, which was higher than FY2020 (56.8%). Across service areas this year, the percentage of youth reporting trauma exposure ranged from 46.2% (Southwestern area) to 76.6% (Central service area). Among those with trauma exposure, the most common types were disrupted attachment/multiple placements (22.8%), witnessing violence (19.3%), being a victim of violence (17.9%), and sexual victimization (15.4%).

DCF Involvement: At intake, **most children (86.7%) served by Mobile Crisis were not involved with DCF**, slightly higher than FY2020 (84.0%). For those families involved with DCF, the most common types of involvement at intake were CPS in-home

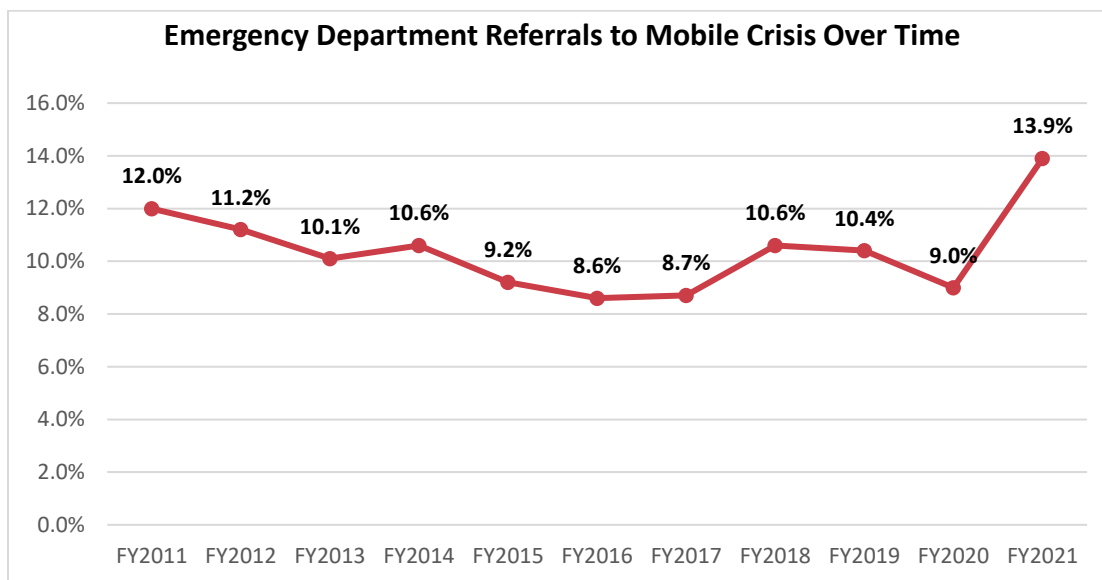
services (4.6%), CPS out-of-home services (4.0%), and Family Assessment Response (2.2%). These rates are similar to results from FY2020, though with a slight decrease in CPS in-home services (7.4% in FY2020).

Juvenile Justice Involvement: Statewide, 2.1% of children served by Mobile Crisis had been arrested in the six months prior to the Mobile Crisis episode, slightly lower than FY2020 (2.7%) and FY2019 (3.2%). Moreover, 0.8% of youth were arrested during the Mobile Crisis episode, which is similar to the rate in FY2020 (0.7%).

School Issues: Across the state, the top four issues at intake that had a negative impact on the youth's functioning at school were emotional (32.7%), behavioral (22.8%), academic problems (22.7%), and social (20.2%). Statewide, 5.9% of youth served by Mobile Crisis had been suspended or expelled in the six months prior to the Mobile Crisis episode. This is lower than the percent suspended or expelled in FY2020 (12.4%) and previous years (14.9% in FY2019). However, because many students were learning remotely for part or all of the school year, there was less opportunity for kids to have been suspended or expelled from school this year.

Alcohol and Other Drug (AOD) Use Problems: In terms of lifetime prevalence of AOD use, 0.7% reported alcohol use, 6.2% reported other drugs, and 2.5% reported both alcohol and other drug use. These are similar to numbers in FY2020.

Emergency Department and Inpatient Hospital Utilization: Statewide, 13.9% of all referrals to Mobile Crisis came from hospital EDs, compared to 9.0% in FY2020. This increase in percentage of all Mobile Crisis episodes is in part a result of fewer total school referrals this year; however, the overall number of referrals from emergency departments did increase as well (1,461 compared to 1,091 in FY2020). Figure 49 in the report (also shown below) demonstrates trends in this rate over the past several years. In FY2021, 26.1% of episodes were evaluated in an ED one or more times during the given Mobile Crisis episode of care, a rate higher than FY2020 (20.3%). 9.7% of Mobile Crisis episodes had an inpatient admission during the episode, which is similar to FY2020 (9.3%).



Performance Measures and Quality Improvement

In FY2021, the PIC worked with collaborators to produce monthly reports, quarterly reports, and this annual report summarizing indicators of access, service quality, performance, and outcomes (visit www.chdi.org or www.mobilecrisisempst.org for all reports). Site visits were conducted with providers quarterly. Performance improvement plans were developed with the six primary service area teams and, when applicable, their satellite offices or subcontractors. Individualized consultation helped Mobile Crisis providers identify best practice areas and identify and address areas in need of improvement. Primary indicators of service access and quality were the focus of many sites' performance improvement plans, but sites increasingly examined other indicators of service and programmatic quality

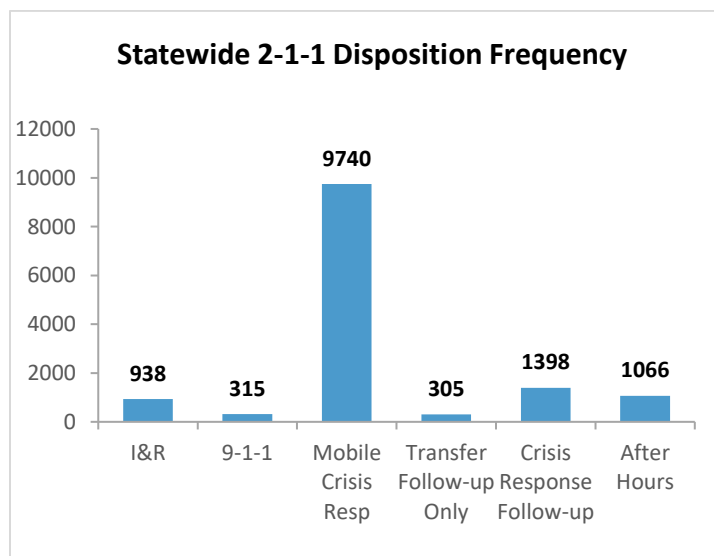
including clinical and administrative processes. During FY2021 there were a total of 67 performance improvement goals developed (includes goals duplicated across more than one quarter). Of those goals, 22% were achieved and an additional 66% of the goals saw improvement. Only 12% of goals developed had no positive progress. The continued impact of the pandemic may have affected providers' ability to meet their goals. See Table 12 for a summary of sites' performance improvement plans.

Data on performance measures and quality improvement activities are reviewed below along with clinical outcomes and special data analysis requests in FY2021.

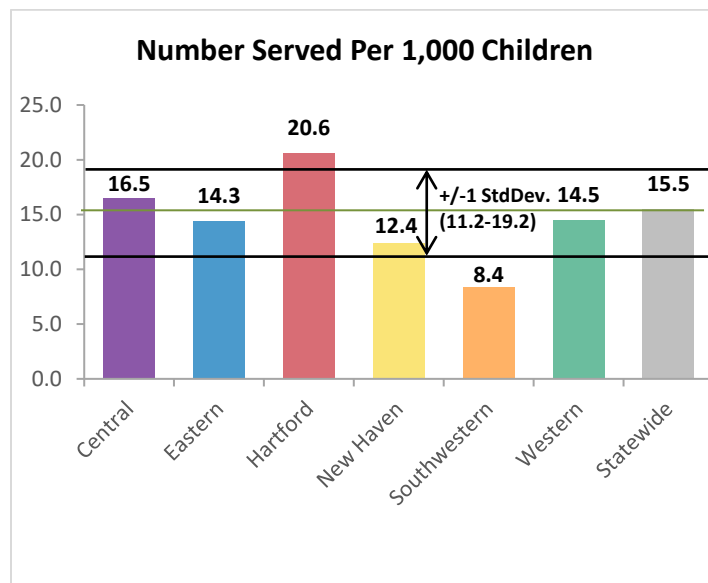
Call Volume: As noted previously, **in FY2021 there were 13,762 calls to 2-1-1 and Mobile Crisis for intervention, resulting in 10,542 Mobile Crisis episodes of care**, both decreases from FY2020 due to continued challenges of the COVID-19 pandemic. These 10,542 episodes of care served a total of **7,791 unique children**. Of these children, 21.9% had more than one episode with mobile crisis, compared to 22.6% in FY2020.

Figure 13 (Section III) provides a visual representation of Mobile Crisis episode volume across the state. The map indicates the rate of Mobile Crisis episodes in each town during FY2021, relative to each town's child population (episodes per 1,000 children). Despite decreases in call volume due to COVID-19, only three towns did not have any episodes. The major cities of Hartford and Waterbury each had over 650 episodes this year, while Bridgeport, New Haven, and Bristol each had over 300 episodes.

Most calls (n=9,740) were transferred to a Mobile Crisis provider for a response. Additionally 1,398 calls in FY2021 were sent to Mobile Crisis for crisis response follow-up (follow up on an open episode of care), 1,066 were transferred to Mobile Crisis for after-hours follow-up, and 305 were transfer follow-up (follow up without a crisis in process). The remaining calls were handled by 2-1-1 only as information and referral (n=938) or as transfers to 9-1-1 (n=315). Please note that 1 of the 13,762 calls was missing disposition information.



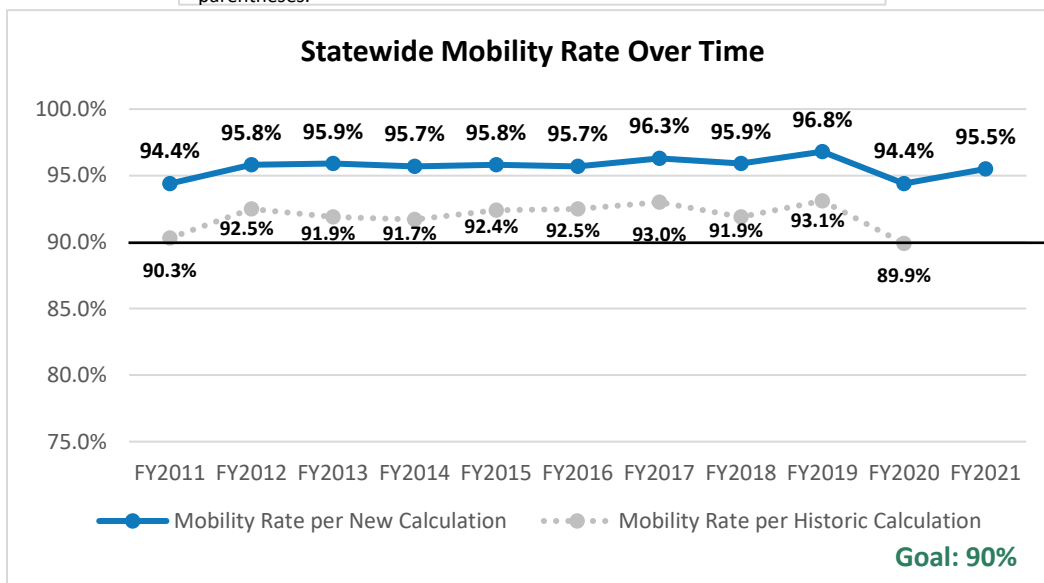
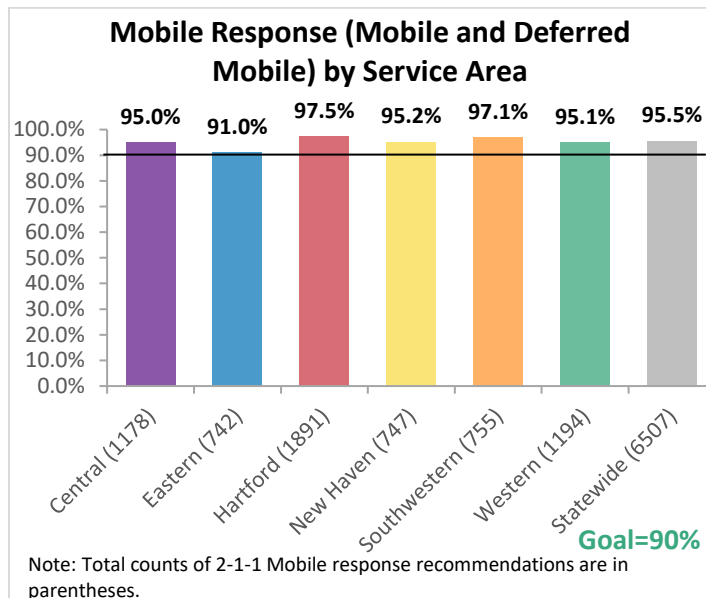
A "service reach rate" examines total episodes relative to the population of children (based on 2020 U.S. Census data) in a given catchment area (see below). Service reach rates are calculated statewide, for each service area, and for each individual provider. The statewide service reach rate for FY2021 was 15.5 episodes per 1,000 children compared to 17.2 in FY2020 and 19.9 in FY2019. The Hartford service area had the highest service reach rate (20.6 per 1,000 children) which was more than one standard deviation above the statewide mean. The lowest service reach rate was in the Southwestern service area (8.4 episodes per 1,000 children), which was more than one standard deviation below the statewide mean.



Mobility Rate: Mobile responsiveness is a key feature of Mobile Crisis service delivery. Since PIC implementation, the established mobility benchmark has been 90%. To calculate mobility, the Mobile Crisis PIC has historically examined all episodes for which 2-1-1 recommended a mobile or deferred mobile response and determines the percentage of those episodes that actually received a mobile or deferred mobile response from a Mobile Crisis provider. Beginning with the FY21 Q2 report, the calculation of mobility changed. If a referral made by a caller other than self/family (e.g. schools, EDs, etc.) is designated by 2-1-1 as mobile or deferred mobile, but is later determined to be non-mobile due to the family declining or not being available after multiple attempts to contact them, the episode will no longer be included in the mobility rate, as these situations are out of the providers’ control. Any mobility rates from prior quarters and years referenced in this report have been recalculated to allow for accurate comparison. As such, they may not be consistent with mobility rates presented in past reports.

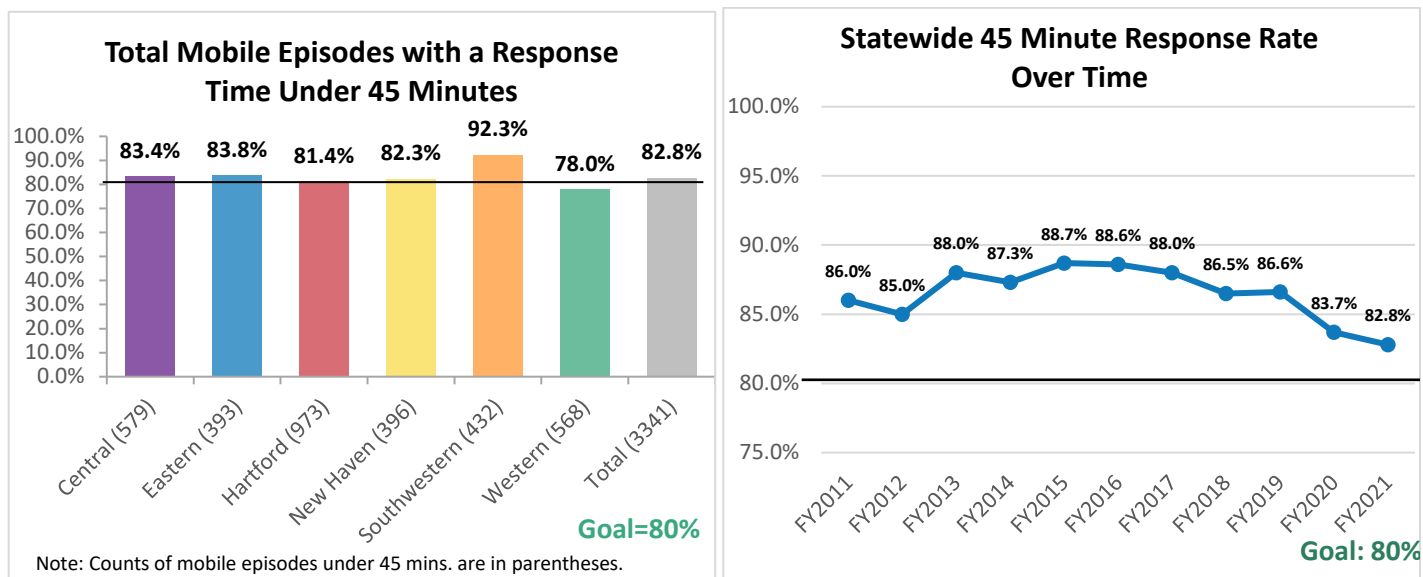
While providers continued to offer mobile responses in homes and community settings as much as possible, many episodes received a phone or video telehealth response due to COVID-19 related concerns and closures, particularly during the height of the pandemic. Due to restrictions of the data system, full assessments completed via video telehealth were considered to be “mobile” episodes.

In FY21, the statewide mobility rate was 95.5%, exceeding the 90% benchmark. The statewide mobility rate this year was slightly higher than FY2020 (94.4%). Note that this FY2020 rate (94.4%) is adjusted per the revised mobility calculation mentioned above. Per the previous method for calculating mobility, the FY2020 rate had been 89.9%. The baseline mobility rate in FY2009, prior to PIC implementation, is estimated at 50%. **All six service areas had an annual mobility rate above the 90% benchmark this year.** The highest rate was in the Hartford region (97.5%) and the lowest was in the Eastern service area (91.0%). The range in mobility rates across all six service areas was 6.5 percentage points, which was slightly higher than FY2020 (4.7 percentage points) and FY2019 (4.9 percentage points). High utilization rates impact sites’ abilities to respond to requests for mobile responses; however, the Mobile Crisis program continues to demonstrate excellent overall mobility.



Response Time: The benchmark for response time is that a minimum of 80% of all mobile responses be provided in 45 minutes or less. **This year, 82.8% of all mobile responses were made within the 45-minute benchmark.** This is a slight decrease from the rate in FY2020 (83.7%), though still remaining above the benchmark. Five of the six service areas were above the 80% benchmark, with service area performance ranging from 78.0% (Western) to 92.3% (Southwestern). **The median response time this year was 31.0 minutes, which was one minute more than FY2020.** Statewide response time performance has been consistently above expectations the last nine fiscal years despite growth in episode volume.

The slight decrease in proportion of responses under 45 minutes this fiscal year may in part be attributable to the continued impact of the pandemic. For those episodes where clinicians did go into homes or the community, it often took extra time to coordinate with families and community members in order to take proper precautions. Clinicians may have also been responding from their homes due to office closures, often resulting in longer travel times. Despite these challenges, the benchmark of 80% was still exceeded.



Clinical Outcomes

Ohio Scales: The Ohio Scales are intended to be completed at intake and discharge by parents and Mobile Crisis clinicians, typically for stabilization plus follow-up episodes in which children are seen in person for multiple sessions over a timeframe of at least 5 and up to 45 days. Statewide, 2,842 clinician-report and 636 parent-report Ohio Scales were completed at both intake and discharge³. **In FY2021, Mobile Crisis clinicians completed the Ohio Scales for 87.1% of episodes at intake and 83.4% at discharge⁴.** Clinician completion rate at both intake and discharge was higher than in FY2020. In FY2021, **parents completed the Ohio Scales at the rate of 45.8% at intake and 21.3% at discharge**, both of which were higher than the rates in FY2020. Throughout the year, providers have been working with their clinicians to improve their parent Ohio Scale completion rate. By including Ohio Scale completion as a part of every provider’s PIP, additional training provided by DCF and providers, and consistent emphasis on the importance of these scales, increasing these numbers will continue to be a goal for Mobile Crisis providers.

Even though the Ohio Scales were designed to assess treatment outcomes for longer-term models of intervention such as outpatient care, pre-post changes indicate **statistically significant and positive changes on all domains of the Ohio Scales** (see Table 4) at the statewide-level. It is important to note that low completion rates (especially for parent-report measures at discharge) present a potential threat to the validity of these results.

Examining “clinically meaningful change” is one way to view change in Ohio Scales from intake to discharge. Clinically meaningful change on the Ohio Scales Functioning Scale, for the purposes of the Mobile Crisis program, is an increase of at least 8 points and a score of 50 or higher at discharge; and on the problem severity scale, a decrease of at least 10 points and a score of 25 or lower at discharge. Using these definitions, there was clinically meaningful change in Functioning for 9.7% of youth according to parent-report and 5.0% of youth according to clinician-report. None of the parent-reported scales met the criteria for clinically meaningful change on Problem Severity, while 8.9% of youth attained clinically meaningful change according to clinician-report.

³ All Ohio Scale completion numbers and rates reported in this paragraph reflect completion of Functioning Scales. Problem Severity Scale completion rates are very similar to those of the Functioning Scales. See Figures 78 and 79 for rates of all scales.

⁴ The percentages of completed Ohios are only reflective of episodes where Ohio Scales are *expected* to be collected; only episodes with a *mobile* response requiring stabilization plus follow up care, and a length of stay of 5 days or longer.

Beginning in FY2019, the Mobile Crisis PIC began using the Reliable Change Index (RCI) to measure additional levels of change in Ohio Scale scores (See Statewide RBA). RCI is a method for taking change scores on an instrument and interpreting them in easily understandable categories. Using the properties of a specific instrument (the mean, standard deviation, and reliability), RCI identifies cut-offs for which there is reasonable confidence that the change is not merely due to chance.⁵ In addition to the clinically meaningful change described above, the RCI includes measures of Reliable Improvement and Partial Improvement. Reliable Improvement reflects a positive change that is equal to or greater than the RCI value, but does not meet the clinical cut off score at discharge. Partial Improvement reflects positive change that is greater than half of the RCI value but less than the full RCI value.

For FY2021, in addition to the clinically meaningful change noted above, 14.9% of children as measured by parent completion of scales and 12.7% as measured by clinician-completed scales demonstrated either partial or reliable improvement in Functioning. On Problem Severity, 12.7% of children per parent-completed scales and additional 12.8% per clinician-completed scales demonstrated either partial or reliable improvement. It's important to note that the primary goal of Mobile Crisis is to stabilize the child and then connect the child to appropriate longer-term care. It is expected that children make additional improvement in functioning and problem severity within the context of the longer-term care.

Statewide Ohio Scale Scores (based on paired intake and discharge scores)	N (5094)	Mean (intake)	Mean (discharge)	t-score	Sig.	% Clinically Meaningful Change	% RCI	% Partial RCI	% Demonstrating Improvement⁶
Parent Functioning Score	636	41.99	44.80	7.84	0.000	9.7%	6.9%	8.0%	24.6%
Worker Functioning Score	2842	44.10	45.35	10.77	0.000	5.0%	3.6%	9.1%	17.7%
Parent Problem Severity Score	647	30.93	27.05	-9.26	0.000	0.0%	0.0%	12.7%	12.7%
Worker Problem Severity Score	2846	29.80	27.54	-16.87	0.000	8.9%	3.6%	9.2%	21.7%

Special Data Analysis Requests

The Mobile Crisis PIC examined PIE and other data submissions and answered a number of important questions related to Mobile Crisis service delivery, access, quality, outcomes, and systems-related issues. Many of these special data requests were generated throughout the year in response to questions from DCF, Mobile Crisis providers, and other stakeholders. This information was used to shape Mobile Crisis practice as well as systems-level decision-making. Several examples are described below.

Results Based Accountability (RBA): Historically, the Mobile Crisis PIC has helped identify appropriate indicators for RBA reporting and has reported on these indicators in the annual report. Beginning in Q2 FY2016, Mobile Crisis PIC integrated the statewide RBA report card into quarterly and annual reports to enhance the capacity for DCF and statewide stakeholders to monitor performance on a more regular basis. In FY2021, the Mobile Crisis PIC continued to provide each regional Mobile Crisis provider with their own RBA with site specific data.

⁵ Jacobson, N. S., & Truax, P. (1991). Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research. *Journal of Consulting and Clinical Psychology*, 59(1), 12–19.

⁶ Total percent of scales meeting the criteria for Partial RCI, RCI, and Clinically Meaningful. Rounding of percentages may result in numbers in tables not adding up precisely.

Impact of COVID-19: Throughout FY2021, the Mobile Crisis PIC conducted analyses of Mobile Crisis data to assess changing trends in needs and services during the COVID-19 pandemic. CHDI staff compared data from the prior year to the data collected during the pandemic, assessing changes across indicators related to service utilization, performance measures, and the behavior health needs and outcomes of children served. Preliminary findings were shared with Mobile Crisis managers and further analysis is currently in progress.

Race and Ethnicity Analysis: As part of both CHDI and DCF's efforts to improve equity in behavioral health care for children in Connecticut, the Mobile Crisis PIC has begun conducting more in-depth analyses to assess whether racial or ethnic disparities exist across a variety of indicators including referral source, presenting problem, discharge status, and behavioral health outcomes. Analysis is in development and a report is forthcoming.

Mobile Crisis Analyses Supporting Related Initiatives: Mobile Crisis data continued to be analyzed in support of the School-Based Diversion Initiative (SBDI) to encourage use of Mobile Crisis services by participating schools as an intervention for students with behavioral needs, and an alternative to law enforcement contact, arrest, and juvenile court referrals. Analyses continued to be conducted to examine differences in trends related to race/ethnicity of students enrolled in SBDI schools who received referrals to Mobile Crisis in comparison to the demographic trends of students who received court referrals. Potential disparities were shared with school staff.

Juvenile Justice: In response to discussions with the Connecticut Juvenile Justice Alliance, CHDI completed an analysis of Mobile Crisis data demonstrating the service provides a timely response statewide, even in less populated areas of the state. Additionally, at the request of the Juvenile Justice Policy and Oversight Committee (JJPOC), CHDI identified a variety of indicators that could be analyzed to track schools' utilization of mobile crisis. This is of interest to the committee as they continue work to divert youth from arrest and instead address unmet behavioral health needs.

Statewide Committee Reporting: The Racial and Ethnic Disparities (RED) Committee, formerly known as Disproportionate Minority Contact (DMC) Committee, periodically requests the PIC to examine response time and referral sources for school districts in Connecticut, particularly Alliance School Districts. Staff from DCF and the PIC provide ongoing participation in the CT Disaster Behavioral Health Response Network which supports the work of the Northeast Terrorism and Disaster Coalition and the JJPOC Diversion Work Group.

Standardized Workforce Development and Technical Assistance

The Mobile Crisis PIC is responsible for designing and delivering a standardized workforce development and training curriculum that addresses the core competencies related to delivering Mobile Crisis services in the community. Providers are required by contract to ensure that their clinicians attend these trainings. CHDI contracts with Wheeler Clinic's CT Clearinghouse to coordinate the logistics associated with implementing training events throughout the year. There were thirteen regular training modules offered in FY2020, including:

1. 21st Century Culturally Responsive Mental Health Care
2. Crisis Assessment, Planning and Intervention
3. Disaster Behavioral Health Response Network
4. Emergency Certificate Training
5. Overview of Intellectual Developmental Disabilities and Positive Behavioral Supports
6. Traumatic Stress and Trauma-Informed Care
7. Assessing Violence Risk in Children and Adolescents
8. Question, Persuade and Refer (in house training by managers)
9. Columbia Suicide Severity Rating Scale (online training)
10. Adolescent Screening, Brief Intervention and Referral to Treatment (A-SBIRT)
11. Autism Spectrum Disorders
12. Problem Sexual Behavior
13. School Refusal

Evaluation forms indicated that participants were generally highly satisfied with the training modules and that the learning objectives were consistently met. Due to restrictions on in-person meetings resulting from COVID-19, all module trainings for the year were online. Evaluation findings continue to be used to inform changes for FY2021. Highlights from the Mobile Crisis PIC training component include the following:

- 26 training modules were held in FY2021 (26 were held in FY2020 as well).
- There were 374 attendees across all Mobile Crisis trainings in FY2021, representing 111 unique individuals that attended at least one training this fiscal year.
- There have been 364 trainings in the ten years of Mobile Crisis PIC implementation, and 684 Mobile Crisis staff members have completed one or more trainings during that time.

In addition to these formal workforce development sessions, the PIC provided Mobile Crisis staff with periodic consultation and technical assistance to address data collection and entry issues, for using data to enhance Mobile Crisis access and service quality, and to inform management and clinical supervision. In an effort to reduce redundancy in content and increase efficiency of delivering the training curriculum, especially in light of continued high episode volume, Columbia Suicide Severity Rating Scale (CSSRS) continues to be offered as an online training module and Question, Persuade and Refer (QPR) is offered at the individual sites by the managers.

In its efforts to transform to becoming an anti-racist agency, DCF prioritized a new area of technical assistance this year. DCF contractually mandates that providers offer equitable services to the individuals they serve. To support this work, DCF offered Health Equity Plan (HEP) training and support to all contracted providers. The role of HEPs will continue to be expanded upon in future years to support providers prioritizing health equity in their work.

Collaborations among Mobile Crisis Partners

There were numerous collaborations among DCF, the Mobile Crisis PIC, Mobile Crisis provider organizations, the Connecticut Behavioral Health Partnership (CTBHP) and Beacon Health Options, 211-United Way, FAVOR, and other stakeholders. Activities in this area include:

- *Monthly Meetings:* Monthly meetings include representatives from the Mobile Crisis PIC, DCF, Mobile Crisis managers and supervisors, 211-United Way, Beacon, and other stakeholders. The meetings are held to review Mobile Crisis practice and policy issues. Due to COVID-19, all meetings were online during FY2021.
- *The School Based Diversion Initiative (SBDI):* SBDI is a school-based initiative that seeks to reduce rates of school-based arrest, expulsion, and out of school suspension through professional development, revisions to school disciplinary policies, and access to mental health services and supports in the school and community. The initiative emphasizes enhanced school utilization of Mobile Crisis as a “front end” diversion to school-based arrest, which disproportionately affects students with behavioral health needs.
- *Client and Referrer Satisfaction:* 211-United Way and the Mobile Crisis PIC worked together to measure and report family and referrer satisfaction with Mobile Crisis services.
- *Database Updates:* To improve accuracy and efficiency of data entry, CHDI worked with DCF, Mobile Crisis providers, and Data Silo Solutions to make changes to DCF’s database, the Provider Information Exchange (PIE), including the ability to identify telehealth vs. in-person visits. As of July 1, 2021, the updated database is in place and being used by 2-1-1 and the providers.
- *Annual Meetings:* Typically, Mobile Crisis Providers, clinicians, DCF and other stakeholders attend a year-end annual meeting at Beacon Health Options. The purpose of the annual meeting is to recognize Mobile Crisis accomplishments throughout the year. The annual meeting was held virtually this year due to gathering restrictions related to COVID-19.
- *MOA Development with School Districts:* Mobile Crisis PIC staff provided technical assistance and support to Mobile Crisis managers to develop MOAs with school districts as one element of Connecticut Public Act 13-178. To date, the PIC has collected MOAs from 201 of 206 districts. Staff from 211-United Way sent outreach mailings to school administrators, and the Mobile Crisis PIC facilitated contact between Mobile Crisis providers and school personnel. The responsibility for acquiring the remaining MOAs has now shifted to the State Department of Education. Staff from 211-United Way posted MOA information and signed MOAs on their website (<http://www.empsct.org/moa/>). Additionally,

a brief video highlighting the mutual benefits that students and schools receive by collaborating with Mobile Crisis service providers was developed and disseminated to school administrators.

- *“Talk it Out” Line*: Amidst the challenges of the COVID-19 pandemic, DCF launched a non-clinical support line for parents. This line is directed through 211 to the Mobile Crisis providers who offer parents support by phone and refer them to other services as needed. With children being home from school and other pandemic-related stressors being present, the intention of this line is to provide parents with support and advice, as well as link them to other resources and services as necessary. This line continued through October 15, 2020, and is no longer in service.
- *Supporting Clinicians during the pandemic*: Continuing work that began in the fourth quarter of FY2020, Mobile Crisis staff, supervisors, and managers met with Dr. Mark Horowitz during the first quarter of FY2021 for technical assistance. The purpose of these meetings was to support Mobile Crisis staff in providing services during the COVID-19 pandemic. Staff, supervisors and managers discussed their experiences providing mobile crisis services during the pandemic and had the opportunity to outline their needs and concerns as they anticipate a demand for increased mobile responses during the “new normal” stage of the COVID-19 crisis.

Model Development and Promotion

Mobile Crisis stakeholders continue to work toward standardized Mobile Crisis practice across the provider network, present to various system stakeholders to ensure awareness of Mobile Crisis throughout the state, and to establish Connecticut’s Mobile Crisis Intervention Services program as a recognized national best practice. Staff at the PIC made a number of contributions in these areas, which are summarized below.

Connecticut continues to engage in efforts to leverage Mobile Crisis to reduce behavioral health emergency department (ED) volume as recommended in a CHDI/Beacon report on behavioral health ED volume. Mobile Crisis providers continue to conduct outreaches to schools to maintain these relationships and provide support during the pandemic to defer referrals to the ED as much as it is safe and appropriate. Additional strategies will be identified in the next fiscal year to continue to strengthen this important collaboration and reduce the number of youth referred from schools to the ED, increase referrals to emerging ED alternatives, and further increase referrals to Mobile Crisis.

State and national consultation was also provided throughout the year. Pandemic relief funds made available to Connecticut through federal COVID-related relief appropriations included several opportunities to expand the crisis-oriented behavioral health continuum, including mobile response services. Mobile Crisis stakeholders, including CHDI and provider representatives, offered consultation to the State of Connecticut on how Mobile Crisis can leverage these opportunities, including expanding to 24/7/365 mobility and serving as a “gatekeeper” for accessing new services that are planned to be added to the crisis continuum of care (i.e., behavioral health urgent care, behavioral health crisis stabilization units/short-term residential). In past years, consultation was provided to other states seeking to establish or expand Mobile Response programs through the Children’s Behavioral Health T.A. Network; however, that ended this year as a result of changes to the TA Center’s federal contract. CHDI, DCF, and some providers have offered consultation to states seeking out Connecticut’s expertise in performance measurement, training, and service delivery.

Two Mobile Crisis videos were completed this year in English and Spanish. One of the videos is a 30 second promotional video and the other is an updated MOA video. These videos can be found at our Mobile Crisis Website. This year we also collaborated with The Project AWARE Team and put together a training on Mobile Crisis Services for their behavioral health curriculum for school staff.

Three manuscripts relating to Connecticut’s youth Mobile Crisis services were completed this year and are currently under review for publication:

- Dubuque-Gallo, C., Kurz, B., Fendrich, M., Becker, J., & Vanderploeg, J. (manuscript under review). Providers’ perspectives on implementing mobile crisis services for children and youth in Connecticut. *Child & Youth Care Forum*.
- Hoge, M.A., Vanderploeg, J.J., Paris, M., Lang, J.M., & Oleseski, C. (manuscript under review). Emergency department use by children and youth with mental health conditions: A health equity agenda. *Community Mental Health Journal*.

Therault, K., Randall, K., Vanderploeg, J.J., & Marshall, T. (manuscript under review). Factors associated with repeated use of a mobile response service for children. *Children and Youth Services Review*.

Goals for Fiscal Year 2022

Despite the circumstances of the past year, Mobile Crisis providers continued to attain goals related to both mobility and response time. COVID-19 brought about a new set of challenges in doing this work, which will continue to be addressed by the PIC, DCF, and Mobile Crisis providers.

Each year, the PIC, in partnership with the providers and DCF, identify opportunities to strengthen the model as well as performance and establish goals for the upcoming year. The PIC will continue to also identify opportunities to provide additional data and analyses that support the providers in ongoing quality improvement. Recommended goals for FY2022 are summarized below.

A. Quality Improvement

1. Continue to maintain volume by engaging in outreach activities, meetings, presentations.
2. Continue to focus on reaching schools, local police, and families that may benefit from Mobile Crisis.
3. Each service area will post mobility at or above the 90% benchmark.
4. Each service area will respond to crises in 45 minutes or less for at least 80% of mobile episodes.
5. Increase Ohio Scales completion rates, particularly the parent discharge measure.
6. Mobile Crisis providers will submit Performance Improvement Plans each quarter with goals in service access, service quality, and outcomes, as well as goals relating to efficient and effective clinical and administrative practices.
7. Continue to monitor changes in episode volume and service delivery related to COVID-19.
8. Analyze data to inform understanding of the use and effectiveness of telehealth.
9. Analyze service delivery and outcomes by race and ethnicity and produce a report with the findings.
10. Continue to focus on self-care activities for the mobile crisis workforce.

B. Standardized Training

1. Maintain or increase the number of training modules that are led by Mobile Crisis managers or supervisors.
2. Consider alternative training approaches to ensure that clinicians complete all training modules in a timely manner.
 - Continuation of Mobile Crisis Training Institute Week during which time most or all modules will be offered during this lower-volume time of year. This will supplement, not replace, existing offerings.
 - Continuation of a web-based Mobile Crisis training module to improve access and decrease cost for service providers.

C. Developing the Mobile Crisis Clinical Model

1. The PIC will work with DCF to provide consultation to one or more states seeking to develop or enhance their state's mobile crisis program, or to the federal government in their support of Mobile Crisis and other crisis-oriented services.

D. Support the implementation of Connecticut Public Act 13-178 components that pertain to Mobile Crisis

1. Support Mobile Crisis expansion by using data to inform how best to increase effective service delivery, including cost-effectiveness analyses, hourly breakdown to better understand patterns of Mobile Crisis use, and evaluation of progress in quarterly service area performance goals.
2. Continue to provide training to Mobile Crisis providers that aligns with the goals in the state's Children's Behavioral Health Plan.

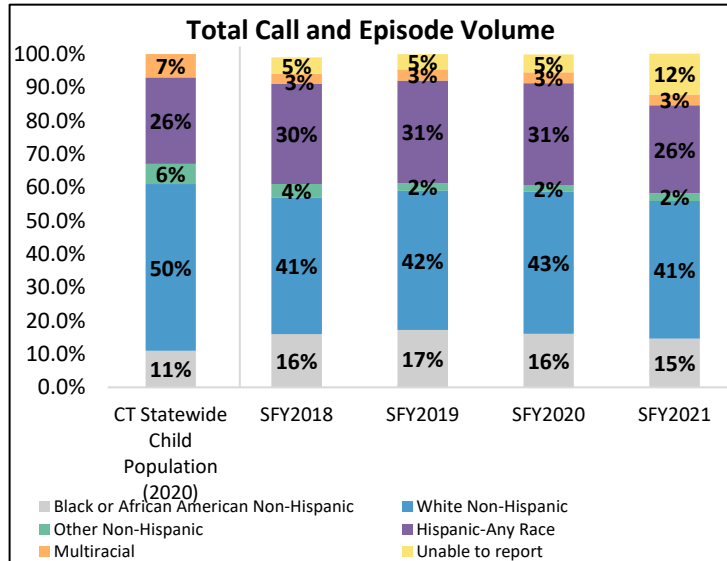
SFY 2021 Annual RBA Report Card: Mobile Crisis Intervention Services

Quality of Life Result: Connecticut’s children will live in stable environments, safe, healthy and ready to lead successful lives.

Contribution to the Result: The Mobile Crisis services provide an alternative, community based intervention to youth visits to hospital emergency rooms, inpatient hospitalizations and police calls that could remove them from their home and potentially negatively impact their growth and success. Mobile Crisis providers are expected to respond to all episodes of care. Partners with DCF include Child and Health Development Institute (CHDI) as the Performance Improvement Center.

Program Expenditures: Estimated SFY2021	State Funding: \$11,970,297
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How Much Did We Do?



	FY2018	FY2019	FY2020	FY2021
Mobile Crisis Episode	14,585	15,306	12,106	10,549*
2-1-1 Only	5,380	5,209	4,442	3,213
Total	19,965	20,515	16,548	13,762

*Includes 1 Information & Referral call. 6 Crisis Response Follow-up calls

Story Behind the Baseline: In SFY 2021, there were 13,762 total calls to the 211 Call center, which was 16.8% less than SFY 2020. The number of Mobile Crisis episodes in SFY 2021 was 10,549, 12.9% lower than SFY 2020 (12,106). This year was significantly affected by the COVID-19 pandemic. Though Mobile Crisis was still operational, there was a significant decrease in call volume due in large part to many schools utilizing some degree of remote learning. Though schools re-opened as the school year went on and call volume increased, it still has not reached pre-pandemic levels. This year the percentage breakdown of race/ethnicity was relatively similar to last year, though with a decrease in Hispanic children served and an increase in those whose race was not reported.

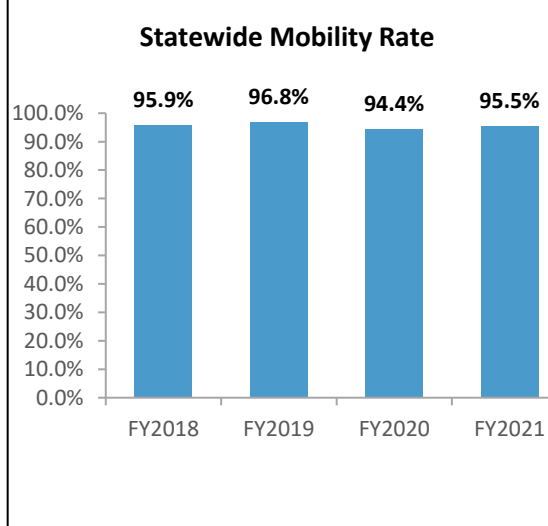
Trend: ↓

Episodes per Child			
	DCF Child	Non-DCF Child	Total
FY2018			
1	767 (71.3%)	5281 (79.2%)	6048
2	190 (17.7%)	948 (14.2%)	1138
3	72 (6.7%)	265 (4.0%)	337
4 or more	47 (4.4%)	173 (2.6%)	220
FY2019			
1	738 (69.8%)	5857 (79.9%)	6595
2	185 (17.5%)	1006 (13.7%)	1191
3	70 (6.6%)	286 (3.9%)	356
4 or more	65 (6.1%)	185 (2.5%)	250
FY2020			
1	562 (71.2%)	4210 (81.1%)	4772
2	126 (16.0%)	670 (12.9%)	796
3	61 (7.7%)	202 (3.9%)	263
4 or more	40 (5.1%)	107 (2.1%)	147
FY2021			
1	390 (72.0%)	3791 (82.0%)	4181
2	96 (17.7%)	570 (12.3%)	666
3	37 (6.8%)	153 (3.3%)	190
4 or more	19 (3.5%)	109 (2.4%)	128

Story Behind the Baseline: In SFY 2021, of the 5,165* children served by Mobile Crisis, 80.9% (4,181) had only one episode of care, 93.8% (4,847) had one or two episodes. These are higher than rates in SFY2020 - 74.7% (4,772) and 87.2% (5,568) respectively. This data indicates the effectiveness of Mobile Crisis in reducing the need for additional mobile crisis services. The proportion of children with 3 and 4 or more episodes of care were proportionally similar to last year.

Trend: →

*Note: Only children that had their DCF or non DCF status identified were reported

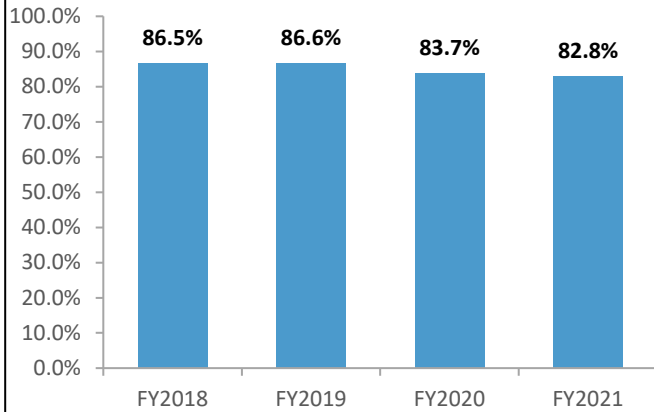


Story Behind the Baseline: Mobile responsiveness is a key feature of Mobile Crisis service delivery which has a 90% mobility benchmark. The statewide mobility rate was estimated at 50% prior to re-procurement of the service. In FY2021, the statewide mobility rate was 95.5%, continuing to exceed the benchmark by a comfortable margin.

Trend: →

How Well Did We Do?

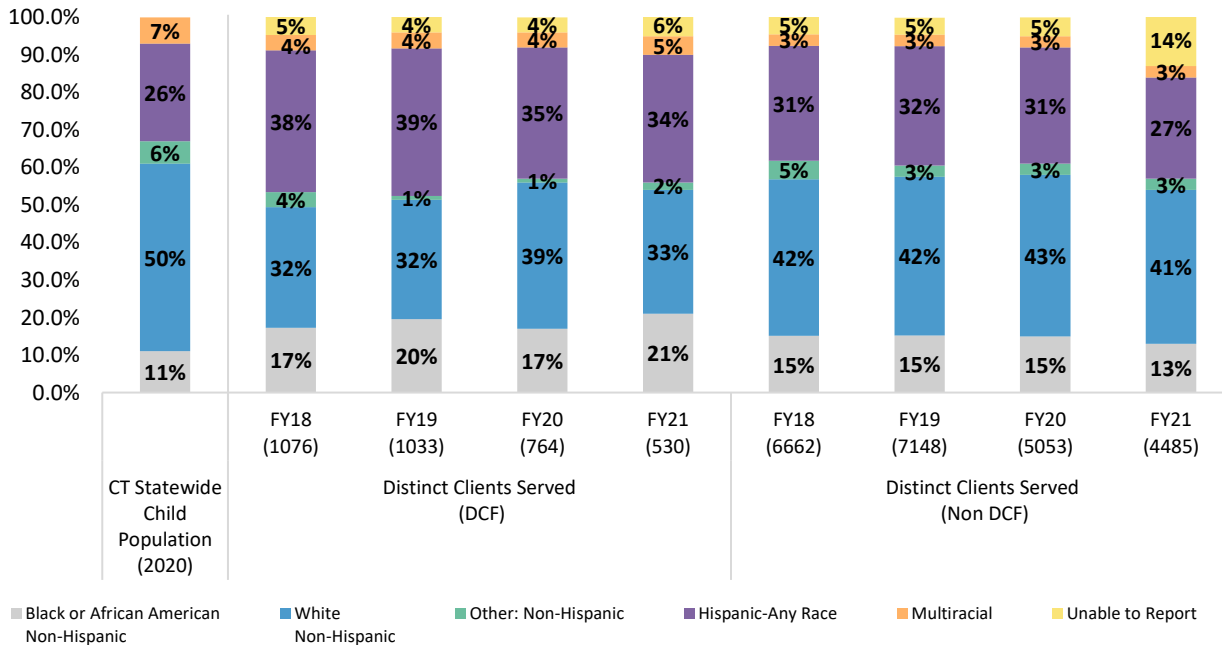
Statewide Response Time Under 45 Minutes



Story Behind the Baseline: Since SFY 2011 mobile crisis has consistently exceeded the 80% benchmark for a 45 minute or less mobile response to a crisis. For SFY 2021, 82.8% of all mobile responses were achieved within the 45 minute mark. **The median response time for SFY 2020 was 31 minutes.** Though there was a slight decrease in responses under 45 minutes, this is likely attributable to the impact of the pandemic. While providers continued to offer mobile responses in homes and community settings, many episodes received a phone or video telehealth response due to COVID-19 related concerns and closures. As the year went on, telehealth responses became less common, but still occurred as needed. For those episodes where clinicians did go into homes or the community, it may have took extra time to coordinate with families in order to take proper precautions. Clinicians were also at times responding from their homes due to office closures, often resulting in longer travel times. Despite these challenges, Mobile Crisis continues to be a highly responsive statewide service system that is immediately present to engage and deescalate a crisis and return stability to the child and family, school or other setting they are in.

Trend: ↓

Race & Ethnicity of DCF & Non DCF Clients Served

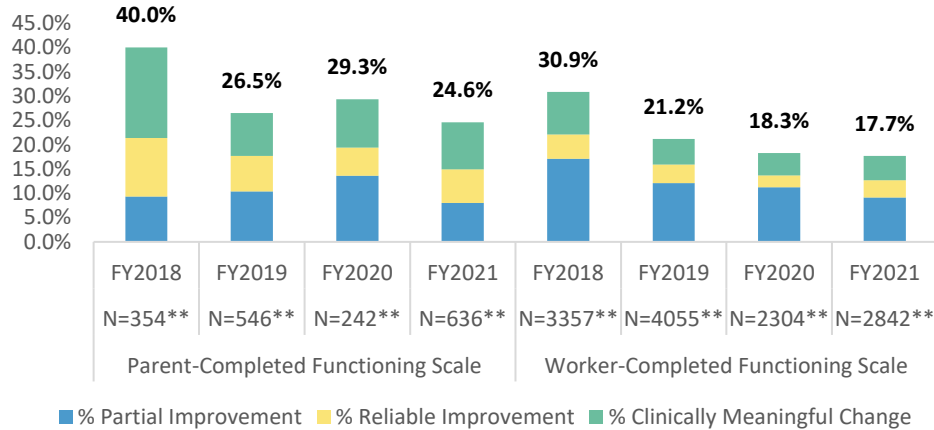


Story Behind the Baseline: Over the 4 years reviewed, slightly higher proportions of Hispanic and Black children are served by Mobile Crisis than are reflected in the overall state population (for both DCF and Non-DCF involved children^{1,2}), while white children (both DCF and Non-DCF involved) utilize the service at lower rates. Both Hispanic and Black DCF involved children utilize Mobile Crisis at higher rates than Non-DCF children, while White Non-DCF involved children utilize Mobile Crisis at higher rates than their DCF counterparts. For DCF-involved children, there were slight decreases in the percentage of Black and Hispanic children served compared to previous years, and a significant increase in those whose race is not reported.

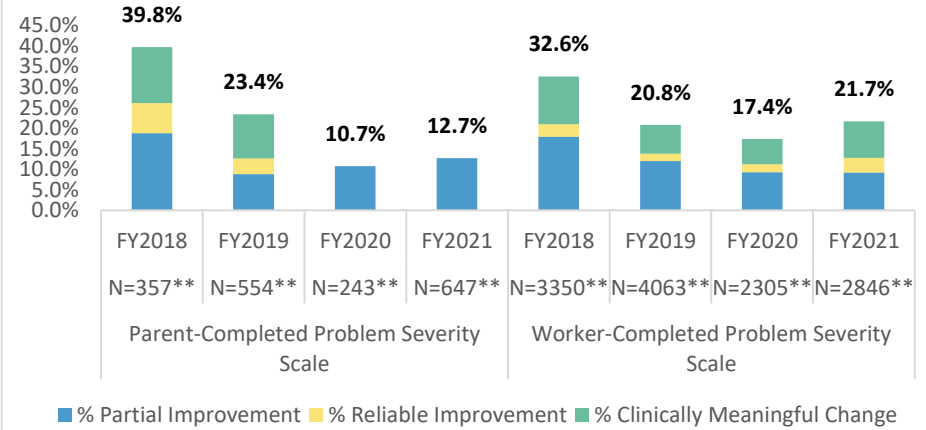
Notes: ¹Only children having their DCF or non-DCF status as well as race/ethnicity identified were included. ²For the Distinct Clients served some had multiple episodes as identified above in Episodes per Child.

Is Anyone Better Off?

Improvement in Functioning as Measured by the Ohio Scales



Improvement in Problem Severity as Measured by the Ohio Scales



Story Behind the Baseline: The Ohio Youth Problems, Functioning, and Satisfaction Scales (Ohio Scales) assesses behavioral health service outcomes. In FY2021, statistically significant changes were observed in both functioning and problem severity as measured by both parent and worker-completed Ohio Scales follow a Mobile Crisis response to a child’s episode of care. The proportion of children demonstrating some level of change in symptoms or functioning, from partial improvement to clinically meaningful change, ranged from 12.7% as measured by the parent-completed Problem Severity Scale to 24.6% as measured by the parent-completed Functioning Scale.

Trend: →

¹Note: Statewide Ohio Scales Scores are based on paired intake and discharge scores. Discharge scales only collected for episodes 5 days or longer. ²Note: Statistical Significance: † .05-.10; * P < .05; **P < 0.01

Proposed Actions to Turn the Curve:

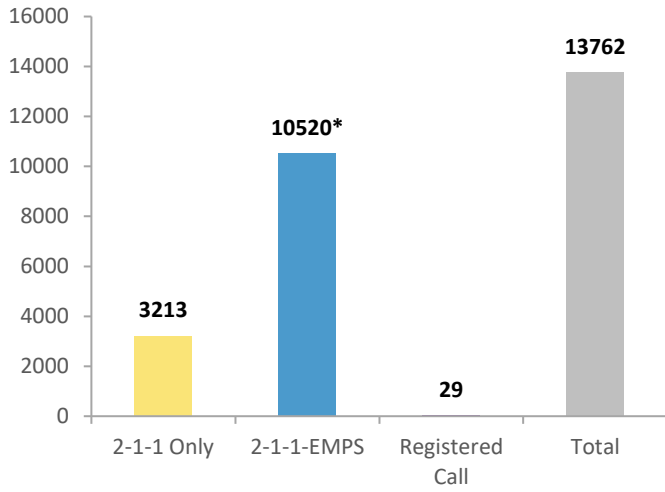
- Mobile Crisis providers will work with schools and Emergency Departments to reduce school utilization of ED’s and increase utilization of Mobile Crisis.
- Continue outreach to Police Departments to support their ongoing collaboration with Mobile Crisis.
- Continue to increase the parent completion rates for the Ohio Scales.
- Review with each provider their self-care activities to support their clinical staff in being continuously effective in delivering Mobile Crisis services.
- Continue to review RBA report cards on a quarterly basis with each Mobile Crisis provider, with a focus on the racial and ethnic distributions of the children served in each region.
- Continue to monitor how providers are addressing COVID-19 challenges and providing additional supports or resources if needed.

Data Development Agenda:

- Work with providers to develop data regarding school, emergency department, police department utilization of Mobile Crisis.
- Work with providers to identify and accurately capture changes in volume and service delivery due to COVID-19.
- Though Mobile Crisis has largely returned to in-person responses, the data system now has the capacity to track telehealth responses should they arise in the future.”

Section II: Mobile Crisis Statewide/Service Area Dashboard

Figure 1. Total Call Volume by Call Type



*Includes 1 Information & Referral call, 6 Crisis Response Followup calls

Figure 2. Total Call Volume per Quarter by Call Type

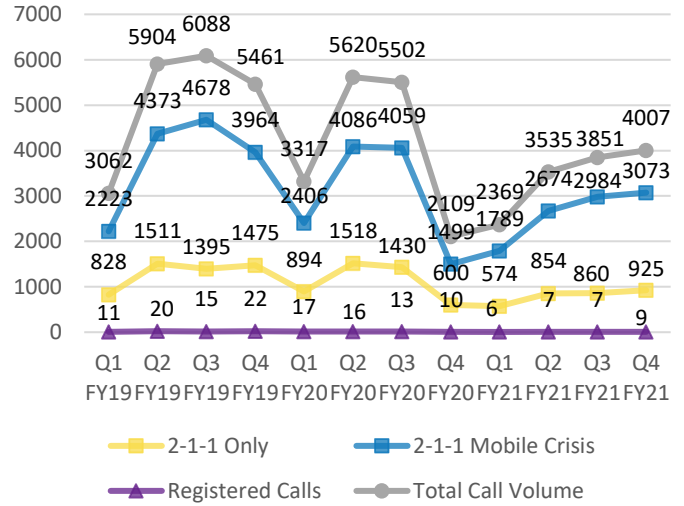
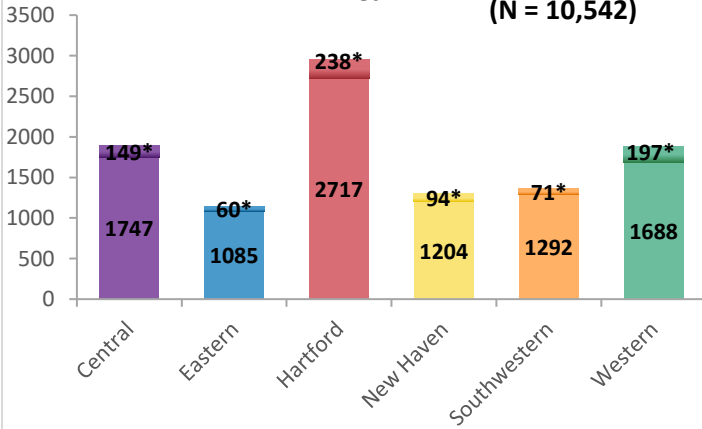


Figure 3. Mobile Crisis Episodes by Service Area (N = 10,542)



*After Hours Calls that resulted in episodes

Figure 4. Mobile Crisis Episodes per Quarter by Service Area

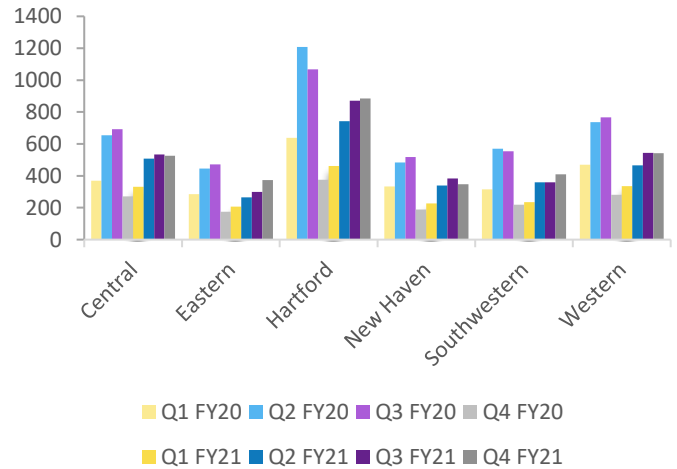


Figure 5. Number Served Per 1,000 Children

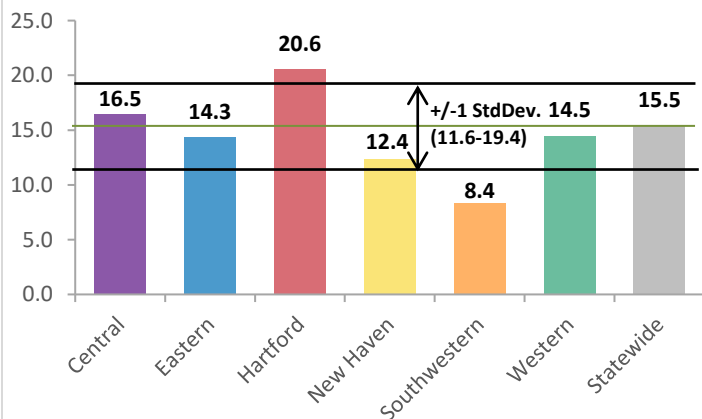


Figure 6. Number Served per 1,000 Children per Quarter by Service Area

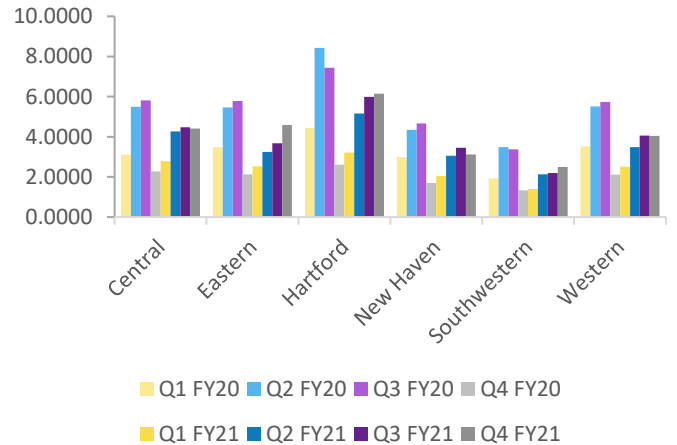


Figure 7. Number Served per 1,000 Children in Poverty

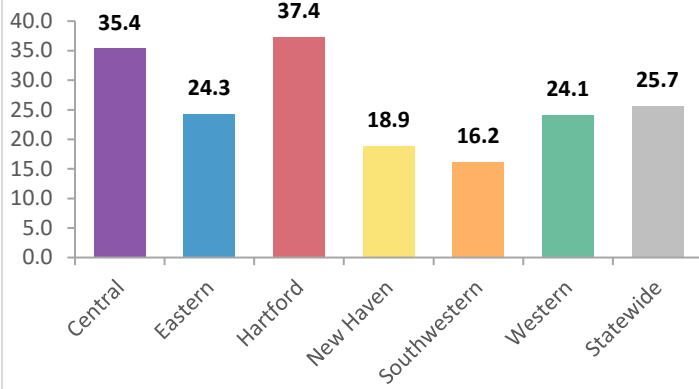


Figure 8. Number Served per 1,000 Children in Poverty per Quarter by Service Area

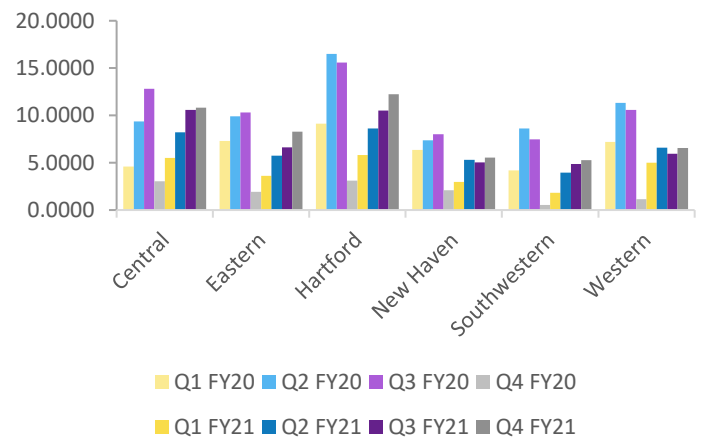
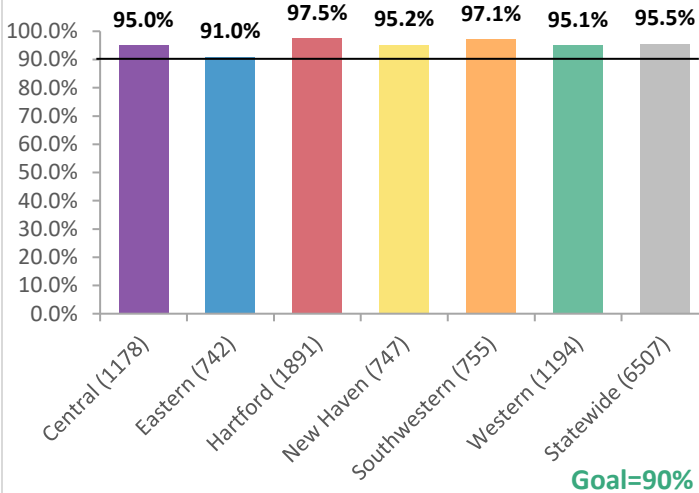


Figure 9. Mobile Response (Mobile and Deferred Mobile) by Service Area



Note: Total counts of 2-1-1 Mobile response recommendations are in parentheses.

Figure 10. Mobile Response (Mobile and Deferred Mobile) per Quarter by Service Area

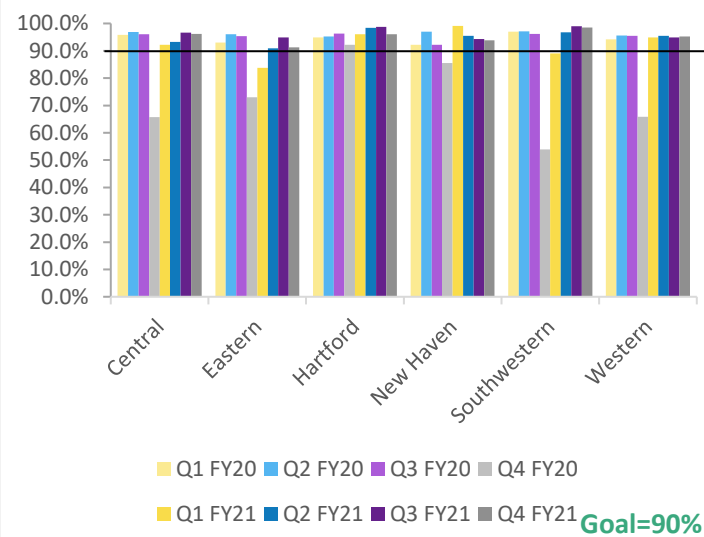
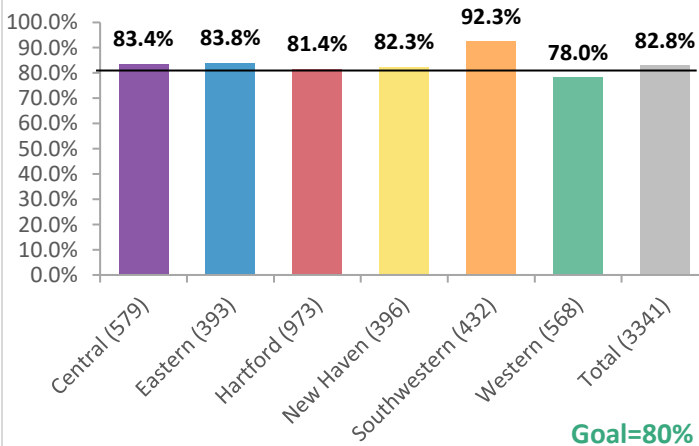
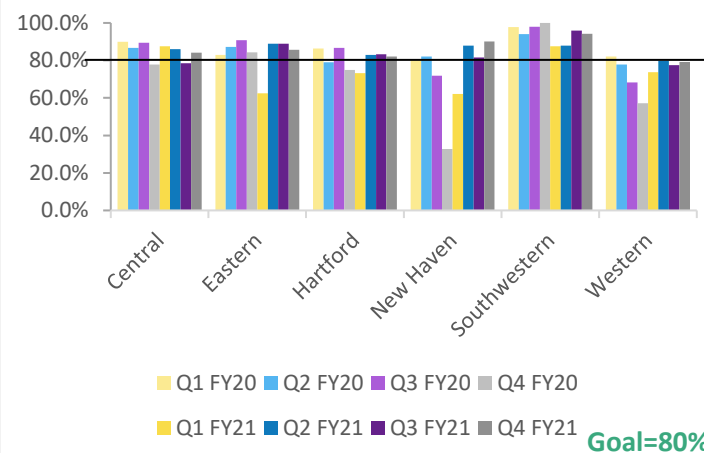


Figure 11. Total Mobile Episodes with a Response Time Under 45 Minutes



Note: Counts of mobile episodes under 45 mins. are in parentheses.

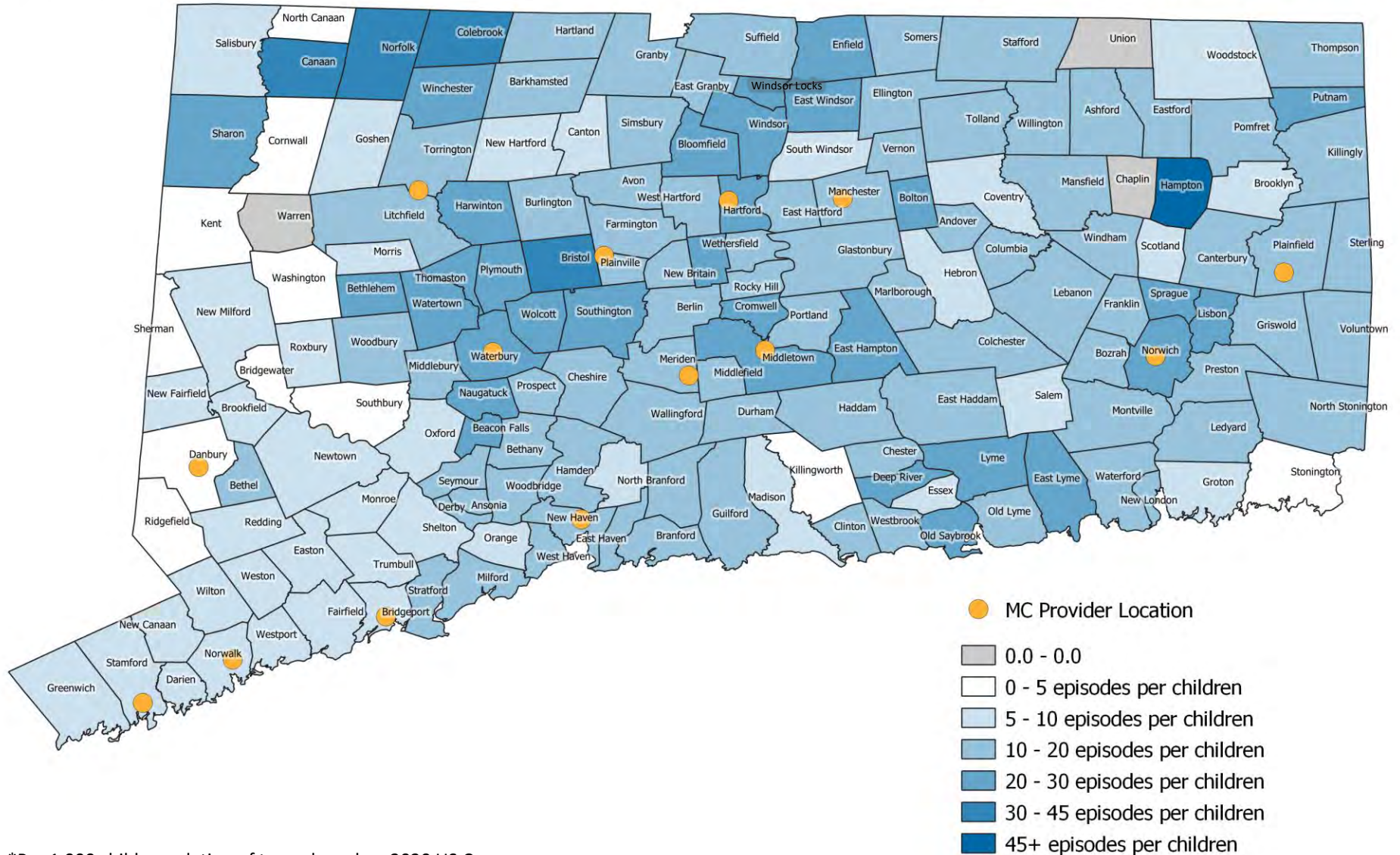
Figure 12. Total Mobile Episodes with a Response Time Under 45 Minutes per Quarter by Service Area



Section III: Mobile Crisis Volume

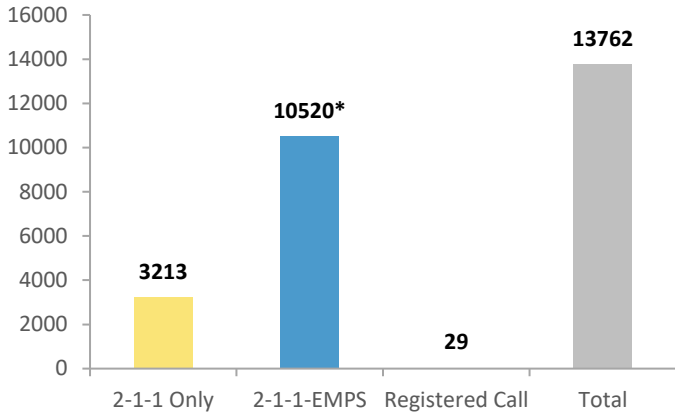
Figure 13. Map – FY2021 Mobile Crisis Episode Volume by Town*

Mobile Crisis Episodes per 1,000 Children by Town (FY2021)



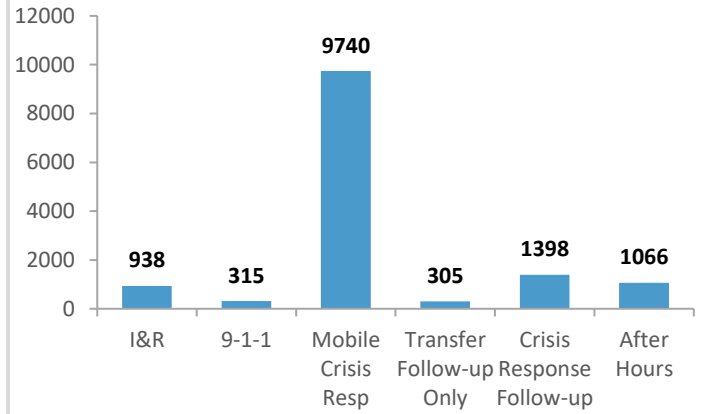
*Per 1,000 child population of town, based on 2020 US Census.

Figure 14. Total Call Volume by Call Type



*1 Information & Referral call, 6 ended as Crisis Response Follow-up calls

Figure 15. Statewide 2-1-1 Disposition Frequency*



*1 call missing disposition information

Figure 16. Call and Episode Volume Over Time

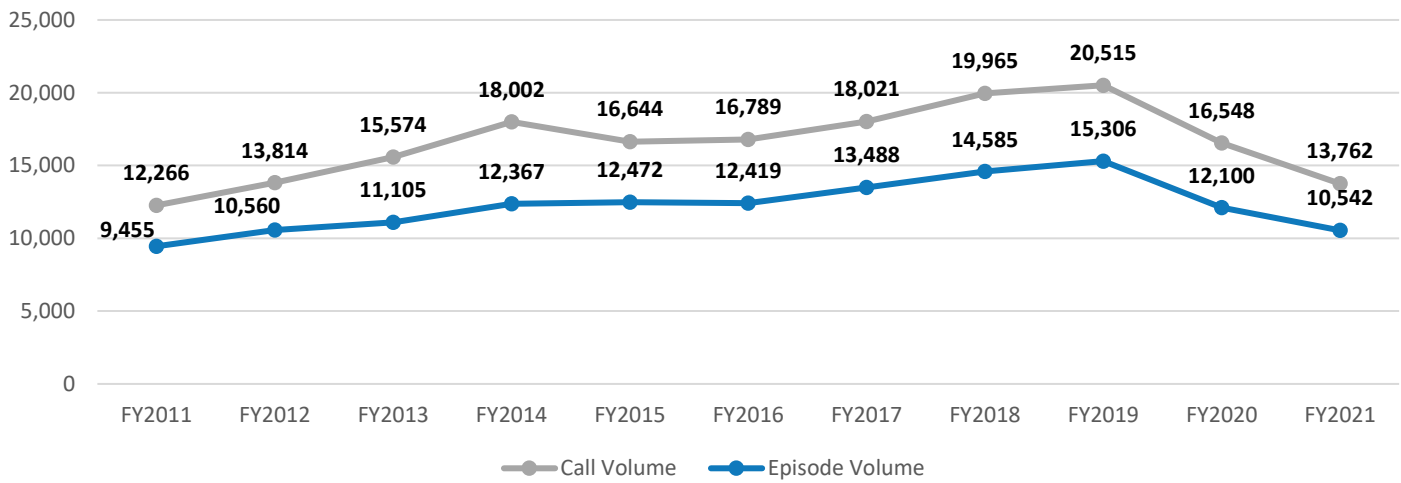
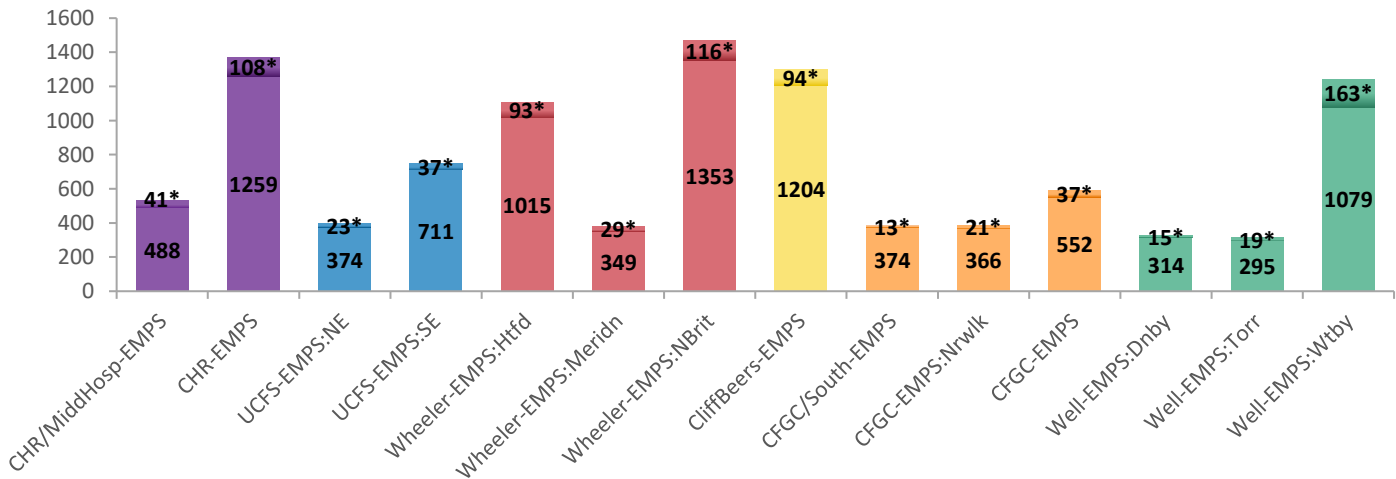


Figure 17. Mobile Crisis Response Episodes by Provider (N = 10,542)



*After Hours Calls

Figure 18. Number Served per 1,000 Children by Provider

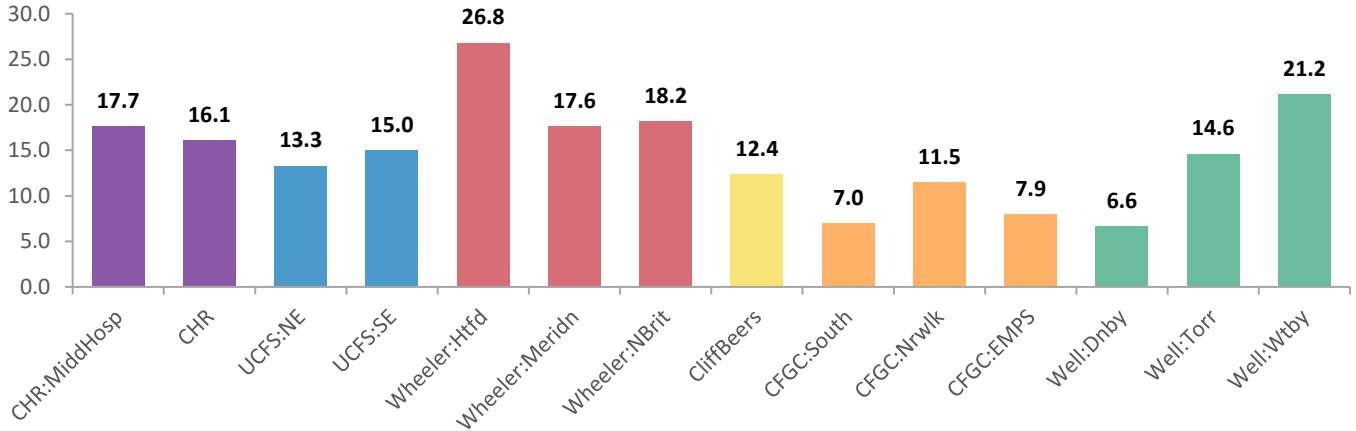


Figure 19. Episode Intervention Crisis Response Types by Service Area

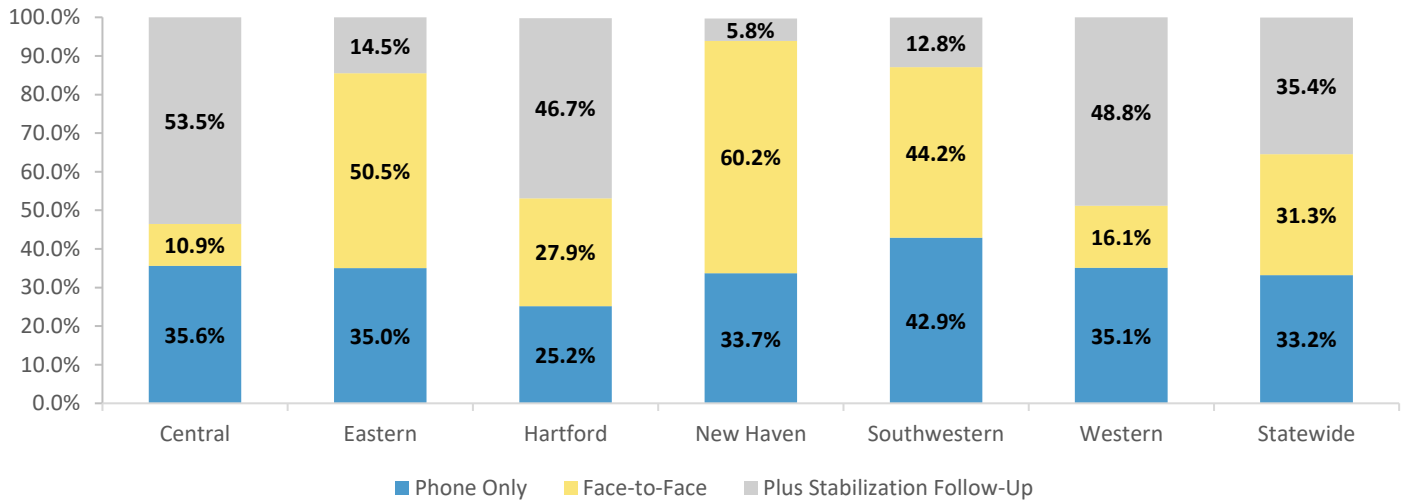
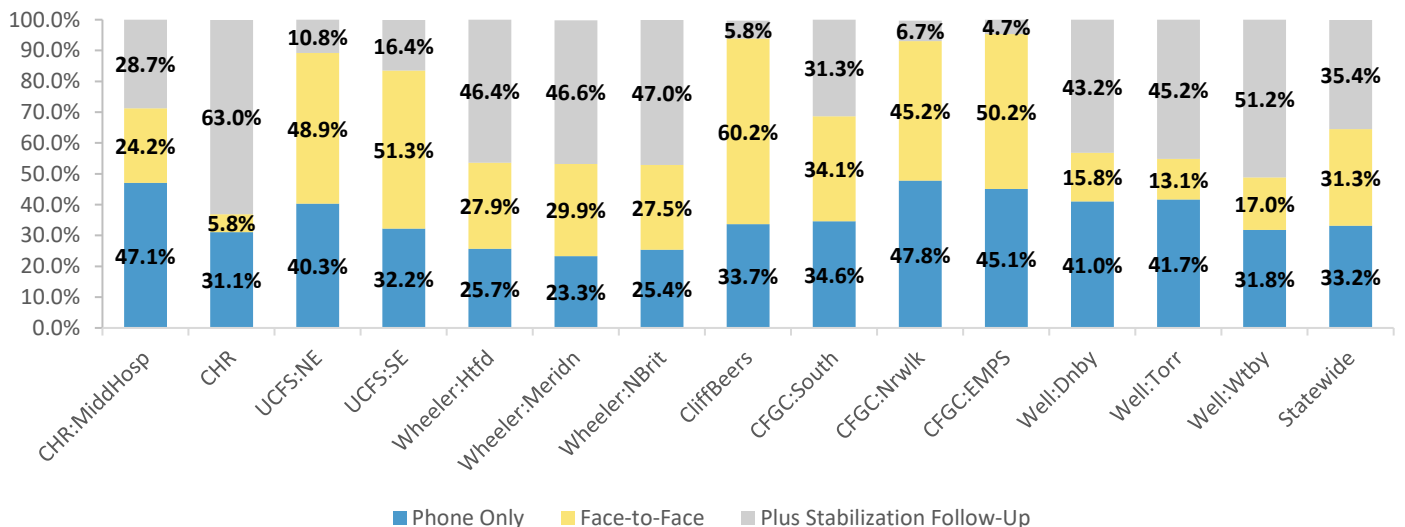


Figure 20. Episode Intervention Crisis Response Type by Provider



Section IV: Demographics⁷

Figure 21. Sex of Children Served Statewide*

(N = 10,542)

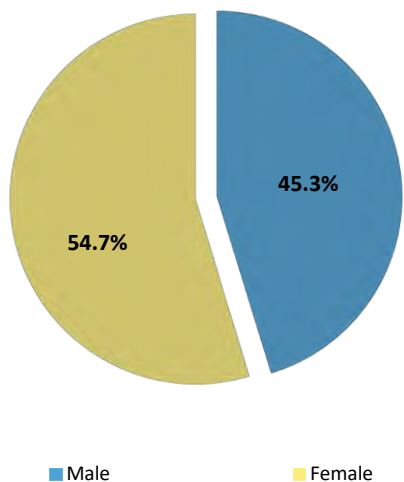


Figure 22. Age Groups of Children Served Statewide

(N = 10,542)

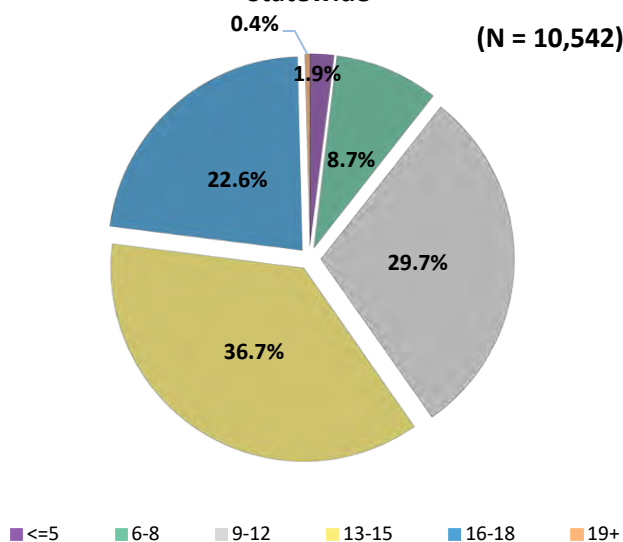


Figure 23. Ethnic Background of Children Served Statewide[^]

(N = 10,345)

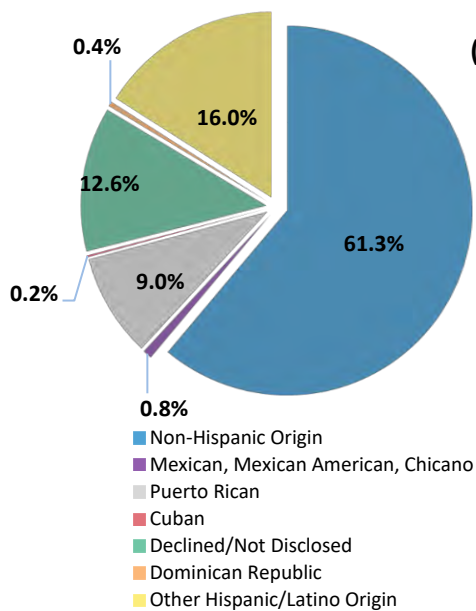
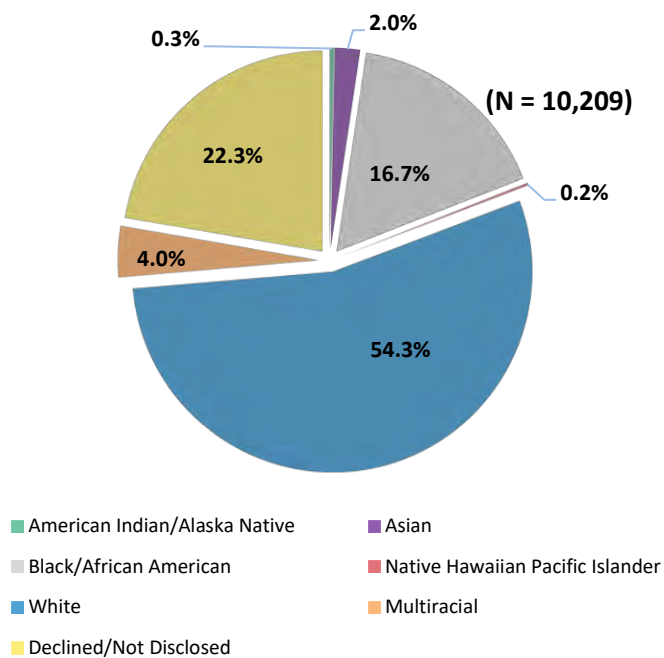


Figure 24. Race of Children Served Statewide

(N = 10,209)



*Per question regarding sex assigned at birth.

[^]Note: Data is collected in alignment with questions from the U.S. Census. According to the U.S. Census Bureau, “[P]eople who identify their origin as Spanish, Hispanic, or Latino may be of any race...[R]ace is considered a separate concept from Hispanic origin (ethnicity) and, wherever possible, separate questions should be asked on each concept.”

⁷ Data reported in this section refer to percentages of *episodes*. Note that children may be counted more than once if they received more than one episode of care within the fiscal year.

Figure 25. Client's Type of Health Insurance at Intake Statewide

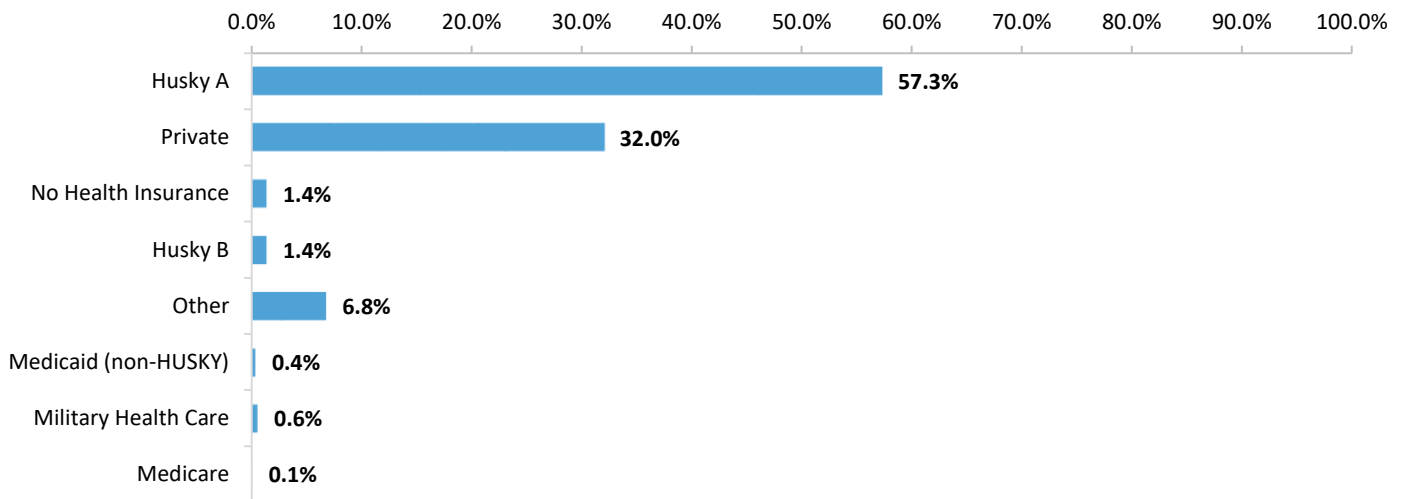
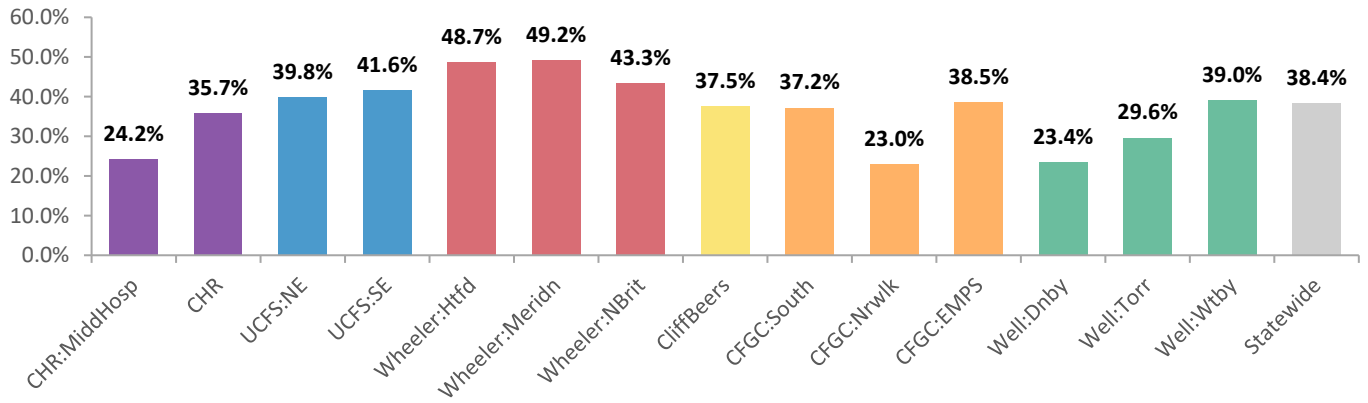
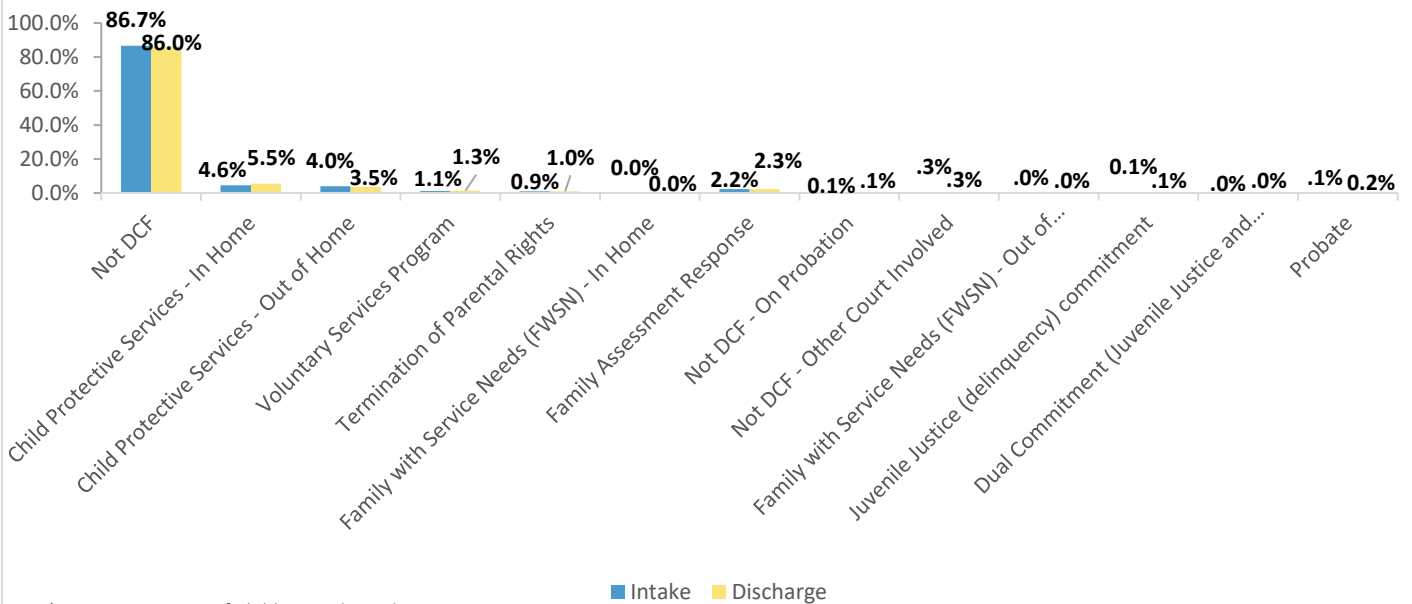


Figure 26. Families that Answered "Yes" TANF* Eligible



*TANF=Temporary Assistance for Needy Families

Figure 27. Client DCF* Status at Intake and Discharge Statewide



*DCF=Department of Children and Families

Section V: Clinical Functioning

Figure 28. Top Six Client Primary Presenting Problems by Service Area

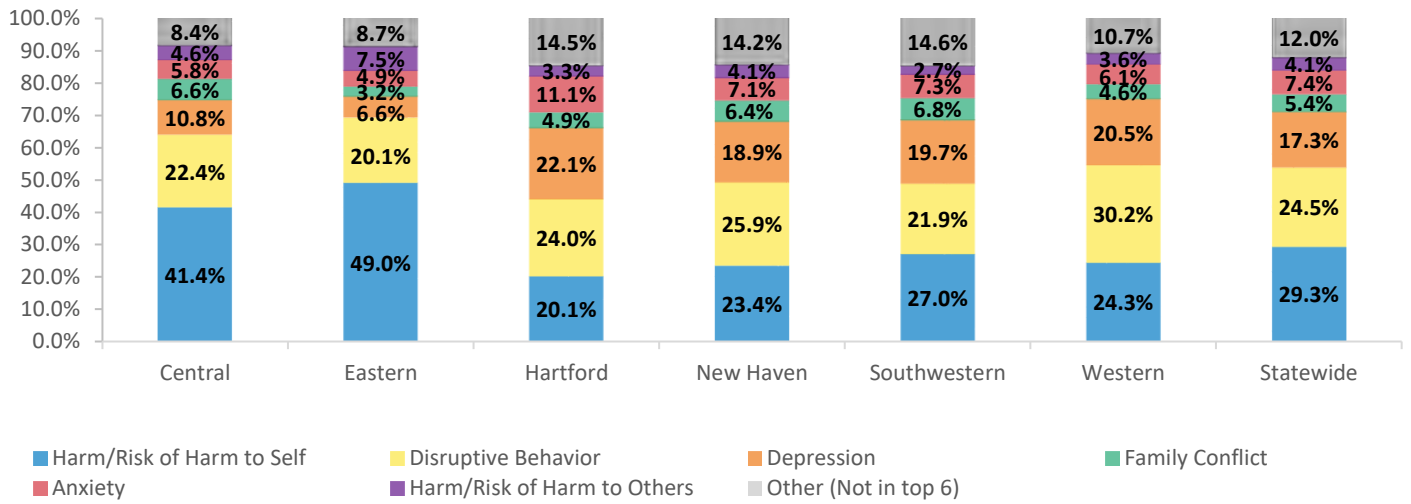
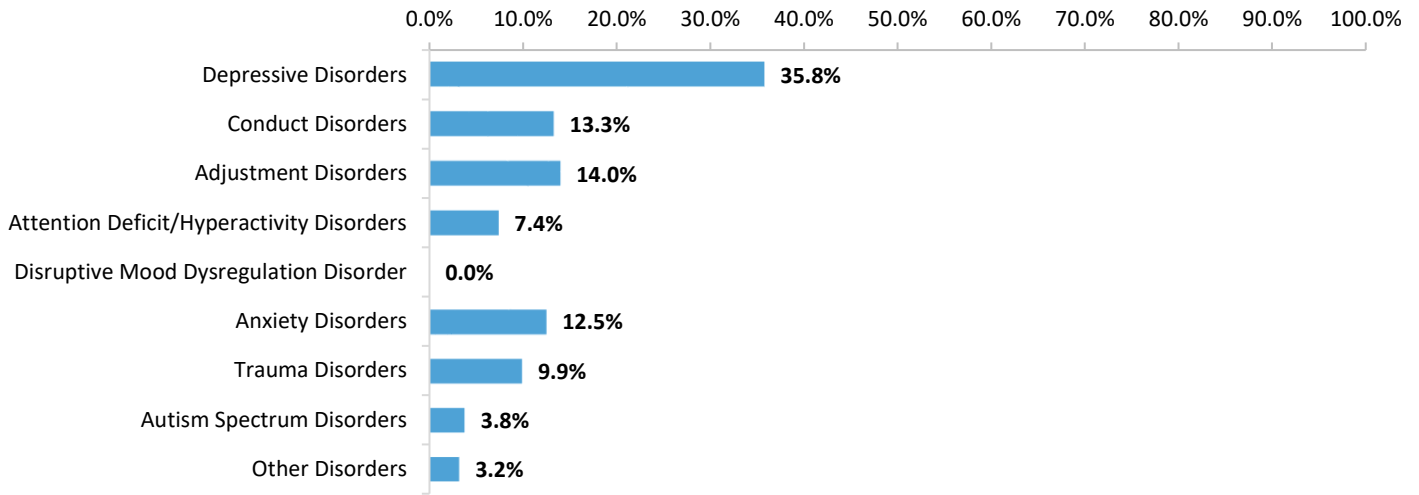


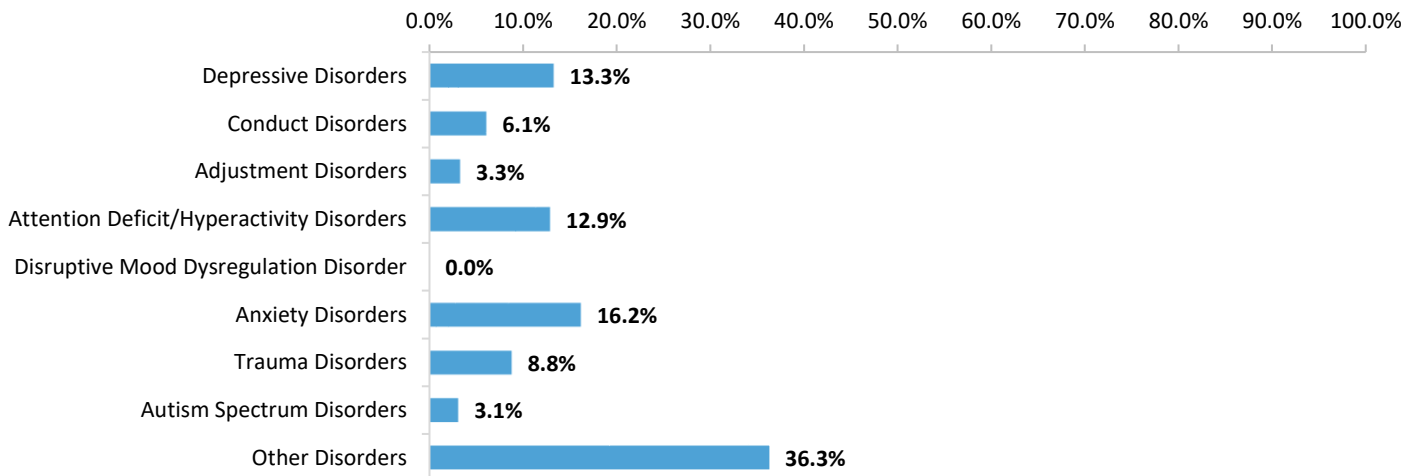
Figure 29. Distribution of Primary Diagnosis Categories* at Intake Statewide



*multiple diagnostic codes combined within category (see "Appendix B" for list)

Note: Excludes missing data

Figure 30. Distribution of Client Secondary Diagnosis Categories* at Intake Statewide



*multiple diagnostic codes combined within category (see "Appendix B" for list)

Note: Excludes missing data

Figure 31. Top 6 Primary Diagnostic Categories at Intake by Service Area

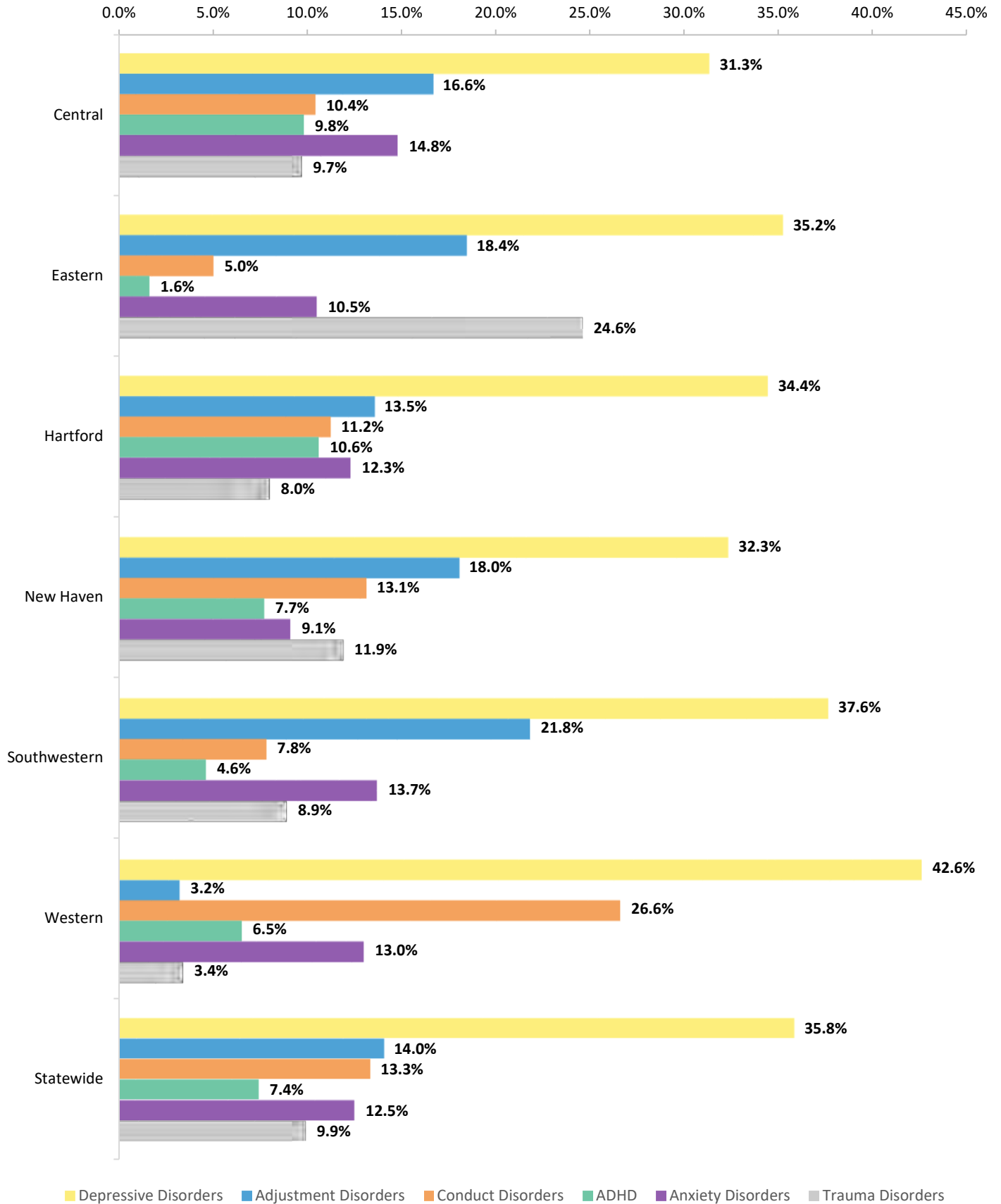


Figure 32. Top 6 Client Secondary Diagnostic Categories at Intake by Service Area

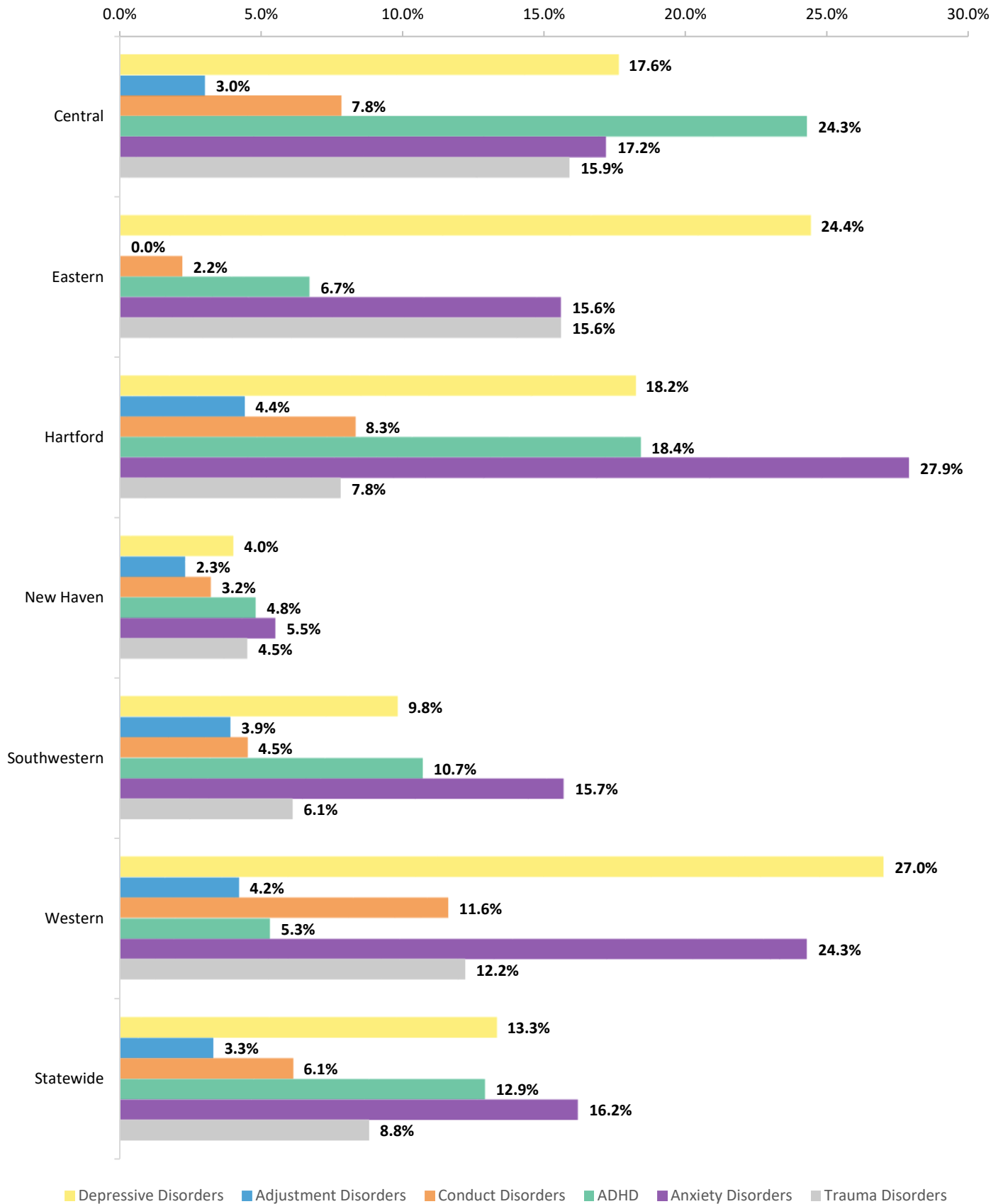
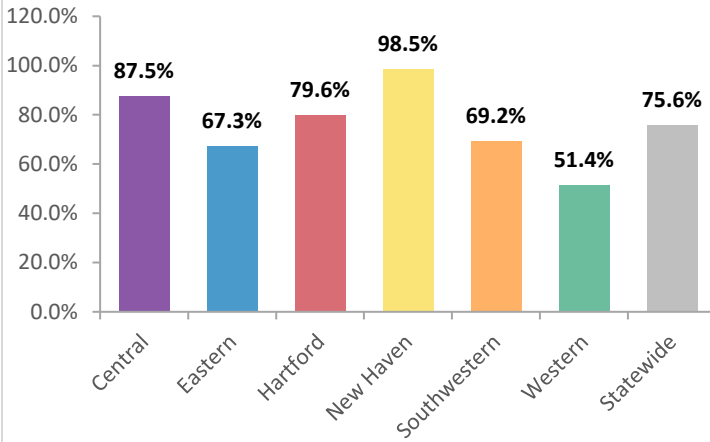


Figure 33. Children Meeting SED* Criteria by Service Area



*Serious Emotional Disturbance

Figure 34. Children with Trauma Exposure Reported at Intake by Service Area

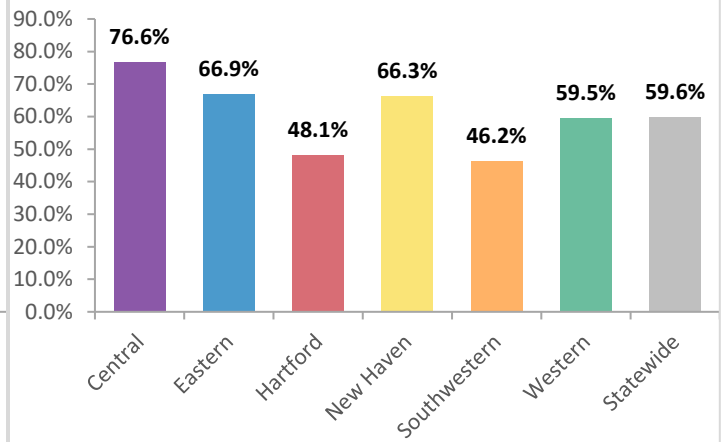


Figure 35. Type of Trauma Reported at Intake by Service Area

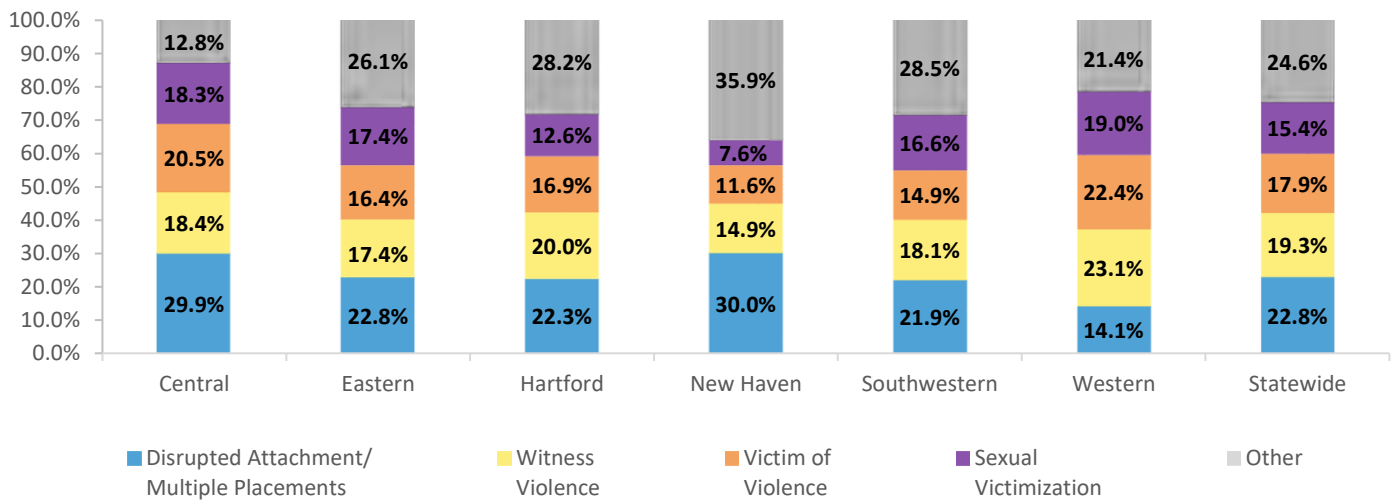


Figure 36. Clients Evaluated in an Emergency Dept. One or More Times in the Six Months Prior and During an Episode of Care

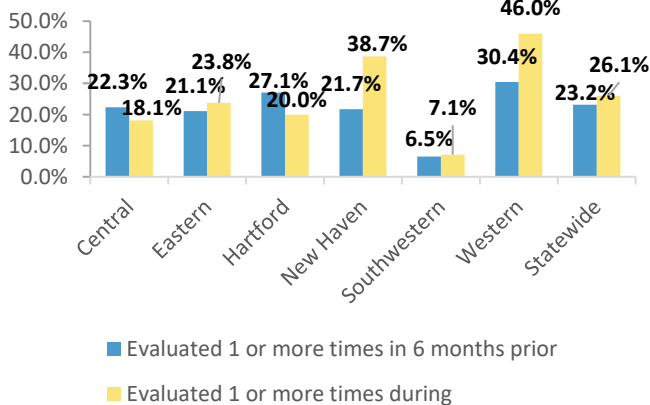


Figure 37. Clients Admitted to a Hospital (Inpatient) for Psychiatric or Behavioral Health Reasons One or More Times in His/Her Lifetime, in Six Months Prior and During the Episode of Care

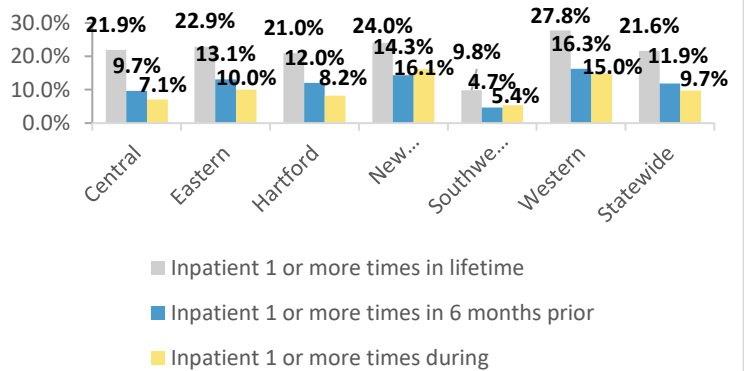


Figure 38. Clients Placed in an Out of Home Setting One or More Times in His/Her Lifetime and in the Six Months Prior to the Episode of Care

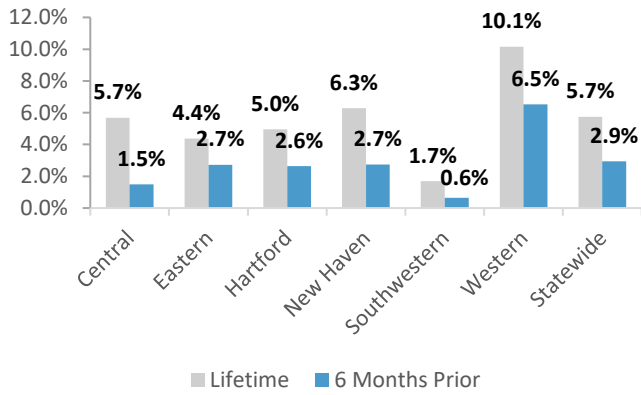


Figure 39. Clients Reported Problems with Alcohol and/or Drugs in His/Her Lifetime, in Six Months Prior to and During the Episode of Care

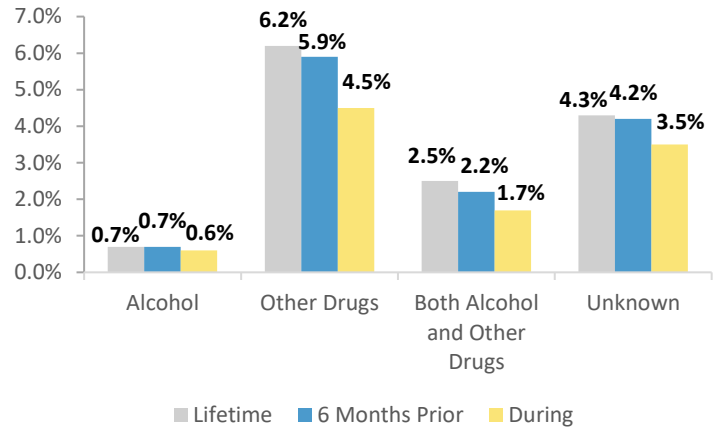


Figure 40. Type of Parent/Guardian Service Need Statewide

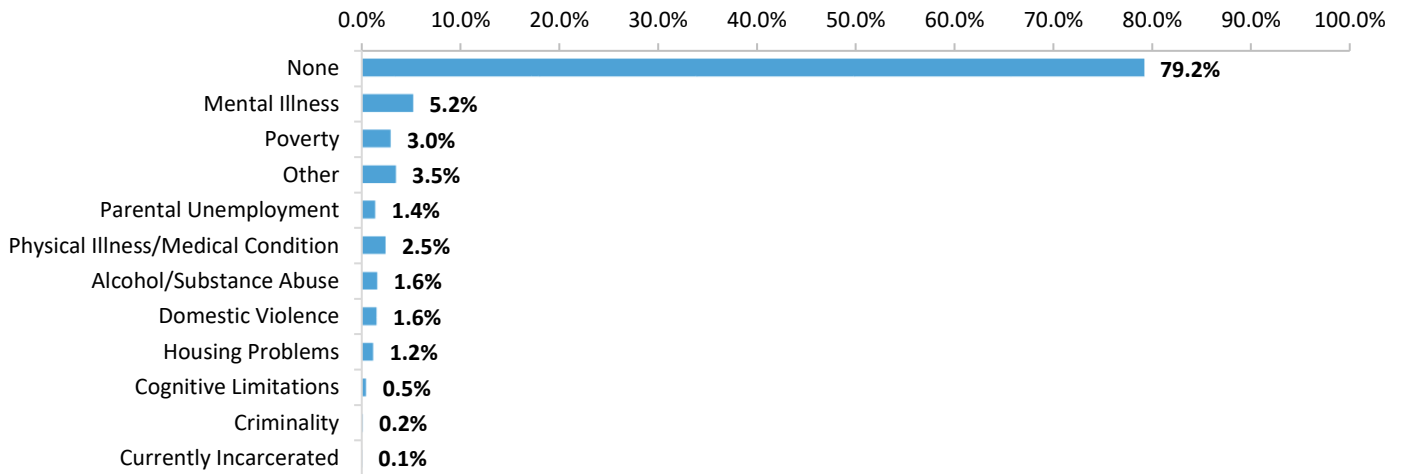


Figure 41. How Capable of Dealing with the Child's Problem Does the Parent/Guardian Feel at Intake and Discharge Statewide

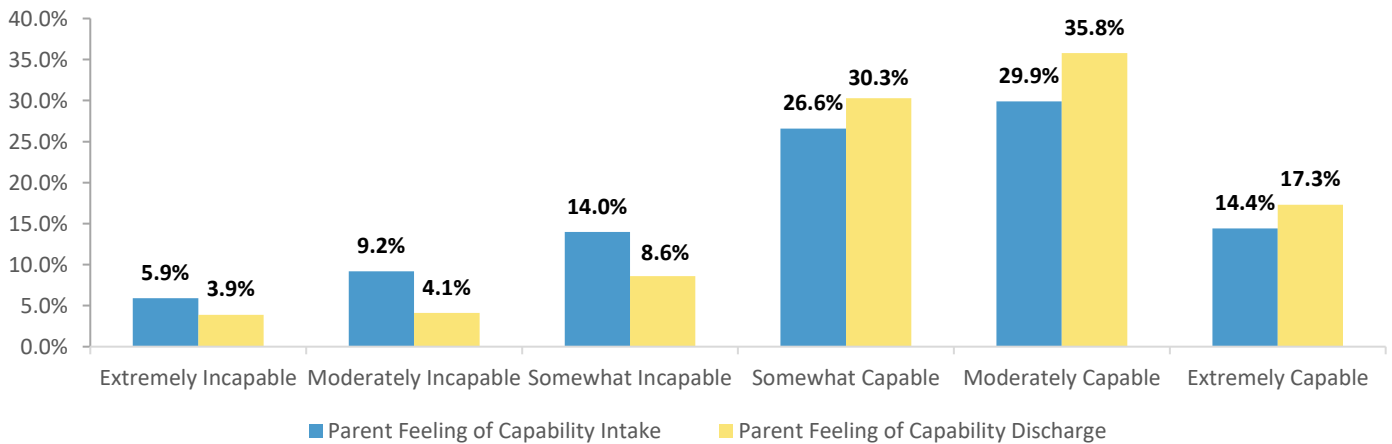


Figure 42. Statewide Parent/Guardian Rating of Client's Attendance at School During the Episode of Care (compared to pre-admission)

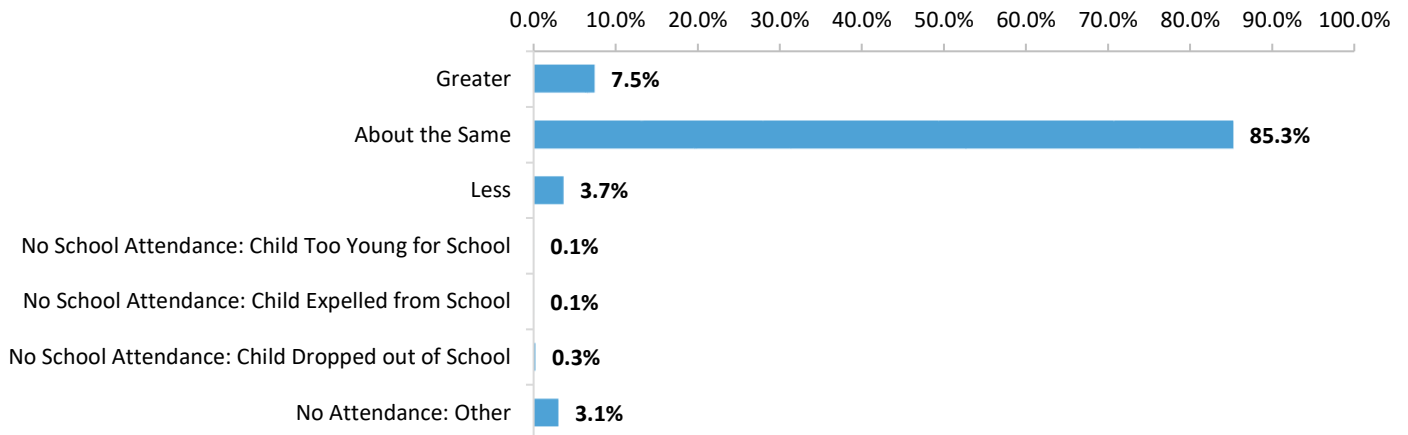


Figure 43. Clients Suspended or Expelled from School in the Six Months Prior to and During the Episode of Care

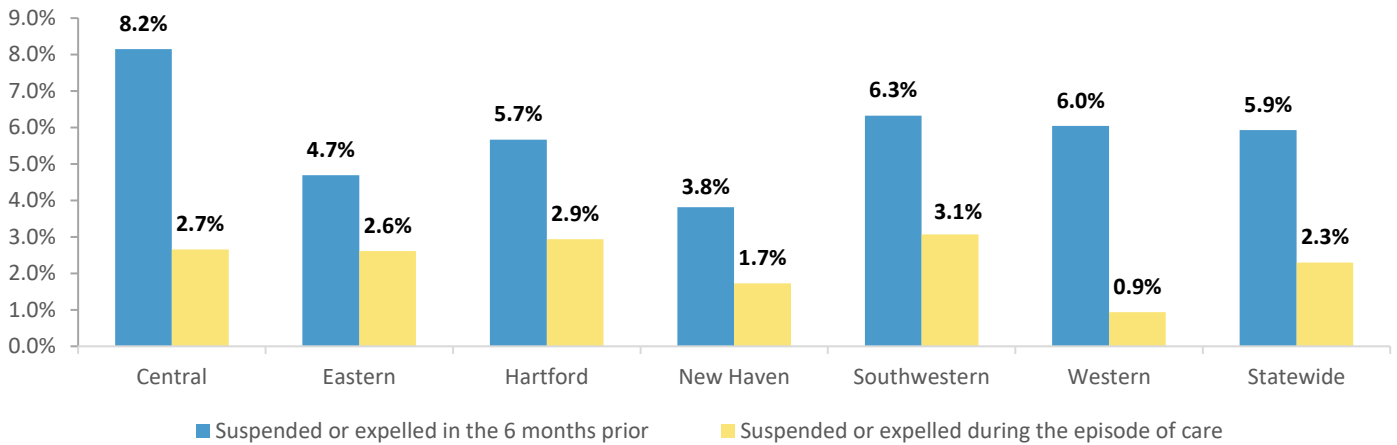


Figure 44. School Issues at Intake that have a Negative Impact on Client's Functioning at School by Service Area

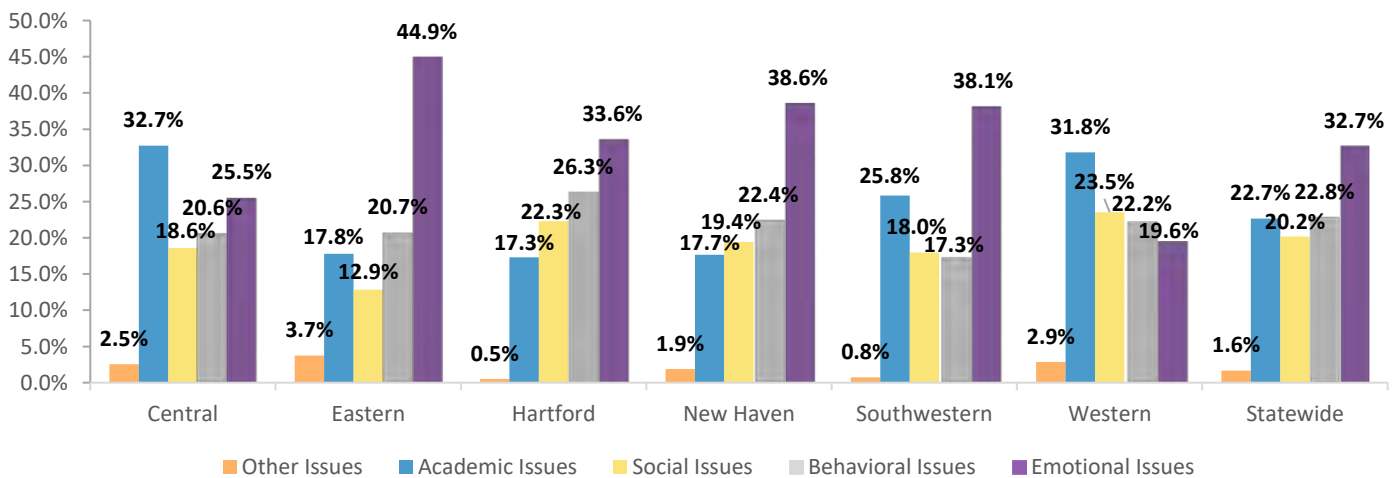
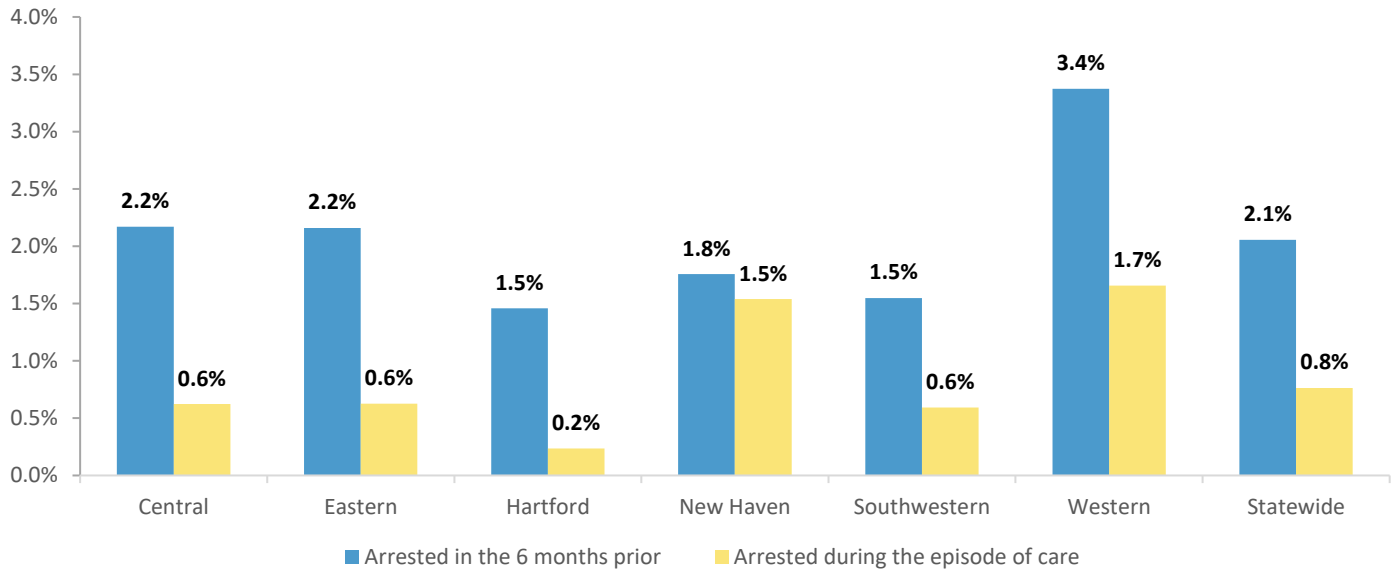
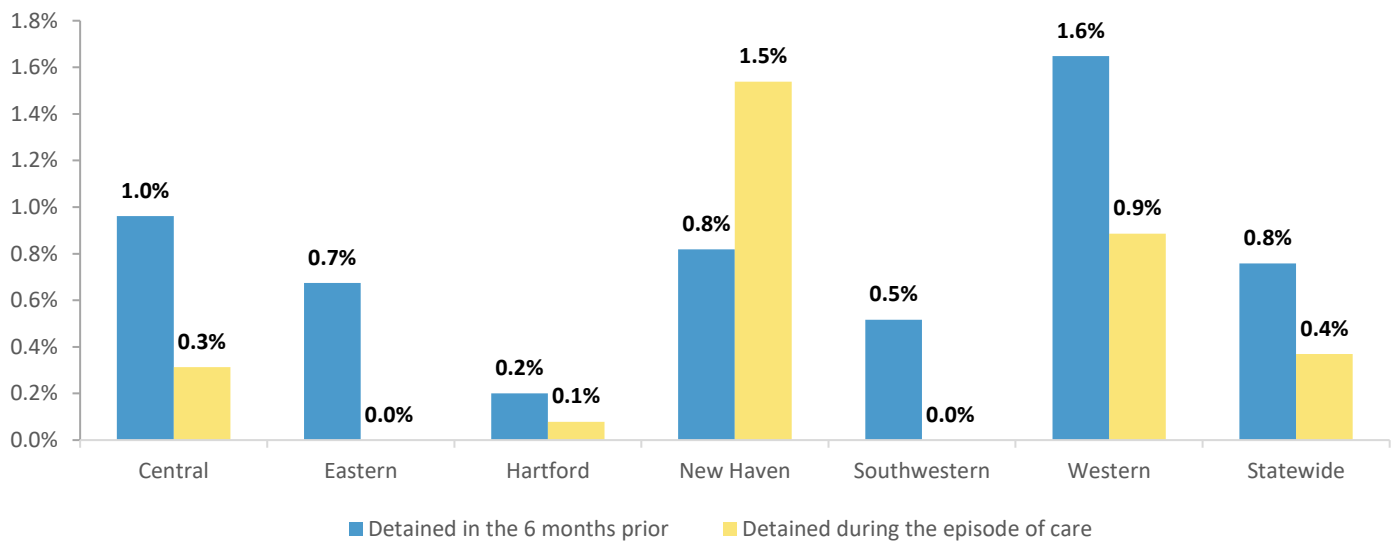


Figure 45. Clients Arrested* in the Six Months Prior to and During the Episode of Care



*Arrested refers to any arrest, regardless of whether it resulted in formal arraignment or adjudication.

Figure 46. Detained* in the Six Months Prior to and During the Episode of Care



*Detained is intended to indicate instances in which the youth has been removed from the community and institutionally confined for legal reasons.

Section VI: Referral Sources

Figure 47. Referral Sources Statewide

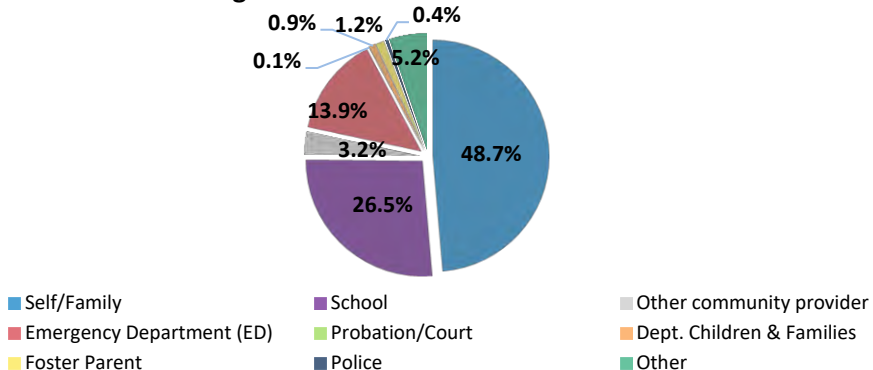


Figure 48. Top Referral Sources Over Time

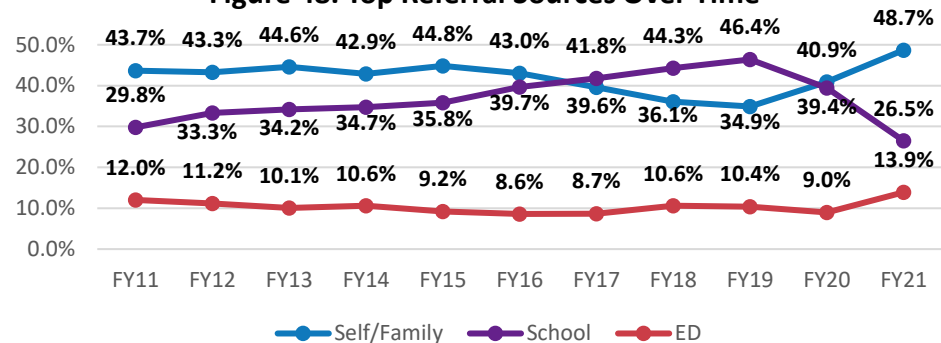


Table 1. Referral Sources

	Self/Family	Family Adv.	School	Info-Line (2-1-1)	Other Prog. w/in Agency	Other Comm. Provider	Emer Dept. (ED)	Prob. or Court	Dept. of Child & Families (DCF)	Psych Hospital	Cong. Care Facility	Foster Parent	Police	Phys.	Comm. Nat. Supp.	Other State Agency
STATEWIDE	48.7%	0.2%	26.5%	0.0%	1.1%	3.2%	13.9%	0.1%	0.9%	2.6%	0.2%	1.2%	0.4%	0.9%	0.2%	0.0%
CENTRAL	49.9%	0.3%	22.5%	0.0%	2.6%	4.3%	12.8%	0.0%	0.9%	3.3%	0.3%	1.4%	0.7%	0.8%	0.2%	0.0%
CHR/MiddHosp-EMPS	52.9%	0.2%	22.9%	0.0%	0.9%	4.5%	11.9%	0.0%	0.4%	2.3%	0.4%	1.1%	0.8%	1.3%	0.4%	0.0%
CHR-EMPS	48.8%	0.3%	22.3%	0.0%	3.3%	4.2%	13.1%	0.0%	1.2%	3.7%	0.2%	1.5%	0.7%	0.7%	0.1%	0.0%
EASTERN	57.4%	0.0%	27.8%	0.0%	1.1%	4.1%	2.1%	0.0%	1.0%	3.1%	0.3%	1.2%	0.2%	1.4%	0.3%	0.0%
UCFS-EMPS:NE	61.5%	0.0%	22.4%	0.0%	1.8%	3.3%	3.5%	0.0%	1.3%	3.0%	0.0%	1.8%	0.3%	1.0%	0.3%	0.0%
UCFS-EMPS:SE	55.2%	0.0%	30.6%	0.0%	0.8%	4.5%	1.3%	0.0%	0.8%	3.2%	0.5%	0.9%	0.1%	1.6%	0.3%	0.0%
HARTFORD	41.2%	0.2%	26.9%	0.0%	0.7%	3.2%	20.9%	0.1%	0.9%	3.7%	0.1%	0.9%	0.3%	0.7%	0.2%	0.0%
Wheeler-EMPS:Htfd	26.2%	0.4%	23.0%	0.0%	0.8%	4.2%	38.7%	0.0%	0.8%	4.1%	0.1%	0.9%	0.2%	0.6%	0.1%	0.0%
Wheeler-EMPS:Meridn	56.9%	0.0%	26.7%	0.0%	0.8%	2.6%	7.1%	0.0%	0.8%	1.3%	0.0%	1.3%	0.5%	1.9%	0.0%	0.0%
Wheeler-EMPS:NBrit	48.5%	0.2%	30.0%	0.0%	0.5%	2.6%	11.1%	0.1%	1.0%	3.9%	0.1%	0.7%	0.3%	0.5%	0.3%	0.0%
NEW HAVEN	61.0%	0.3%	21.6%	0.0%	0.8%	2.5%	7.6%	0.2%	1.4%	0.5%	0.1%	1.9%	0.6%	1.1%	0.3%	0.0%
CliffBeers-EMPS	61.0%	0.3%	21.6%	0.0%	0.8%	2.5%	7.6%	0.2%	1.4%	0.5%	0.1%	1.9%	0.6%	1.1%	0.3%	0.0%
SOUTHWESTERN	55.8%	0.1%	34.9%	0.0%	0.6%	2.3%	1.4%	0.1%	1.0%	1.0%	0.1%	1.3%	0.4%	0.8%	0.1%	0.1%
CFGC/South-EMPS	52.7%	0.0%	38.5%	0.0%	0.8%	2.6%	0.8%	0.0%	0.8%	0.5%	0.0%	0.8%	0.3%	2.1%	0.0%	0.3%
CFGC-EMPS:Nrwk	58.4%	0.3%	30.7%	0.0%	0.8%	2.3%	2.8%	0.0%	1.3%	1.0%	0.0%	1.6%	0.8%	0.0%	0.0%	0.0%
CFGC-EMPS	56.2%	0.0%	35.3%	0.0%	0.3%	2.2%	0.8%	0.2%	1.0%	1.2%	0.2%	1.5%	0.3%	0.5%	0.2%	0.0%
WESTERN	40.1%	0.2%	26.4%	0.0%	1.0%	2.6%	24.3%	0.1%	0.6%	2.3%	0.2%	0.8%	0.4%	1.0%	0.1%	0.0%
Well-EMPS:Dnby	53.8%	0.6%	34.7%	0.0%	0.6%	3.3%	1.5%	0.0%	0.9%	1.2%	0.0%	0.6%	1.2%	1.2%	0.3%	0.0%
Well-EMPS:Torr	45.9%	0.0%	30.6%	0.0%	1.3%	2.5%	7.6%	0.3%	0.0%	8.0%	0.3%	0.6%	1.0%	1.6%	0.3%	0.0%
Well-EMPS:Wtby	34.9%	0.1%	23.1%	0.0%	1.0%	2.4%	34.5%	0.0%	0.7%	1.1%	0.2%	1.0%	0.1%	0.8%	0.0%	0.0%

Figure 49. Emergency Department Referrals to Mobile Crisis Over Time

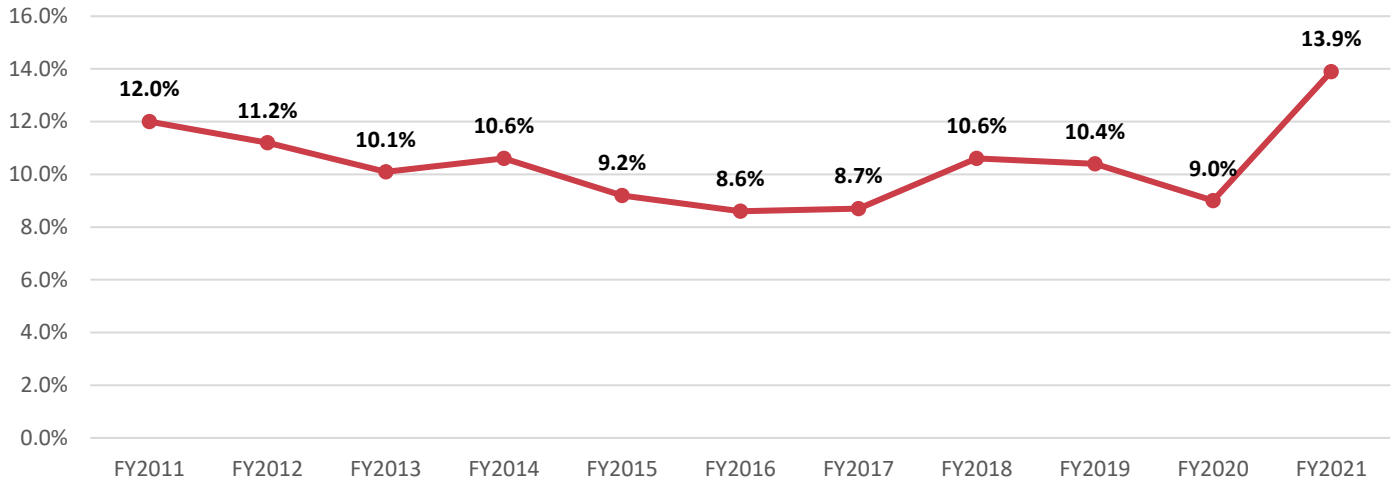
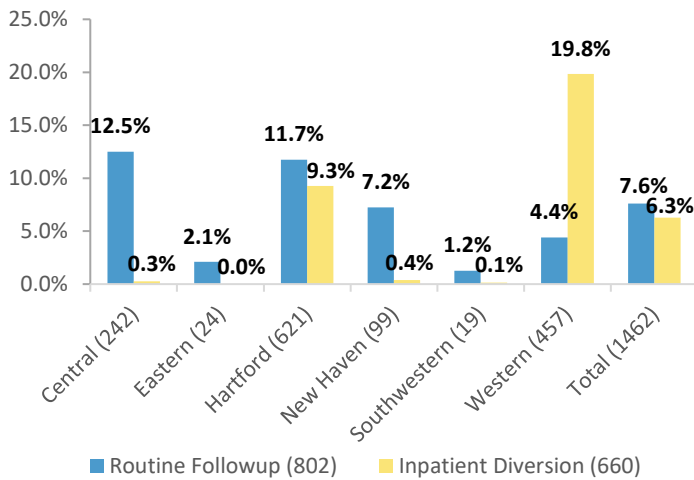
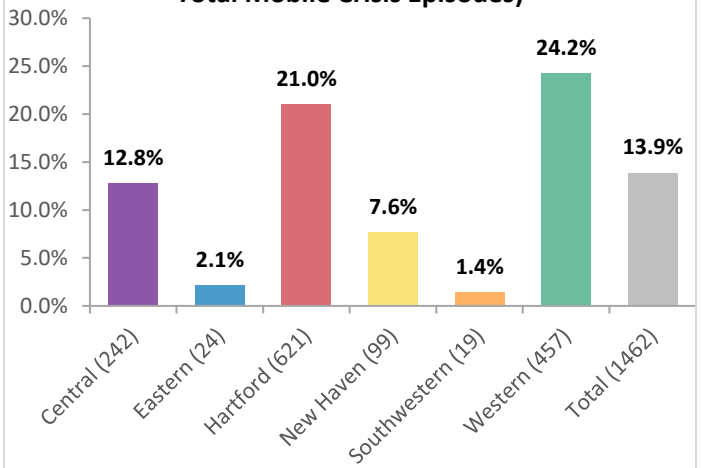


Figure 50. Type of Emergency Dept. Referral



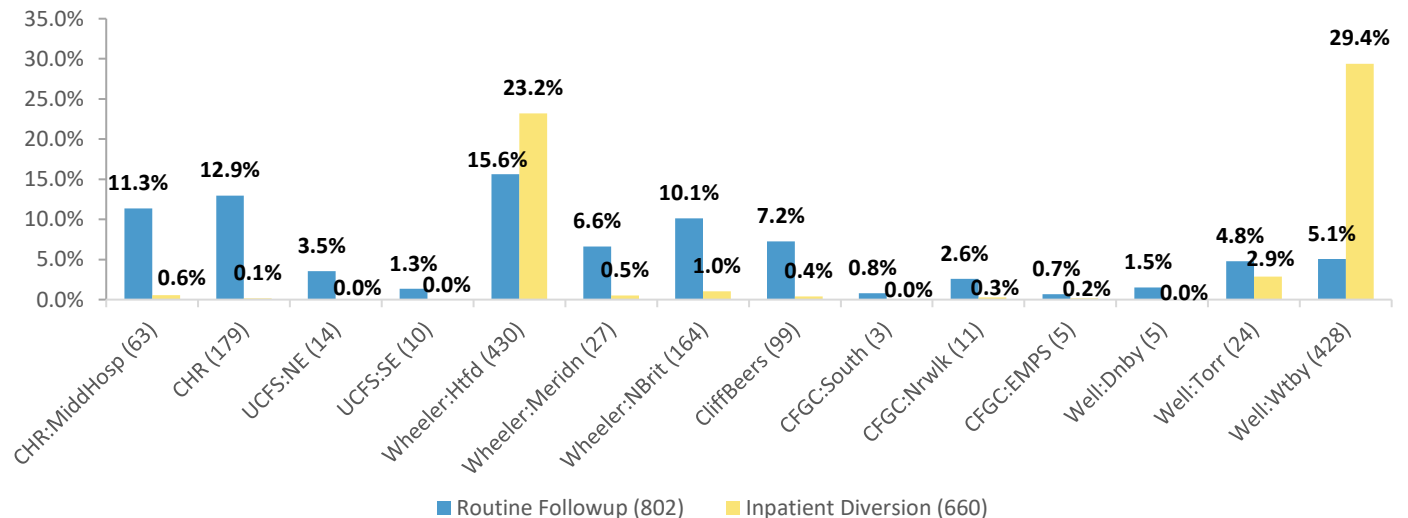
Note: Counts of ED referrals are in parentheses

Figure 51. Emergency Dept. Referral (% of Total Mobile Crisis Episodes)



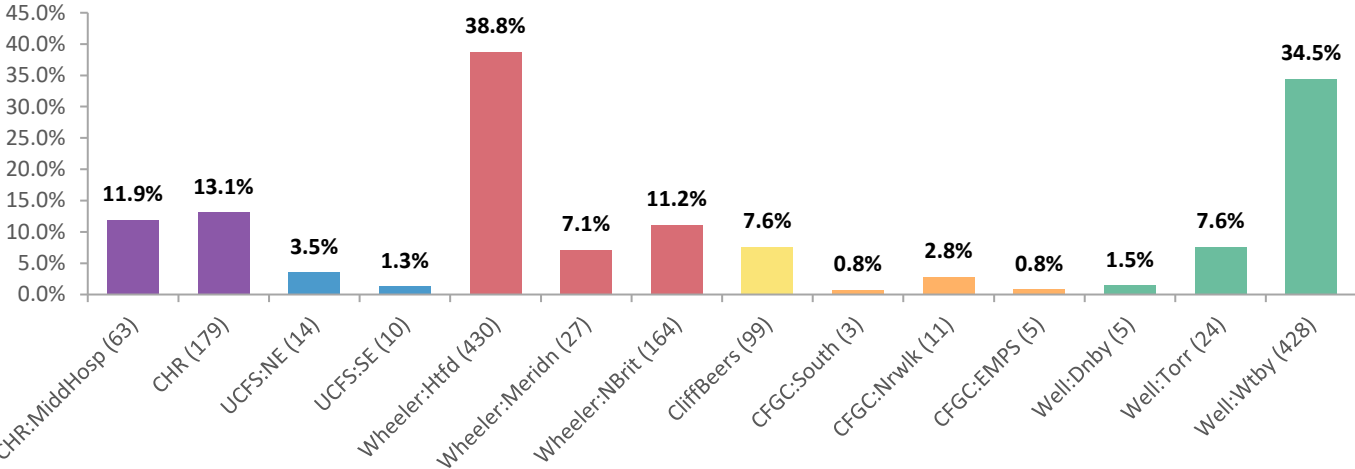
Note: Counts of ED referrals are in parentheses

Figure 52. Type of Emergency Department Referrals by Provider



Note: Counts of ED referrals are in parentheses

Figure 53. Emergency Dept. Referrals (% of Total Mobile Crisis Episodes) by Provider



Note: Counts of ED referrals are in parentheses

Section VII: 211 Recommendations and Mobile Crisis Response

Figure 54. 2-1-1 Recommended Initial Response

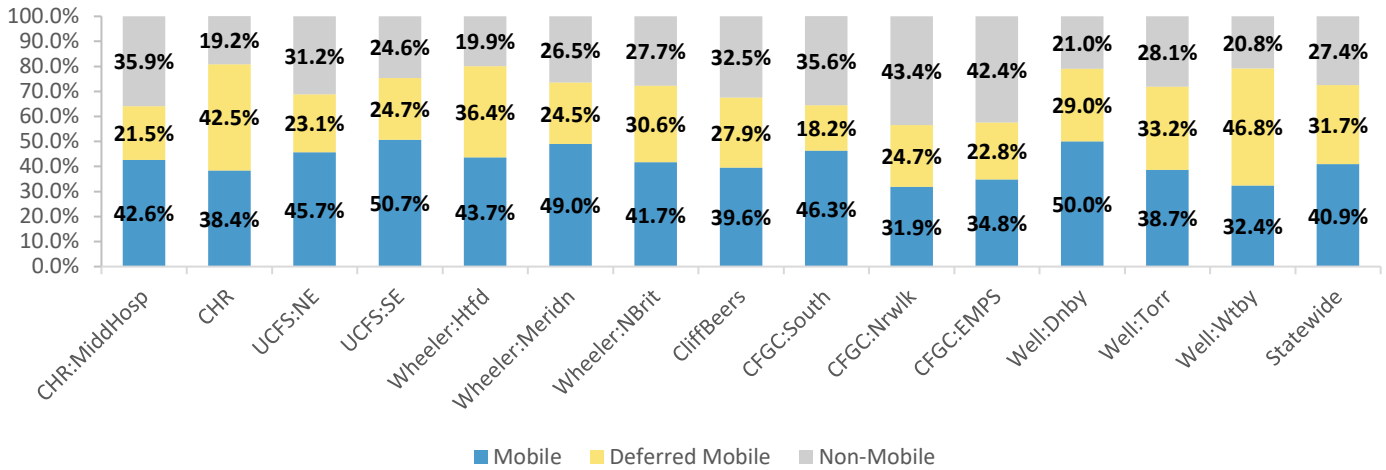


Figure 55. Actual Initial Mobile Crisis Provider Response

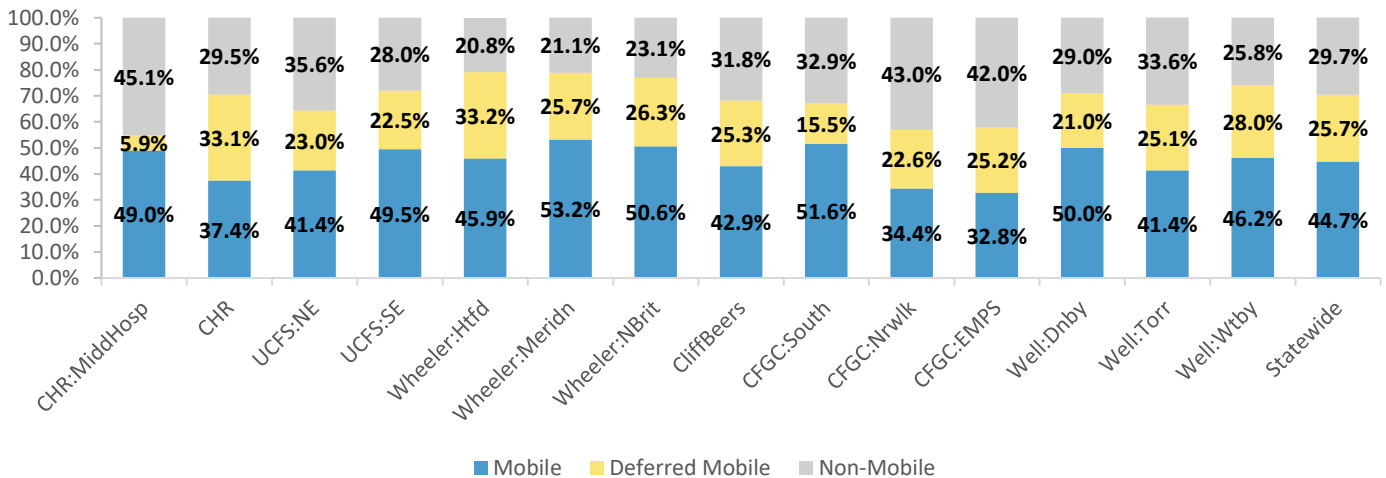
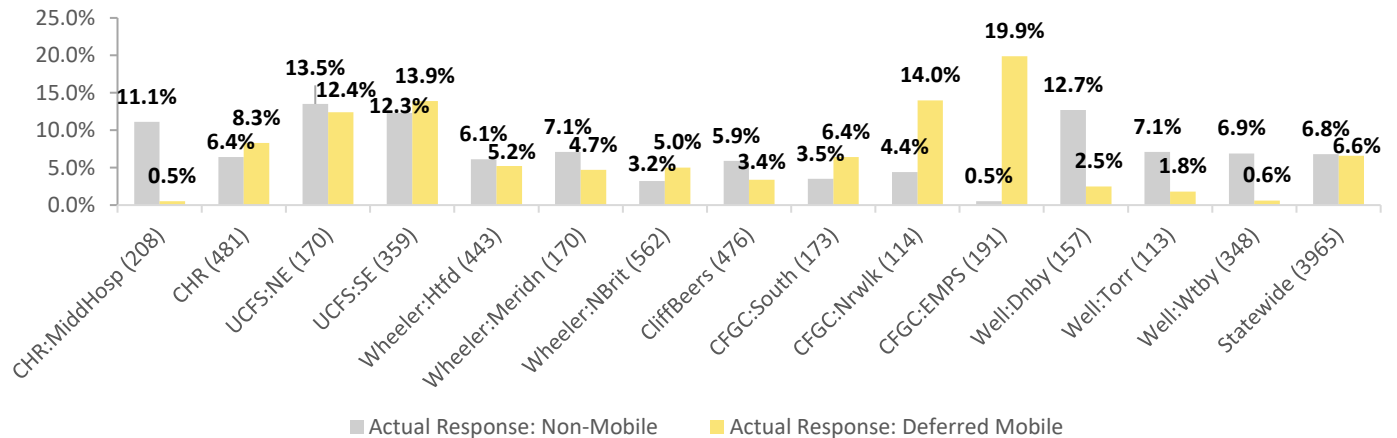


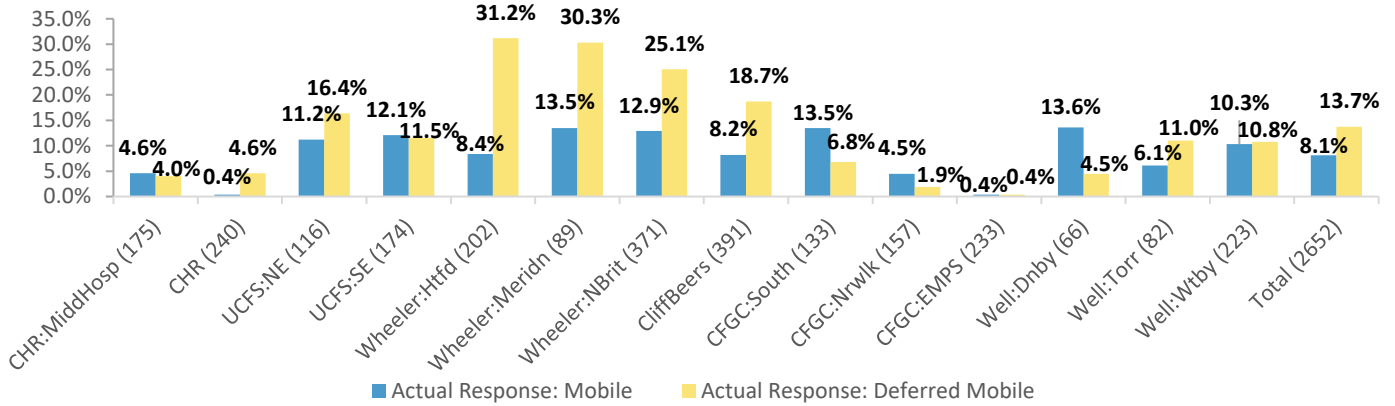
Figure 56. 2-1-1 Recommended Mobile Response Where Actual Mobile Crisis Response was Non-Mobile or Deferred Mobile



*Total count of 2-1-1 recommended mobile responses is in parentheses.

Note: Responses to COVID-related questions may have influenced some changes from recommended to actual mobile responses.

Figure 57. 2-1-1 Recommended Non-Mobile Response Where Actual Mobile Crisis Response was Mobile or Deferred Mobile



*Total count of 2-1-1 recommended non-mobile responses is in parentheses.

Note: COVID-related factors may have influenced both the recommended and actual mobile response.

Figure 58. Statewide Mobility Rate Over Time

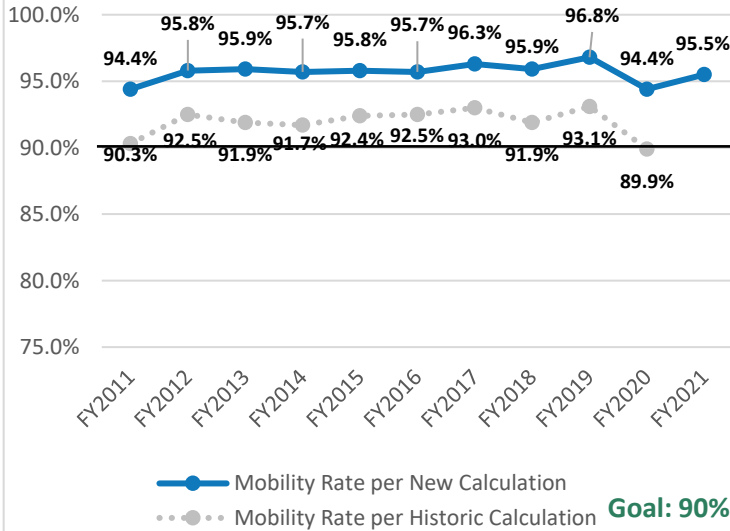
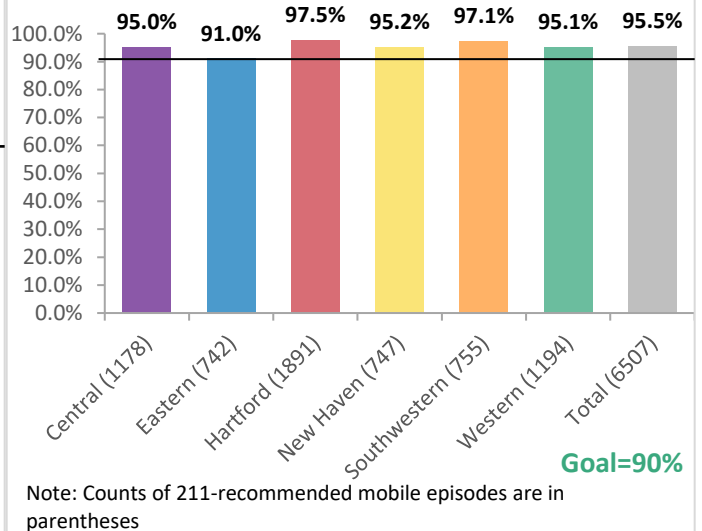
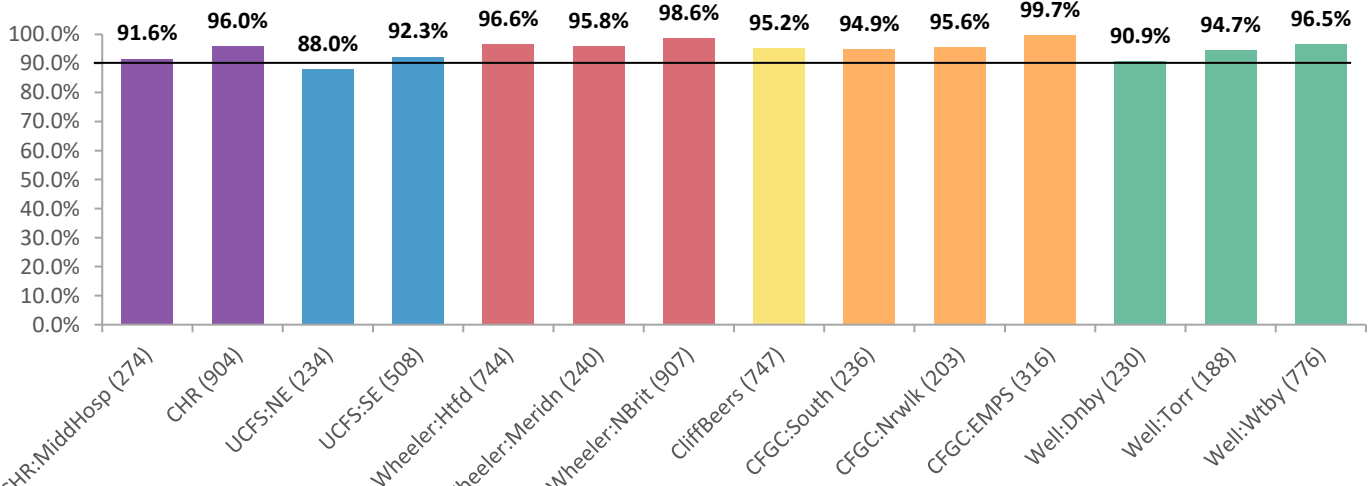


Figure 59. Mobile Response (Mobile & Deferred Mobile) By Service Area



Note: Counts of 211-recommended mobile episodes are in parentheses

Figure 60. Mobile Response (Mobile & Deferred Mobile) By Provider



Note: Counts of 211-recommended mobile episodes are in parentheses

Goal = 90%

Figure 61. Mobile Crisis First Contact Mobile Site by Service Area

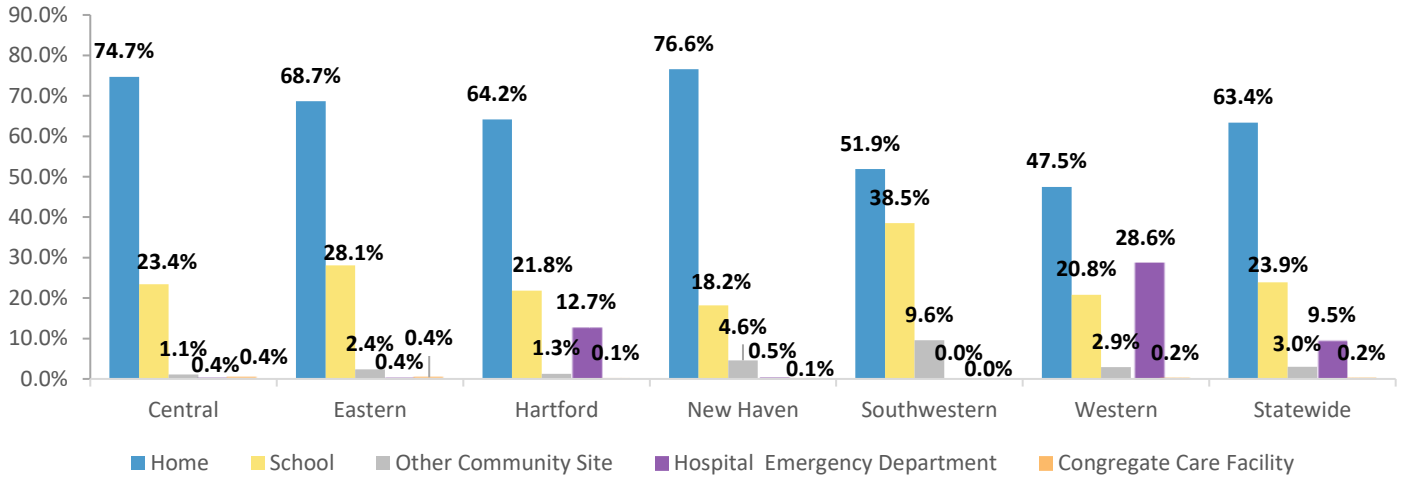
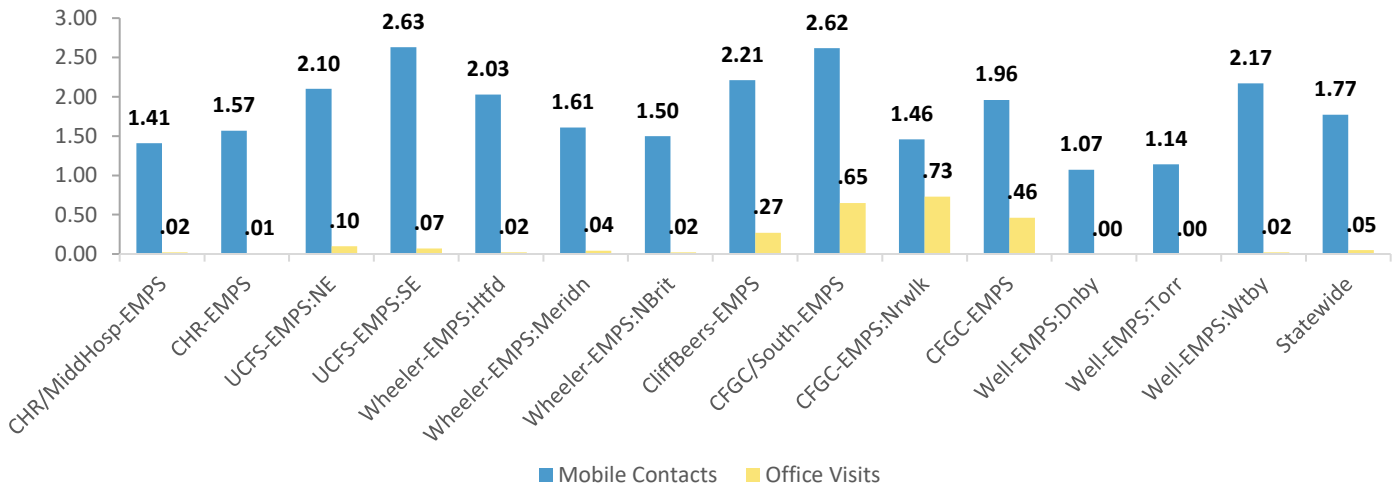
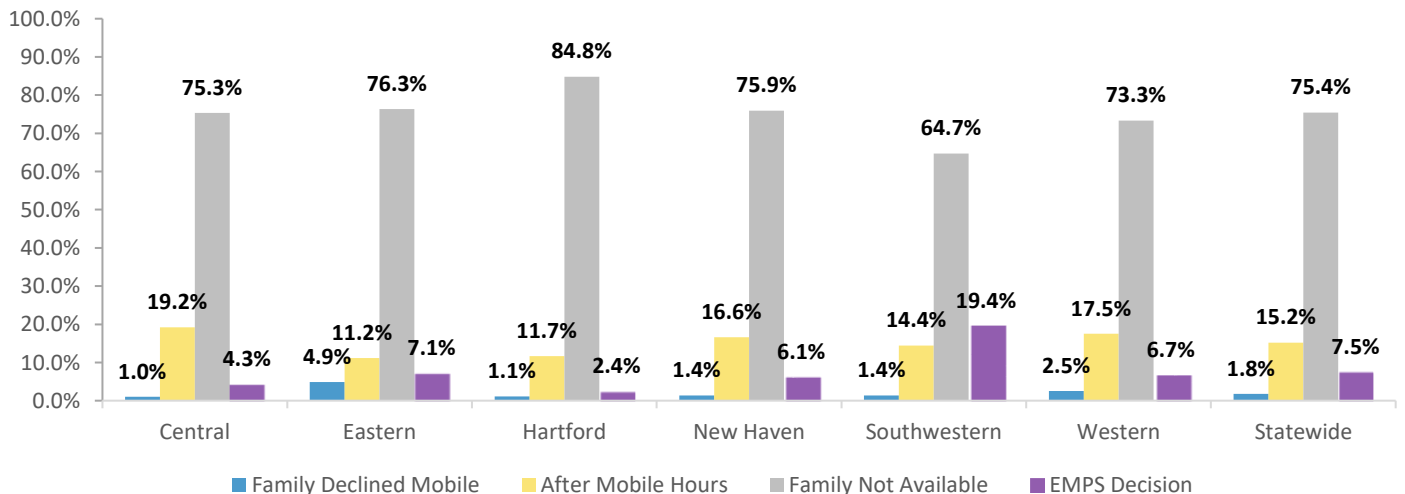


Figure 62. Mean Number of Mobile Contacts and Office Visits During an Episode of Care by Provider



Note: Only episodes with a Crisis Response of Plus Stabilization Follow-up are included.

Figure 63. Mobile Crisis Non-Mobile Reason by Service Area



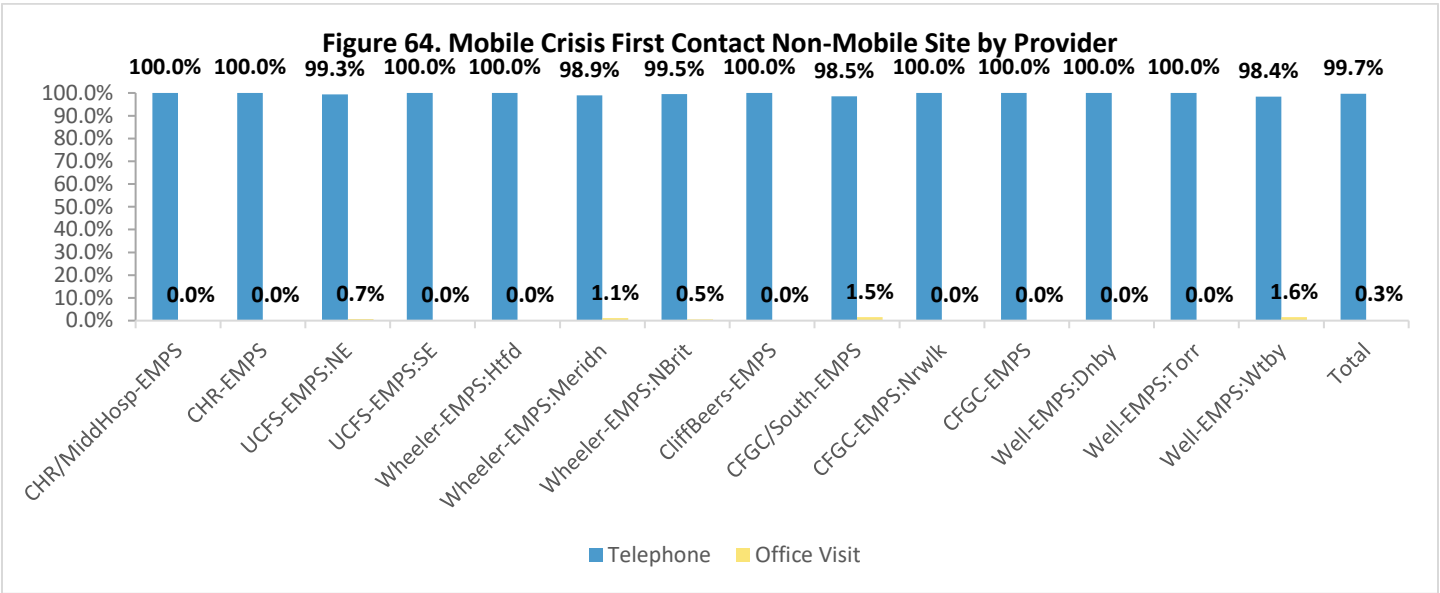
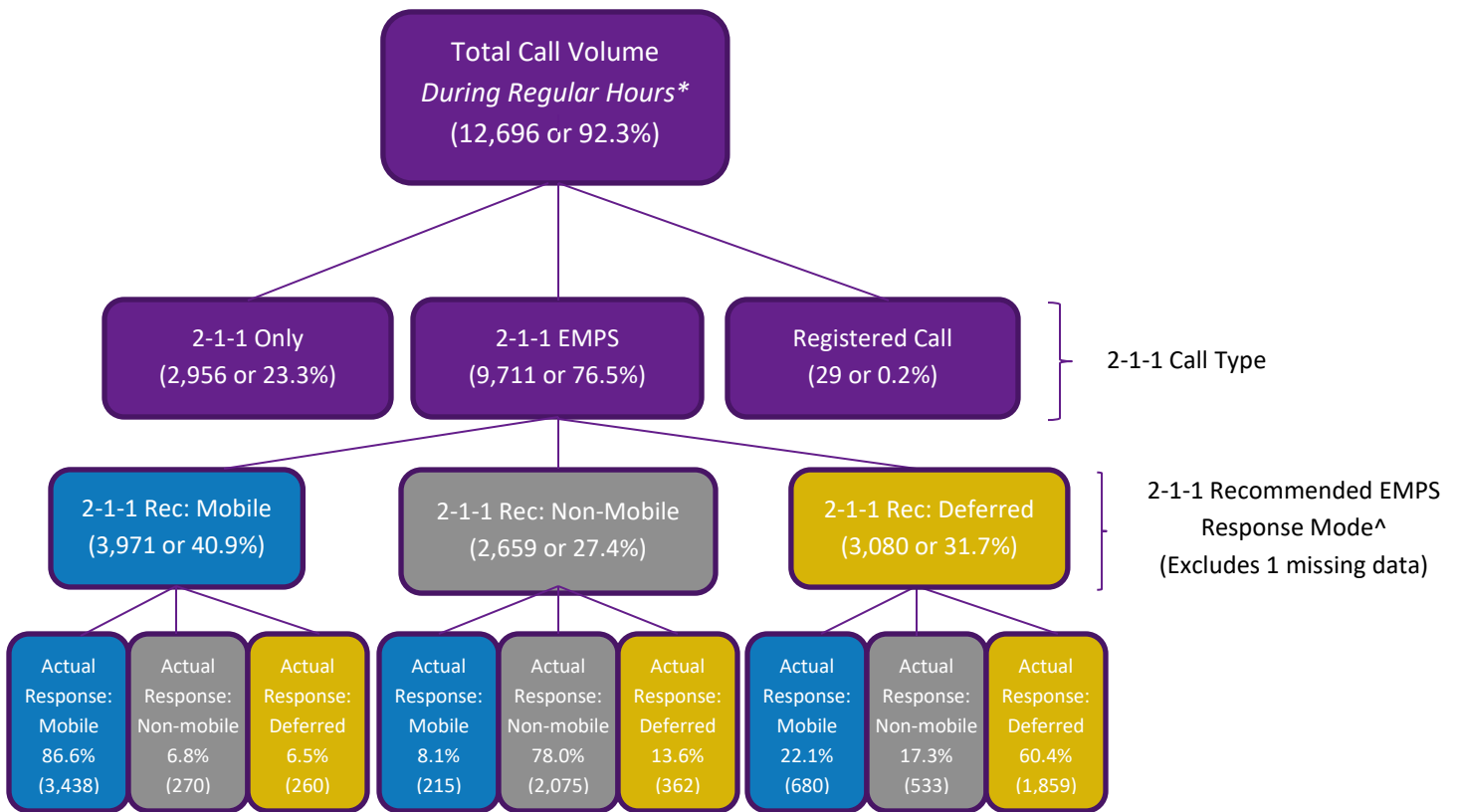


Figure 65. Breakdown of Call Volume by Call Type and Response Mode*



(Excludes 3 that are missing data) (Excludes 7 that are missing data) (Excludes 8 that are missing data)

	Mobile
	Non-Mobile
	Deferred Mobile

*After hours calls, which are primarily responded to with either a deferred mobile or non-mobile response, are not included in this breakdown. Because after hours calls are not included in this figure, numbers may not be consistent with those reported in previous figures.

^COVID-19 restrictions may have led to a greater amount of deferred mobile and non-mobile recommendations or actual responses than in a typical year.

Section VIII: Response Time

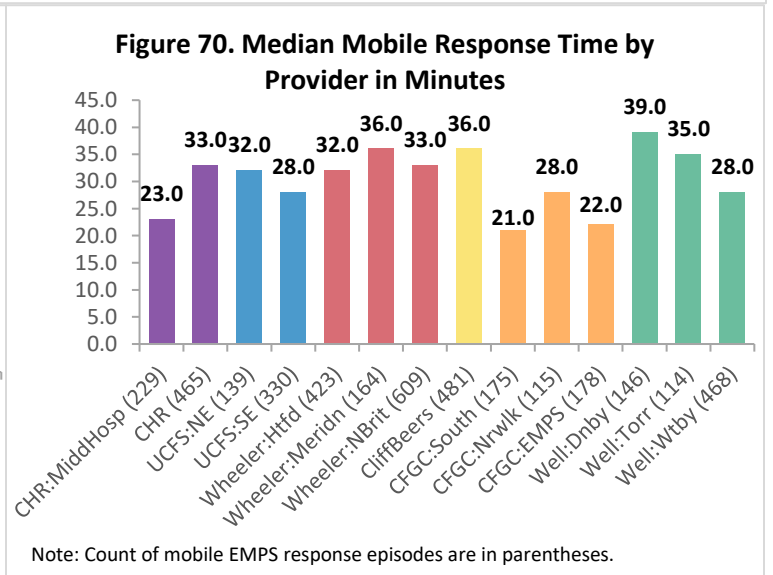
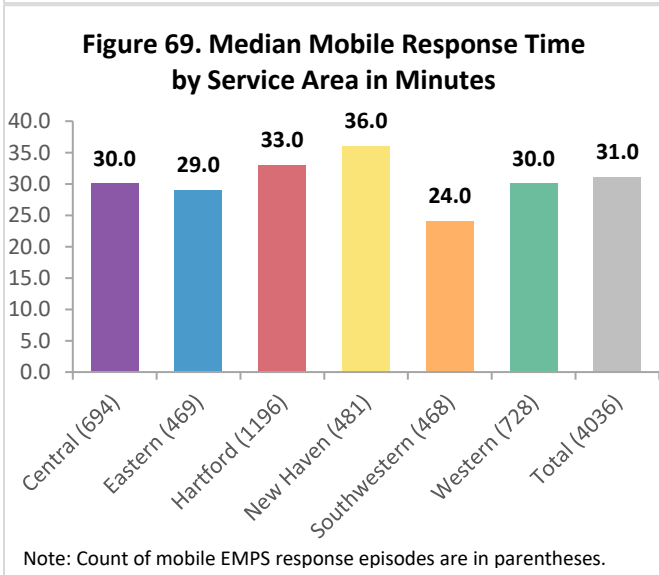
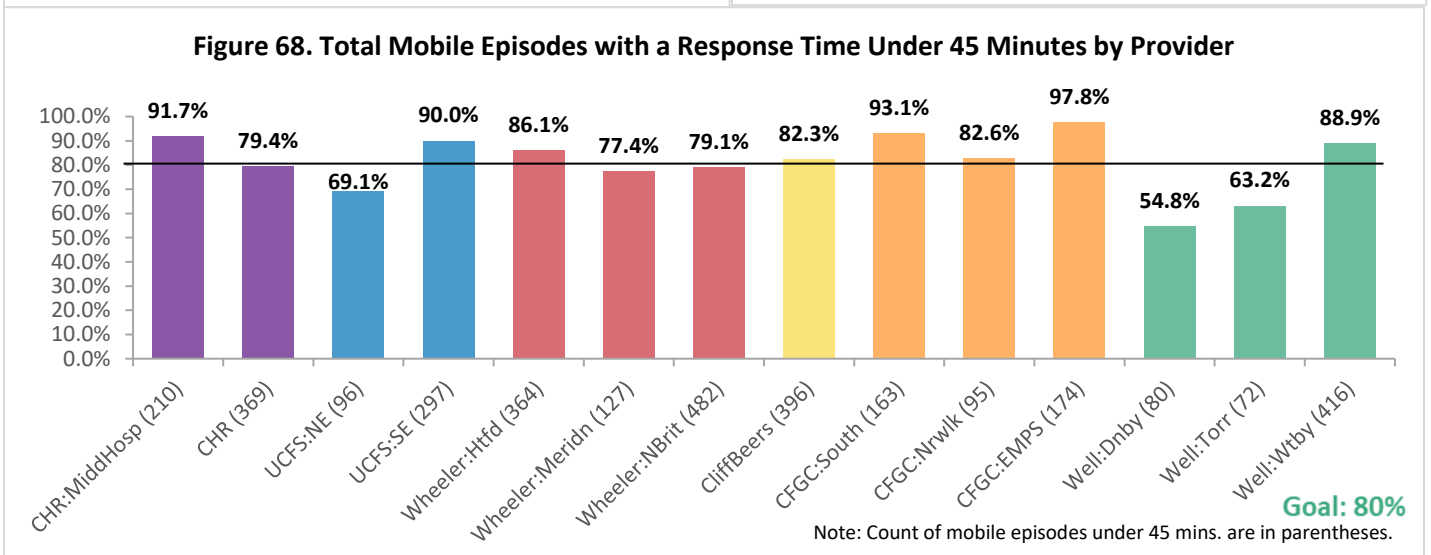
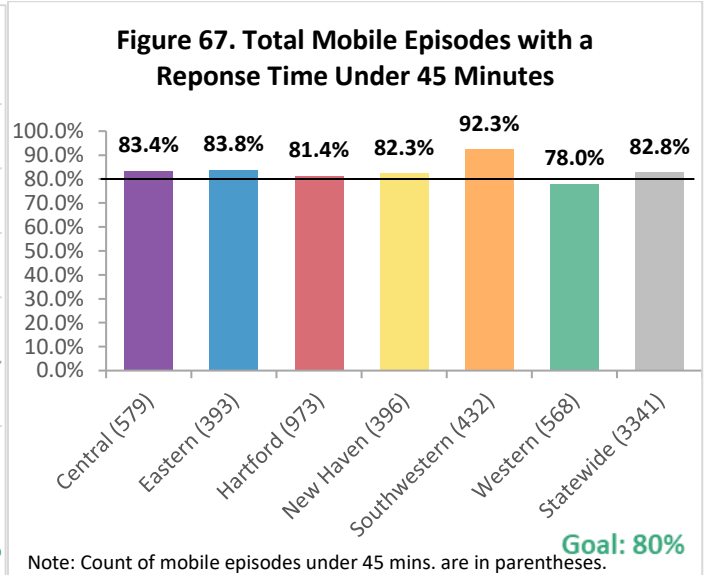
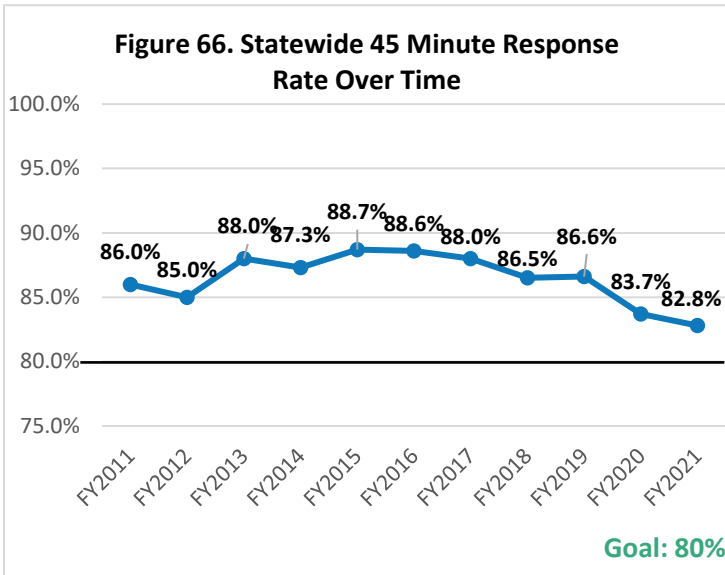
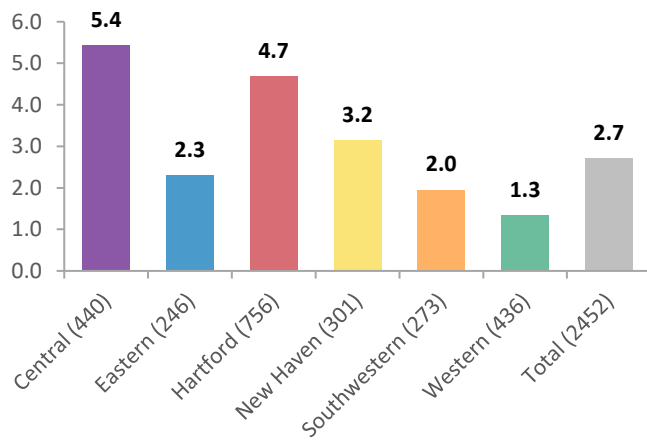
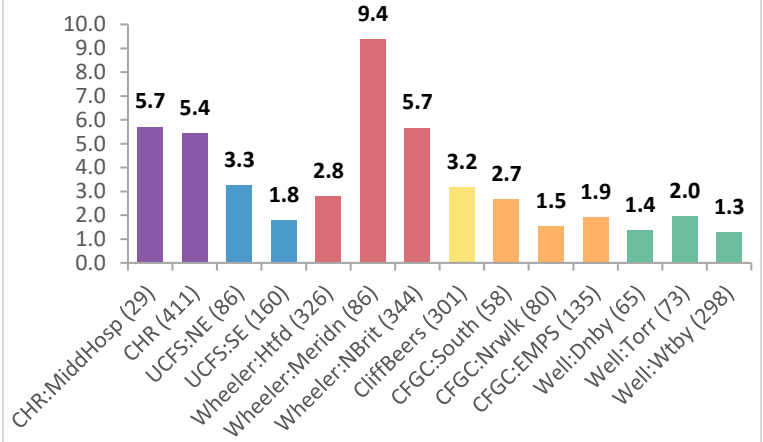


Figure 71. Median Deferred Mobile Response Time by Provider in Hours



Note: Count of mobile EMPS response episodes are in parentheses.

Figure 72. Median Deferred Mobile Response Time by Provider in Hours



Note: Count of mobile EMPS response episodes are in parentheses.

Section IX: Length of Stay and Discharge Information

Table 2. Length of Stay for Discharged Episodes of Care in Days

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	
	<i>Discharged Episodes for Current Reporting Period</i>									<i>n of Discharged Episodes for FY2021</i>						
	Mean			Median			Percent			n used Mean/Median			n used for Percent			
	LOS: Phone	LOS: FTF	LOS: Stab.	LOS: Phone	LOS: FTF	LOS: Stab.	Phone > 1	FTF > 5	Stab. > 45	LOS: Phone	LOS: FTF	LOS: Stab.	LOS: Phone	LOS: FTF	LOS: Stab.	
1	STATEWIDE	1.4	8.5	18.1	0.0	4.0	14.0	19.9%	33.3%	3.3%	3456	3159	3597	687	1051	119
2	Central	3.4	7.4	20.7	1.0	3.0	17.0	46.9%	27.8%	6.5%	670	180	971	314	50	63
3	CHR/MidHosp-EMPS	7.0	5.2	14.1	4.0	3.0	12.0	75.4%	27.0%	0.0%	248	126	152	187	34	0
4	CHR-EMPS	1.3	12.5	21.9	0.0	1.0	18.0	30.1%	29.6%	7.7%	422	54	819	127	16	63
5	Eastern	0.2	4.6	21.5	0.0	4.0	20.0	4.5%	20.3%	3.7%	401	577	162	18	117	6
6	UCFS-EMPS:NE	0.2	4.7	21.1	0.0	4.0	20.0	5.0%	22.3%	4.9%	160	193	41	8	43	2
7	UCFS-EMPS:SE	0.2	4.5	21.7	0.0	4.0	20.0	4.1%	19.3%	3.3%	241	384	121	10	74	4
8	Hartford	1.0	3.5	16.1	0.0	1.0	13.0	20.8%	16.3%	1.5%	745	810	1326	155	132	20
9	Wheeler-EMPS:Htfd	1.0	5.2	18.5	0.0	1.0	16.0	20.0%	29.2%	1.4%	285	298	484	57	87	7
10	Wheeler-EMPS:Meridn	1.0	3.5	16.4	1.0	2.0	14.0	23.3%	12.7%	2.5%	86	110	162	20	14	4
11	Wheeler-EMPS:NBrit	0.9	2.3	14.2	0.0	1.0	12.0	20.9%	7.7%	1.3%	374	402	680	78	31	9
12	New Haven	1.5	20.6	41.4	0.0	14.0	32.0	12.4%	76.5%	31.3%	429	710	67	53	543	21
13	CliffBeers-EMPS	1.5	20.6	41.4	0.0	14.0	32.0	12.4%	76.5%	31.3%	429	710	67	53	543	21
14	Southwestern	0.3	8.0	23.0	0.0	4.0	22.0	3.8%	32.1%	1.8%	581	583	170	22	187	3
15	CFGC/South-EMPS	0.3	3.9	21.8	0.0	0.0	21.0	3.1%	20.3%	0.0%	131	128	118	4	26	0
16	CFGC-EMPS:Nrwlk	0.5	8.7	27.1	0.0	5.0	24.0	5.4%	40.2%	7.7%	184	169	26	10	68	2
17	CFGC-EMPS	0.2	9.4	24.3	0.0	4.0	24.0	3.0%	32.5%	3.8%	266	286	26	8	93	1
18	Western	1.3	3.0	15.2	0.0	2.0	13.0	19.8%	7.4%	0.7%	630	299	901	125	22	6
19	Well-EMPS:Dnby	1.1	3.5	14.5	0.0	3.0	13.0	21.6%	9.6%	0.0%	125	52	140	27	5	0
20	Well-EMPS:Torr	1.6	2.2	14.9	0.0	2.0	13.0	23.0%	5.0%	0.7%	126	40	139	29	2	1
21	Well-EMPS:Wtby	1.2	3.0	15.4	0.0	2.0	13.0	18.2%	7.2%	0.8%	379	207	622	69	15	5

* Discharged episodes, as of June 30, 2021, with end dates from July 1, 2020 to June 30, 2021.

Note: Blank cells indicate no data was available for that particular inclusion criteria

Definitions:

LOS: Phone

Length of Stay in Days for Phone Only

LOS: FTF

Length of Stay in Days for Face To Face Only

LOS: Stab.

Length of Stay in Days for Stabilization Plus Follow-up Only

Phone > 1

Percent of episodes that are phone only that are greater than 1 day

FTF > 5

Percent of episodes that are face to face that are greater than 5 days

Stab. > 45

Percent of episodes that are stabilization plus follow-up that are greater than 45 days

Table 3. Length of Stay for Open Episodes of Care in Days

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	
	<i>Episodes Still in Care*</i>									<i>N of Episodes Still in Care*</i>						
	Mean			Median			Percent			n used Mean/Median			n used for Percent			
	LOS: Phone	LOS: FTF	LOS: Stab.	LOS: Phone	LOS: FTF	LOS: Stab.	Phone > 1	FTF > 5	Stab. > 45	LOS: Phone	LOS: FTF	LOS: Stab.	Phone > 1	FTF > 5	Stab. > 45	
1	STATEWIDE	116.8	57.6	35.2	95.0	41.0	21.0	100.0%	100.0%	43.6%	51	138	133	51	138	58
2	Central	123.6	43.1	33.9	57.0	42.0	25.5	100.0%	100.0%	54.8%	5	27	42	5	27	23
3	CHR/MiddHosp-EMPS	1.0	6.5	0.0	1.0	6.5	0.0	100.0%	100.0%	N/A	1	2	0	1	2	0
4	CHR-EMPS	154.3	46.0	33.9	165.0	43.0	25.5	100.0%	100.0%	54.8%	4	25	42	4	25	23
5	Eastern	0.0	26.0	17.5	0.0	26.0	16.0	N/A	100.0%	50.0%	0	1	4	0	1	2
6	UCFS-EMPS:NE	0.0	26.0	30.5	0.0	26.0	30.5	N/A	100.0%	100.0%	0	1	2	0	1	2
7	UCFS-EMPS:SE	0.0	0.0	4.5	0.0	0.0	4.5	N/A	N/A	0.0%	0	0	2	0	0	0
8	Hartford	60.0	86.6	41.2	60.0	66.0	16.0	100.0%	100.0%	40.0%	2	14	55	2	14	22
9	Wheeler-EMPS:Htfd	0.0	85.1	41.8	0.0	51.0	15.0	N/A	100.0%	36.7%	0	11	30	0	11	11
10	Wheeler-EMPS:Meridn	60.0	92.3	63.6	60.0	81.0	64.5	100.0%	100.0%	71.4%	2	3	14	2	3	10
11	Wheeler-EMPS:NBrit	0.0	0.0	11.0	0.0	0.0	7.0	N/A	N/A	9.1%	0	0	11	0	0	1
12	New Haven	208.2	63.7	44.1	263.0	45.5	34.5	100.0%	100.0%	50.0%	9	72	8	9	72	4
13	CliffBeers-EMPS	208.2	63.7	44.1	263.0	45.5	34.5	100.0%	100.0%	50.0%	9	72	8	9	72	4
14	Southwestern	50.8	41.0	23.8	32.5	28.0	22.0	100.0%	100.0%	40.0%	4	19	5	4	19	2
15	CFGC/South-EMPS	30.7	9.8	17.3	29.0	8.0	16.0	100.0%	100.0%	0.0%	3	4	3	3	4	0
16	CFGC-EMPS:Nrwlk	111.0	84.5	0.0	111.0	43.0	0.0	100.0%	100.0%	N/A	1	6	0	1	6	0
17	CFGC-EMPS	0.0	25.9	33.5	0.0	28.0	33.5	N/A	100.0%	100.0%	0	9	2	0	9	2
18	Western	101.4	36.8	23.6	95.0	35.0	14.0	100.0%	100.0%	26.3%	31	5	19	31	5	5
19	Well-EMPS:Dnby	78.2	0.0	20.0	69.5	0.0	20.0	100.0%	N/A	50.0%	10	0	2	10	0	1
20	Well-EMPS:Torr	125.8	26.0	74.0	138.0	26.0	54.0	100.0%	100.0%	66.7%	5	1	3	5	1	2
21	Well-EMPS:Wtby	108.2	39.5	13.3	96.0	39.5	12.0	100.0%	100.0%	14.3%	16	4	14	16	4	2

* Data includes episodes still in care, as of June 30, 2021, with referral dates from July 1, 2020 to June 30, 2021.

Note: Blank cells indicate no data was available for that particular inclusion criteria

Definitions:

LOS: Phone

Length of Stay in Days for Phone Only

LOS: FTF

Length of Stay in Days for Face To Face Only

LOS: Stab.

Length of Stay in Days for Stabilization Plus Follow-up Only

Phone > 1

Percent of episodes that are phone only that are greater than 1 day

FTF > 5

Percent of episodes that are face to face that are greater than 5 days

Stab. > 45

Percent of episodes that are stabilization plus follow-up that are greater than 45 days

Figure 73. Top Six Reasons for Client Discharge Statewide

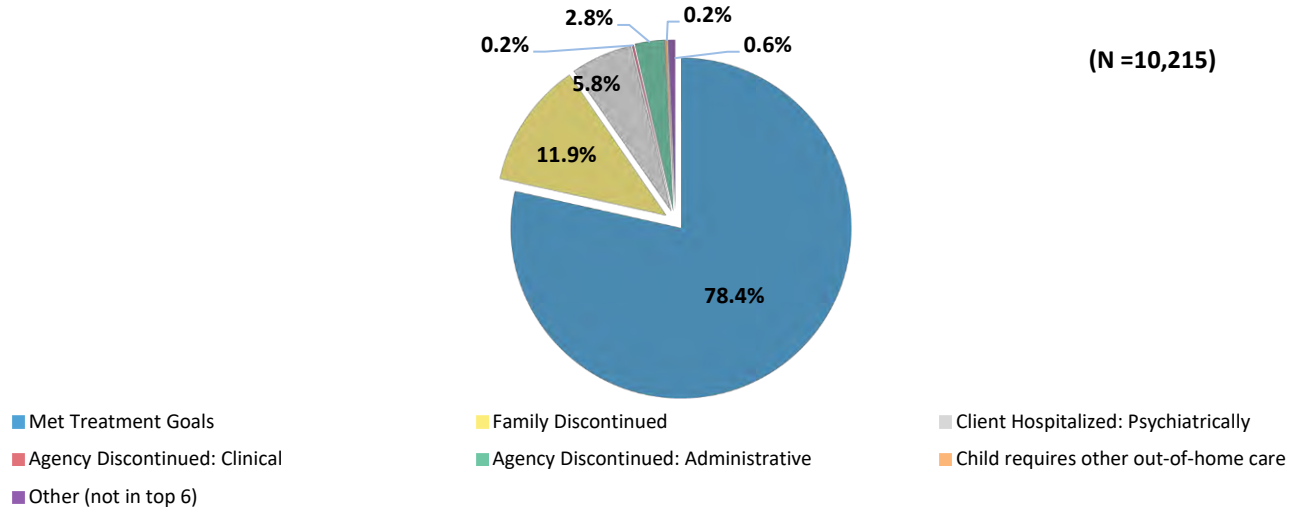


Figure 74. Top Six Places Clients Live at Discharge Statewide

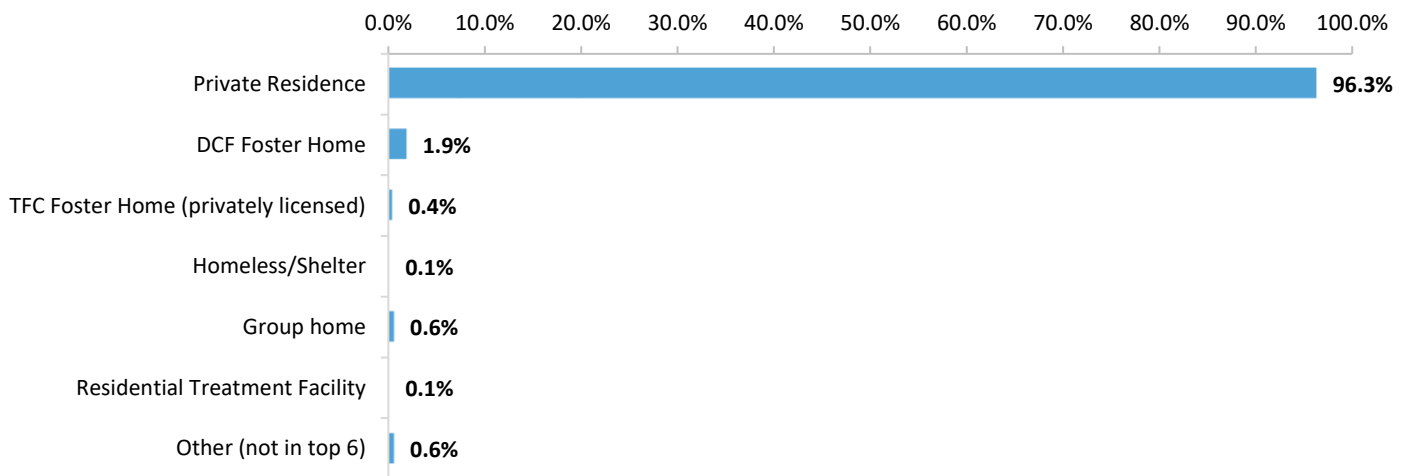
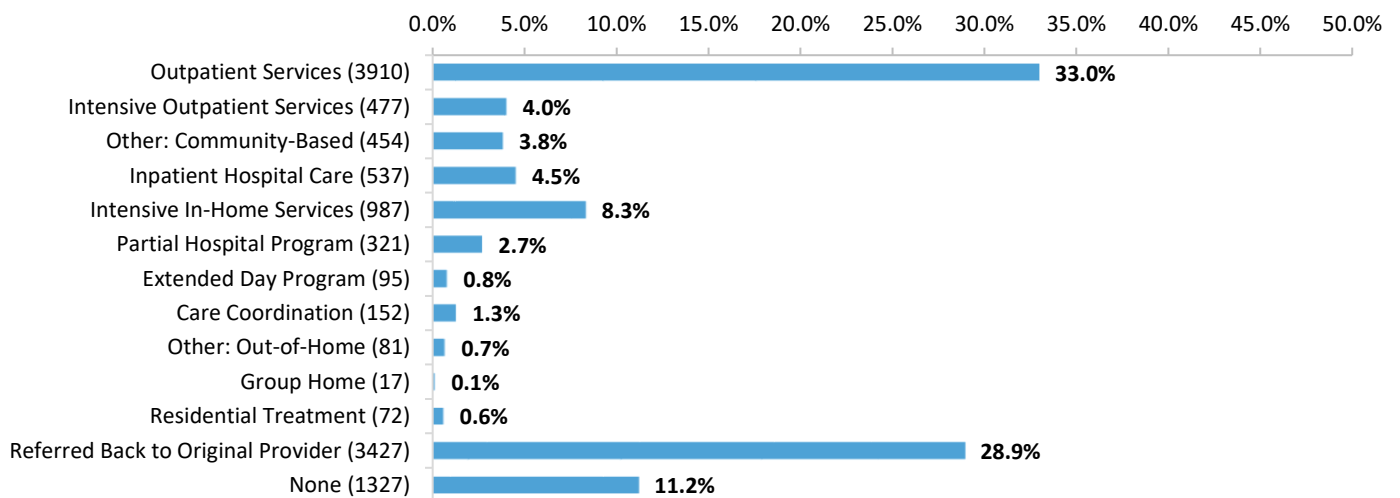


Figure 75. Type of Services Client Referred* to at Discharge Statewide



* Count for each type of service referral is in parentheses. Data include clients referred to more than one type of service.

**May include referrals back to existing providers.

Table 4. Ohio Scales Scores by Service Area

Service Area	<i>n</i> (paired intake & discharge)	Mean (paired intake)	Mean (paired discharge)	Mean Difference (paired cases)	<i>t</i> -score	Sig.	† .05-.10 * <i>P</i> < .05 ** <i>P</i> < .01
STATEWIDE							
Parent Functioning Score	636	41.99	44.80	2.81	7.84	0.000	**
Worker Functioning Score	2842	44.10	45.35	1.24	10.77	0.000	**
Parent Problem Score	647	30.93	27.05	-3.88	-9.26	0.000	**
Worker Problem Score	2846	29.80	27.54	-2.26	-16.87	0.000	**
Central							
Parent Functioning Score	33	43.06	47.09	4.03	2.60	0.014	*
Worker Functioning Score	770	42.74	44.55	1.81	10.79	0.000	**
Parent Problem Score	33	32.00	27.12	-4.88	-2.31	0.027	*
Worker Problem Score	770	30.29	28.59	-1.69	-11.75	0.000	**
Eastern							
Parent Functioning Score	20	44.20	48.80	4.60	2.59	0.018	*
Worker Functioning Score	70	42.77	45.09	2.31	2.26	0.027	*
Parent Problem Score	20	32.50	23.25	-9.25	-3.52	0.002	**
Worker Problem Score	70	32.34	27.61	-4.73	-3.33	0.001	**
Hartford							
Parent Functioning Score	192	39.78	40.83	1.05	2.81	0.005	**
Worker Functioning Score	796	46.08	46.21	0.13	0.71	0.476	
Parent Problem Score	197	31.98	31.42	-0.57	-1.63	0.104	
Worker Problem Score	798	30.44	29.16	-1.28	-6.15	0.000	**
New Haven							
Parent Functioning Score	8	34.13	45.38	11.25	1.68	0.137	
Worker Functioning Score	48	42.48	45.15	2.67	1.83	0.073	†
Parent Problem Score	8	34.75	25.00	-9.75	-1.96	0.091	†
Worker Problem Score	48	27.25	23.75	-3.50	-2.64	0.011	*
Southwestern							
Parent Functioning Score	47	51.51	52.43	0.92	0.74	0.465	
Worker Functioning Score	125	47.27	49.53	2.26	3.57	0.001	**
Parent Problem Score	47	23.04	19.85	-3.19	-2.32	0.025	*
Worker Problem Score	125	21.30	18.57	-2.73	-3.62	0.000	**
Western							
Parent Functioning Score	336	41.87	45.51	3.65	6.50	0.000	**
Worker Functioning Score	1033	43.38	44.79	1.41	6.37	0.000	**
Parent Problem Score	342	31.12	25.79	-5.33	-7.98	0.000	**
Worker Problem Score	1035	29.92	26.76	-3.16	-11.51	0.000	**

paired' = Number of cases with both intake and discharge scores

Section X: Client & Referral Source Satisfaction

Table 5. Client and Referrer Satisfaction for 211 and Mobile Crisis*

211 Items	Q1 FY2020	Q2 FY2021	Q3 FY2021	Q4 FY2021	Q1 FY2020	Q2 FY2021	Q3 FY2020	Q4 FY2021
	Clients (n=55)	Clients (n=61)	Clients (n=61)	Clients (n=60)	Referrers (n=61)	Referrers (n=62)	Referrers (n=60)	Referrers (n=60)
The 211 staff answered my call in a timely manner	3.96	4.28	4.30	4.67	4.25	4.39	4.17	4.47
The 211 staff was courteous	4.05	4.28	4.30	4.70	4.25	4.43	4.17	4.68
The 211 staff was knowledgeable	4.05	4.27	4.27	4.72	4.25	4.41	4.17	4.67
My phone call was quickly transferred to the Mobile Crisis provider	4.05	4.27	4.27	4.70	4.25	4.41	4.17	4.70
Sub-Total Mean: 211	4.03	4.28	4.28	4.70	4.25	4.41	4.17	4.63
Mobile Crisis Items								
Mobile Crisis responded to the crisis in a timely manner	4.09	4.27	4.25	4.63	4.25	4.36	4.17	4.50
The Mobile Crisis staff was respectful	4.13	4.28	4.28	4.67	4.25	4.41	4.13	4.68
The Mobile Crisis staff was knowledgeable	4.13	4.25	4.25	4.65	4.25	4.38	4.13	4.68
The Mobile Crisis staff spoke to me in a way that I understood	4.13	4.27	4.28	4.63	X	X	X	X
Mobile Crisis helped my child/family get the services needed or made contact with my current service provider (if you had one at the time you called Mobile Crisis)	4.13	4.17	4.17	4.47	X	X	X	X
The services or resources my child and/or family received were right for us	4.13	4.18	4.13	4.42	X	X	X	X
The child/family I referred to Mobile Crisis was connected with appropriate services or resources upon discharge from Mobile Crisis	X	X	X	X	4.25	4.36	4.17	4.53
Overall, I am very satisfied with the way that Mobile Crisis responded to the crisis	4.13	4.27	4.18	4.67	4.25	4.38	4.15	4.55
Sub-Total Mean: Mobile Crisis	4.12	4.24	4.22	4.59	4.25	4.38	4.15	4.59
Overall Mean Score	4.09	4.25	4.24	4.63	4.25	4.40	4.16	4.62

*All items collected by 2-1-1, in collaboration with the PIC and DCF; measured on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree)

Client Comments:

- Mom stated she is extremely grateful for the therapist from Clifford Beers who worked with her daughter. Per mom she got more than she expected from MCI and her daughter has opened up so much.
- Mom thought the process was great. Mom stated the clinician really connected with her daughter, who is generally shy.
- 1st time parent and they felt the whole process was outstanding. Father stated that her daughter had an instant connection with Clinician and only wish she could see her ongoing.
- Parent reports youth has used the service frequently for support. She reports she feels it has been helpful for youth to have an outside person to speak to in order to assist during times of need.
- Caller reports MCI did their job but the youth did not respond to the attempt to speak by phone.
- Caller reports she is overall disappointed with the wait time for 211 and that youth is too volatile for the time she has to wait.

Referrer Comments:

- Foster mother reports everything went well that day and they have not had the same concerns since.
- ED clinician reports being very happy with the service and referrals she has made when calling for services.
- Caller stated that she really loves the two level connection: 211 to the provider.
- DCF supervisor reports the collaboration with both 211 and youth MCI was very good for this very difficult situation. He reports being very happy with the follow-up beyond the initial assessment.
- DCF investigator stated she appreciates all that we have done and stated generally her work is made easier from us.
- Caller reports youth is still receiving the inpatient treatment youth MCI helped to facilitate, "Thank you so much for your help."
- "Sometimes I have trouble getting through when I call and I wait on hold but everything else is fine."
- Clinical case manager upset that the male clinician told her to give him a tablet and that they can do a zoom. She felt that there should have been more done as it was not effective.

Figure 76. Parent/Guardian Satisfaction with the Mental Health Services their Child Received by Service Area

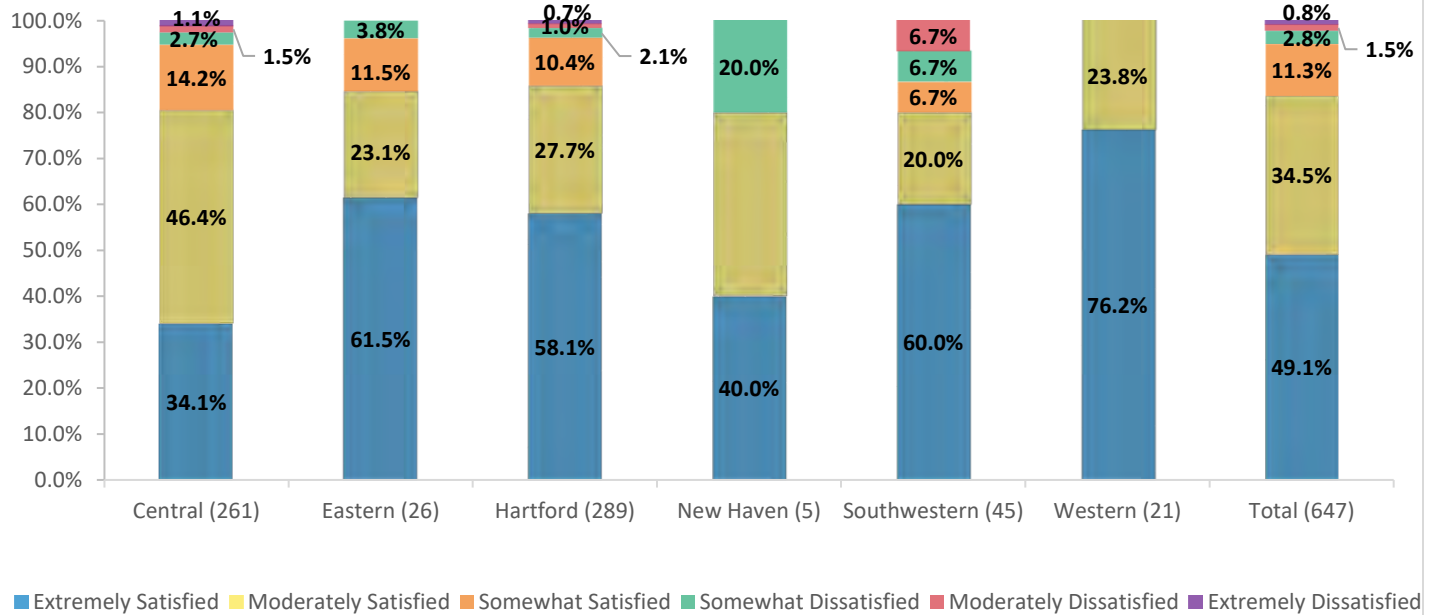
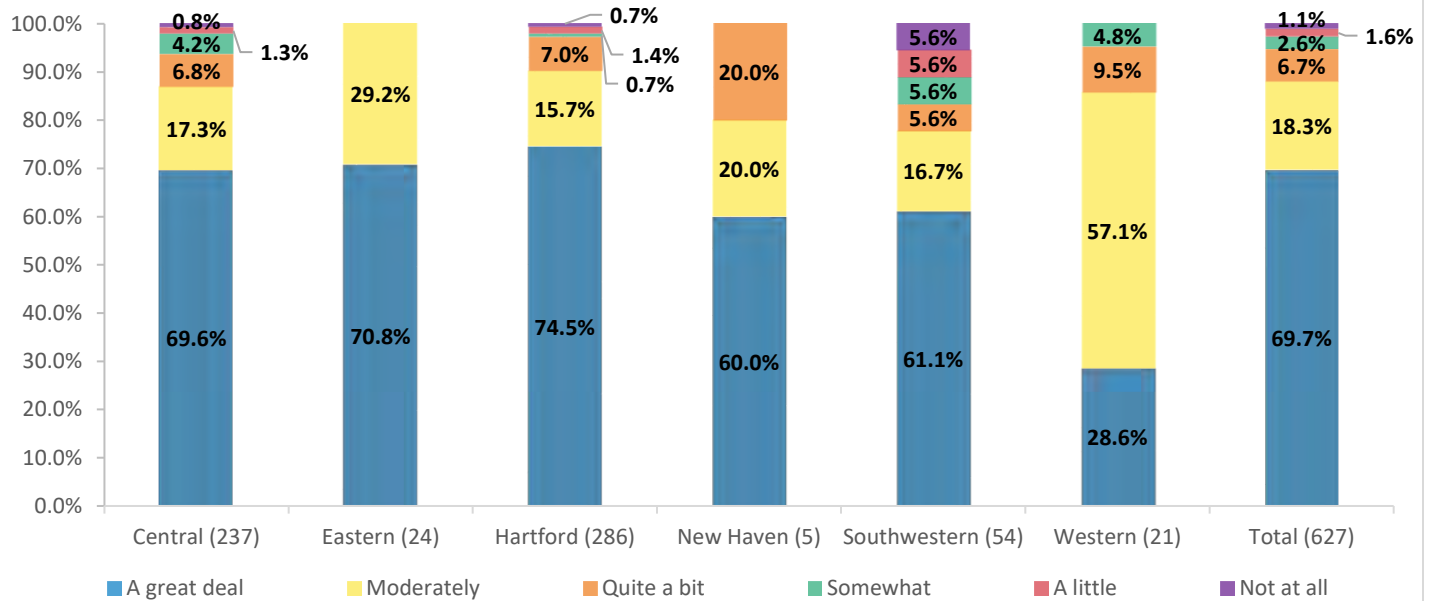


Figure 77. Parent/Guardian Rating of the Extent to Which the Child's Treatment Plan Included their Ideas about their Child's Treatment Needs by Service Area



Section XI: Training Attendance

	DBHRN	Crisis API	DDS	CCSRs	Trauma	Violence	CRC	Emerg. Certificate	QPR	A-SBIRT	ASD	PSB	SR	All 13 Trainings Completed	All 13 Completed for Full-Time Staff Only
Statewide (148)*	56%	66%	49%	46%	57%	42%	51%	52%	25%	36%	60%	44%	54%	5%	7%
CHR:MidHosp (10)*	80%	80%	60%	90%	80%	80%	70%	70%	100%	70%	90%	60%	50%	20%	20%
CHR (11)*	36%	73%	27%	91%	36%	36%	27%	45%	18%	9%	55%	45%	55%	0%	0%
UCFS:NE (8)*	75%	75%	38%	100%	88%	38%	75%	38%	25%	88%	63%	25%	63%	13%	14%
UCFS:SE (14)*^	57%	71%	50%	93%	57%	50%	50%	43%	43%	93%	43%	21%	64%	0%	0%
Wheeler:Htdf (22)*^	55%	64%	59%	5%	59%	32%	55%	59%	9%	5%	59%	55%	32%	0%	0%
Wheeler:Meridn (3)*	33%	67%	33%	33%	100%	33%	67%	67%	0%	0%	100%	67%	100%	0%	0%
Wheeler:NBrit (14)*	93%	93%	50%	14%	71%	71%	86%	86%	0%	7%	93%	0%	86%	0%	0%
CliffBeers (20)*	50%	55%	60%	70%	50%	35%	35%	40%	55%	60%	65%	55%	60%	10%	11%
CFGC:South (4)*	50%	75%	75%	25%	50%	25%	75%	50%	0%	25%	25%	0%	50%	0%	0%
CFGC:Nrwk (3)*	33%	33%	33%	67%	33%	33%	33%	33%	0%	33%	67%	33%	33%	0%	0%
CFGC:EMPS (8)*	100%	100%	88%	75%	100%	63%	100%	100%	38%	63%	100%	88%	100%	38%	43%
Well:Dnby (3)*^	33%	67%	67%	0%	33%	33%	33%	33%	0%	0%	33%	33%	33%	0%	0%
Well:Torr (3)*^	100%	100%	100%	33%	100%	100%	100%	100%	33%	67%	100%	33%	33%	0%	0%
Well:Wtby (25)*^	24%	36%	20%	0%	28%	16%	16%	24%	0%	8%	24%	16%	32%	0%	0%
Full-Time Staff Only (99)	64%	73%	57%	51%	61%	42%	58%	57%	27%	42%	67%	49%	65%	7%	

* Count of active staff for each provider or category is in parentheses. Includes all full-time, part-time and per diem staff employed by the provider as of 6/30/21.

^Includes staff without assigned location or working across multiple sites.

**1 staff member missing active status information. 4 active staff missing part/full-time status information.

Training Title Abbreviations

DBHRN=Disaster Behavioral Health Response Network
 QPR= Question, Persuade and Refer
 Crisis API = Crisis Assessment, Planning and Intervention
 A-SBIRT= Adolescent Screening, Brief Intervention and Referral to Treatment
 DDS=An Overview of Intellectual Developmental Disabilities and Positive Behavioral Supports
 ASD = Autism Spectrum Disorder

CCSRs=Columbia Suicide Severity Rating Scale
 Trauma = Traumatic Stress and Trauma Informed Care
 Violence = Violence Assessment and Prevention
 CRC = 21st Century Culturally Responsive Mental Health Care
 Emerg. Certificate= Emergency Certificate
 PSB = Problem Sexual Behavior (Added October 2019)
 SR = School Refusal (Added August 2019)

Section XII: Ohio Scales Completion

Figure 78. Ohio Scales Collected at Intake by Provider

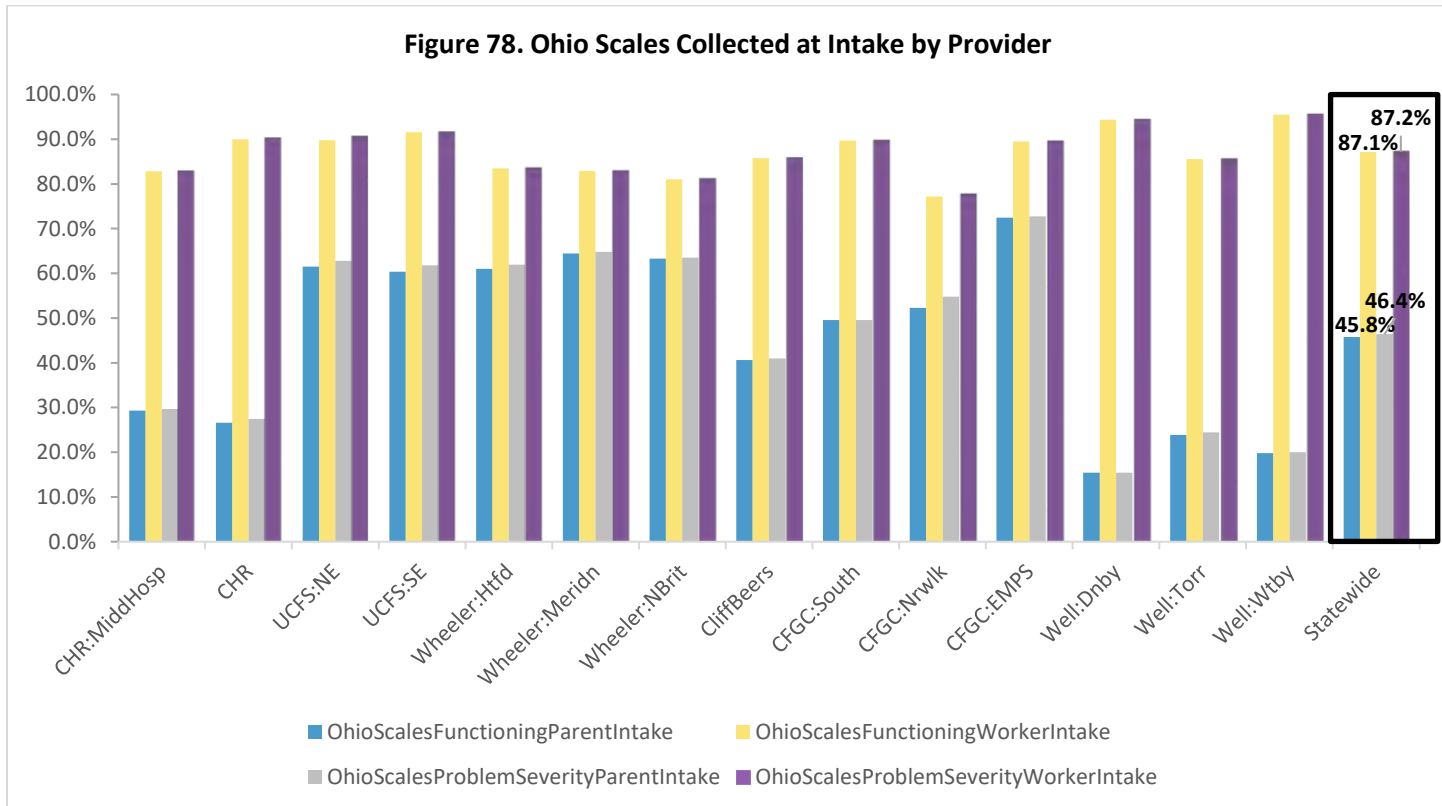
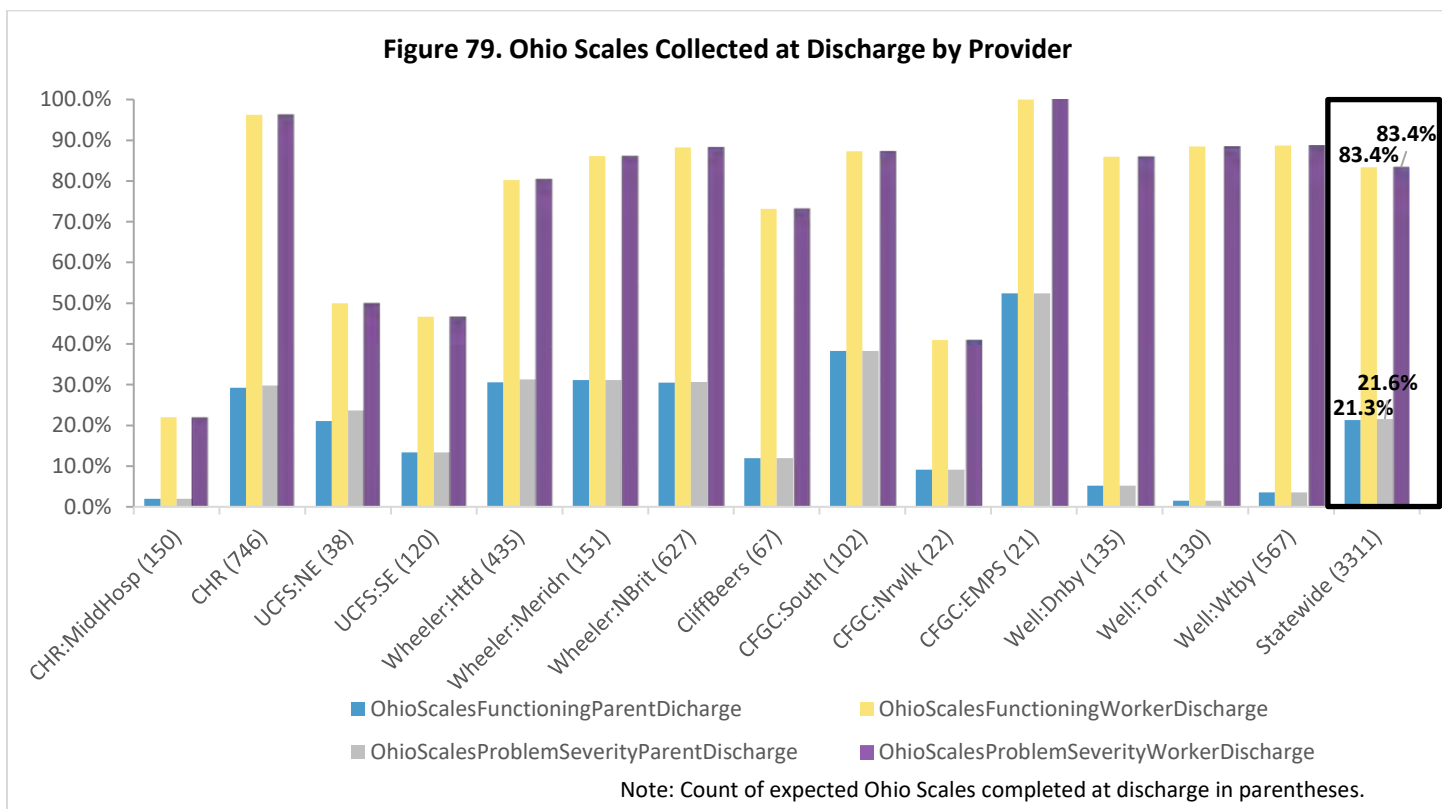


Figure 79. Ohio Scales Collected at Discharge by Provider



Note: Count of expected Ohio Scales completed at discharge in parentheses.

Section XIII: Provider Community Outreach

Table 7. Number of Times Providers Conducted Formal* Outreach to the Community

<u>Provider</u>	<u>Q1 FY20</u>	<u>Q2 FY20</u>	<u>Q3 FY20</u>	<u>Q4 FY20</u>	<u>Total</u>
CENTRAL	4	2	5	5	16
CHR/MiddHosp-EMPS	0	1	2	3	6
CHR-EMPS	4	1	3	2	10
EASTERN	1	7	3	4	15
UCFS-EMPS:NE	0	3	0	0	3
UCFS-EMPS:SE	1	4	3	4	12
HARTFORD	3	3	2	0	8
Wheeler-EMPS:Htfd	3	1	1	0	5
Wheeler-EMPS:Meridn	0	0	0	0	0
Wheeler-EMPS:NBrit	0	2	1	0	3
NEW HAVEN	1	1	2	4	8
CliffBeers-EMPS	1	1	2	4	8
SOUTHWESTERN	0	4	7	0	11
CFGC/South-EMPS	0	2	4	0	6
CFGC-EMPS:Nrwk	0	0	3	0	3
CFGC-EMPS	0	2	0	0	2
WESTERN	6	3	2	3	14
Well-EMPS:Dnby	1	2	1	2	6
Well-EMPS:Torr	0	0	0	1	1
Well-EMPS:Wtby	5	1	1	0	7
Statewide	15	20	21	16	72

*Formal outreach refers to: 1) In person presentations lasting 30 minutes, preferably more, using the Mobile Crisis PowerPoint slides and including distribution to attendees of marketing materials and other Mobile Crisis resources; 2) Outreach presentations that are in person that include workshops, conferences, or similar gatherings in which Mobile Crisis is discussed for at least an hour or more; 3) Outreach presentations that are not in person which may include workshops, conferences, or similar gatherings in which the Mobile Crisis marketing video, banner, and table skirt are set up for at least 2 hours with marketing materials made available to those who would like them; 4) The Mobile Crisis PIC considers other outreaches for inclusion on a case-by-case basis, as requested by Mobile Crisis providers.

Appendices

Appendix A: Description of Calculations

Section II: Primary Mobile Crisis Performance Indicators and Monthly Trends

- Figures 1 and 2 tabulate the total number of calls by 211-Only, 211-EMPS, or Registered Calls. Figure 1 also notes the number of Crisis-Response Follow-up calls that did not result in episodes, but were coded with a call type “211-EMPS”.
- Figures 3 and 4 calculate the total number of Mobile Crisis episodes, including After Hours calls for the designated service area. Mobile Crisis operates between 6:00 a.m. and 10:00 p.m. Monday through Friday, and 1:00 p.m. to 10:00 p.m. on weekends and holidays. Calls that come are placed outside of these times are considered “After Hours calls”.
- Figures 5 and 6 show the number of children served by Mobile Crisis per 1,000 children. This is calculated by summing the total number of episodes for the specified service area multiplied by 1,000; this result is then divided by the total number of youth in that particular service area as reported by U.S. Census data.
- Figures 7 and 8 determine the number of children served by Mobile Crisis that are TANF eligible out of the total number of children in that service area that are eligible for free or reduced lunch⁸.
- Figures 9 and 10 calculate a mobility rate by dividing the number of episodes that both received a mobile or deferred mobile response from a Mobile Crisis provider *and* were recommended by 2-1-1 for a mobile or deferred mobile response by the total number of episodes that were recommended to receive a mobile or deferred mobile response by 2-1-1. This calculation excludes calls that were referred by a third party (schools, EDs, etc.) where the family declined services or was not available.
- Figures 11 and 12 isolate the total number of episodes that were coded as having a mobile response and had a response time under 45 minutes divided by the total number of episodes that were coded as having a mobile response. Response time is calculated by subtracting the episode Call Date Time (time of the call to 2-1-1) from the First Contact Date Time (time Mobile Crisis arrived on site). The calculation then subtracts 10 minutes from the response time to account for the time it generally takes to complete the intake with 2-1-1 and transfer the call to a Mobile Crisis provider.

Section III: Episode Volume

- Figure 13 is a map showing the number of Mobile Crisis Episodes relative to the child population of each town. The total number of episodes in a town is multiplied by 1,000 and then divided by the child population. 211-Only calls are not assigned a town and thus excluded from this calculation.
- Figure 14 tabulates the total number of calls by the “Call Type” categories of 211 Only, 211-EMPS, or Registered Calls. Calls categorized as “211-EMPS” or “Registered Calls” generally result in new episodes of care, whereas calls categorized as “211 Only” may be calls that resulted in follow up responses to already open episodes, transfers to 9-1-1, provision of information and referrals, etc.
- Figure 15 shows the 2-1-1 disposition of all calls received.
- Figure 16 displays the trend in call and episode volume since FY2011.
- Figure 17 shows the total Mobile Crisis response episodes, including After Hours calls by provider.
- Figure 18 show the number served per 1,000 children in the population by provider and uses the same calculation as Figure 5.
- Figure 19 is a stacked bar chart that represents the percent of episodes that have a crisis response of phone only, face-to-face, or plus stabilization follow-up (episodes that required follow up care by Mobile Crisis in addition to the immediate crisis stabilization). Each percentage is calculated by counting the number of episodes in the respective category (e.g., phone only) divided by the total number of episodes coded for crisis response for that specified service area.
- Figure 20 calculates the same percentage as Figure 19, but is shown by provider.

⁸ National Center for Education Statistics, 2016-2017 via PolicyMap

Section IV: Demographics

- Figure 21 shows the percentage of male and female children served per the response provided to the intake question regarding sex assigned at birth.
- Figure 22 age groups reflect episode counts, and may include duplicate counts of children who were served for multiple episodes within the year.
- Figure 23 shows the percentage of episodes with children identified as Hispanic by their ethnic background. Figure 23 and 24 report data as collected which aligns with the categories used by the U.S. Census.
- Figure 24 breaks out the percentages of episodes by the races of children served.
- Figure 25 is calculated by taking the count of each type of health insurance reported at intake, dividing by the total number of responses.
- Figure 26 is calculated by taking the count of "yes" TANF responses across episodes by each provider, and dividing by the total number of TANF responses collected across episodes by provider.
- Figure 27 is calculated by taking the count of each DCF status category reported at intake, dividing by total count of responses collected.

Section V: Diagnosis and Clinical Functioning

- Figure 28 shows the percentages for the top six primary presenting problems by service area. The top 6 presenting problems are Harm/Risk of Harm to Self, Disruptive Behavior, Depression, Family Conflict, Anxiety, and Harm/Risk of Harm to Others. Remaining presenting problems reported are combined into the category "other". The count of each presenting problem is divided by the total reported.
- Figure 29 is calculated by taking the count of each primary diagnostic category reported at intake, dividing by total count collected.
- Figure 30 is calculated by taking the count of each secondary diagnostic category reported at intake, dividing by total count collected.
- Figure 31 is calculated by taking the count of each primary diagnostic category reported at intake for each provider and dividing by the total count collected for the given provider. Only the top 6 diagnostic categories are included in this chart: Depressive Disorders, Adjustment Disorders, Conduct Disorders, ADHD, Anxiety Disorders, and Trauma Disorders.
- Figure 32 reports on the secondary diagnostic category, and is calculated in the same way as figure 31.
- Figure 33 shows the percentage of children meeting SED criteria. Serious Emotional Disturbance is defined by the federal statute as applying to a child with a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM), and whose condition results in functional impairment, substantially interfering with one or more major life activities or the ability to function effectively in social, familial, and educational contexts.
- Figure 34 is calculated by taking the count of "yes" responses to trauma history at intake divided by the total count of responses. Calculations are broken down by service area.
- Figure 35 is calculated by dividing the count of each individual type of trauma by the total of yes responses to trauma history by service area. Calculations are broken down by service area.
- Figure 36 is calculated by taking the number of clients evaluated in an ED 1 or more times (during the episode and in the six months prior) divided by the total number of responses. The data is broken down by service area.

- Figure 37 is calculated by taking the number of clients admitted (inpatient) 1 or more times divided by the total responses. Inpatient history was considered during the child's lifetime, in the six months prior to the episode, and during the episode. The data is broken down by service area.
- Figure 38 is calculated in the same way as Figure 36, but considering whether or not the client has been placed in an out of home setting.
- Figure 39 is calculated in the same way as Figure 37, but reports the child's history of alcohol and drug use.
- Figure 40 shows the percentages of each type of parent/guardian service needs statewide, out of the total responses provided.
- Figure 41 shows the parent reported feeling of capability for dealing with the child's problems, rated from extremely capable to extremely incapable. The percentage of each response is calculated, and reported comparing intake scores to discharge scores.
- Figure 42 shows the parent/guardian rating of the child's school attendance during the episode of care compared to pre-admission. The percentages are calculated using the count answered in each category (ranging from less attendance to greater, or indicating no school attendance), divided by the total number answered.
- Figure 43 is calculated in the same way as Figure 36, but reports whether the child has been suspended or expelled from school.
- Figure 44 shows the percentage of school issues that impact the client's functioning at school, reported at intake. This is calculated by taking the count of each type of school issue (Academic, Social, Behavioral, Emotional, Other) divided by the total responses provided. Data is broken down by service area.
- Figure 45 is calculated in the same way as Figure 36, but reports the child's history of arrest in the 6 months prior to and during the episode of care.
- Figure 46 is calculated in the same way as Figure 36, but reports the child's history of being detained in the six months prior to or during the episode of care.

Section VI: Referral Sources

- Figure 47 and Table 1 are percentage break outs of referral sources across the state. Table 1 is broken down by service area and provider, in addition to reporting statewide percentages.
- Figure 48 displays trends since 2011 for the top 3 referral sources – self/family, school, and emergency departments.
- Figure 49 is the same as Figure 48, but only showing the trends in Emergency Department referrals.
- Figure 50 counts the number of referrals made to Mobile Crisis by the ED (categorized as routine follow-up or in-patient diversion) out of total episodes, and is broken down by service area.
- Figure 51 calculates the percent of Mobile Crisis episodes that were referred by EDs by service area. This is calculated by counting the total number of ED referrals for the specified service area divided by the total number of Mobile Crisis response episodes for that service area.
- Figures 52 and 53 use the same calculation as 50 and 51 respectively, but are broken down by provider.

Section VII: 211 Recommendations and Mobile Crisis Response

- Figure 54 calculates the percent of each response mode (i.e., mobile, non-mobile, deferred mobile) recommended by 2-1-1, broken down by provider.
- Figure 55 (in contrast to Figure 54) shows the percentage of the actual Mobile Crisis response mode (i.e., mobile, non-mobile, deferred mobile), regardless of recommended response, broken down by provider.

- Figures 56 and 57 show the percent of 2-1-1 recommended response of mobile and non-mobile episodes where the actual Mobile Crisis response was different than the recommended response. These are broken down by provider.
- Figure 58 shows the trend in statewide mobility rate since FY2011.
- Figure 59 is the same graph as Figure 9 from the Dashboard section of the report.
- Figure 60 uses the same calculation as Figure 9 but shows the mobility rate (percent mobile & deferred mobile) by provider.
- Figure 61 shows the percent of each type of mobile site location (i.e., home, school, emergency department, etc.) where the first mobile contact for the episode took place, broken down by service area.
- Figure 62 shows the mean number of mobile contacts and office visits occurring during an episode of care. This is calculated by finding the average number of all mobile contacts and all office visits occurring during an episode of care. Only episodes with a crisis response of *stabilization plus follow up* are included.
- Figure 63 provides the percent break down of the different reasons for an episode receiving a non-mobile Mobile Crisis response.
- Figure 64 shows the rate at which the first contact for a non-mobile response occurs via telephone or office visit.
- Figure 65 is a visual representation of actual Mobile Crisis responses for each of the 2-1-1 recommended response categories for the total number of calls to Mobile Crisis.

Section VIII: Response Time

- Figure 66 shows the trend in statewide response rate under 45 minutes since FY2011.
- Figure 67 is the same graph as shown in Figure 11 from the Dashboard section of the report.
- Figure 68 uses the same calculation as Figure 11 but shows the percent of mobile episodes with response time under 45 minutes by provider.
- Figure 69 reports the median response time for mobile responses by service area. The median is calculated by selecting the middle response time when listing all response times from shortest to longest.
- Figure 70 uses the same calculation as Figure 69 but is broken down by provider.
- Figure 71 uses the same calculation as Figures 69 and 70, but includes only deferred mobile responses and is reported in hours by services area.
- Figure 72 uses the same calculation as Figure 71, but is broken down by provider.

Section IX: Length of Stay and Discharge Information

- Table 2 shows the mean and median lengths of stay for episodes with Phone Only, Face to Face, and Plus Stabilization Follow-up responses, broken down by service area and by provider for discharged episodes for the current reporting period. Additionally, the table reports the percentages of episodes within each response type that are open beyond the identified threshold for each type of response (for Phone Only, the percentage reflects the proportion of discharged episodes with a Phone Only response that were open for more than one day; for Face to Face, the percentage reflects episodes open for more than five days, and for Stabilization Plus Follow-up, the percentage reflects episodes open for more than 45 days). N/A indicates that there were no episodes fitting the criteria to include in the calculation. This table also shows the total number of episodes used to calculate the mean, median and percentages.
- Table 3 shows the same information as Table 2 but for open episodes still in care.
- Figure 73 shows the top six reasons for client discharge statewide. This percentage is calculated based upon the number of discharged episodes with the “Reason for Discharge” response completed.

- Figure 74 represents the statewide percentages of the top six places where clients live at discharge. Only episodes with an end date are included.
- Figure 75 shows percentages for the types of services clients were referred to at discharge. Only episodes with an end date are included.
- Table 4 shows the number and mean scores of the Ohio Scales collected at intake and discharge. Ohio Scales are a reliable and valid assessment tool used to track progress of children and youth receiving mental health intervention services. Ohio Scales measure both the youth’s problem severity (rated across 44 items related to common problems for youth), as well as his/her ability to function (rated across 20 items related to typical daily activity).⁹ Ohio Scales are completed separately by the parent, the clinician, and the youth.

In the table the term “paired” refers to pairing an intake and discharge score; i.e., only episodes with both intake and discharge scales collected were included. The table also only includes episodes with a mobile or deferred mobile response and a crisis response type of Face-to-Face or Plus Stabilization Follow-up. The Mean Intake and Mean Discharge refer to the average scores at intake and discharge for the given region, and the Mean Difference refers to the difference between the two averages. Statistical significance associated with a given scale indicates a likelihood that the difference from intake to discharge is not due to chance.

Section X: Client and Referral Source Satisfaction

- Table 5 shows the mean outcomes of the client and referral source satisfaction survey collected for 2-1-1 and Mobile Crisis. All items are measured on a scale of 1 (strongly disagree) to 5 (strongly agree). A sample of comments are also included. These survey responses are collected by 2-1-1 each quarter across approximately 30 client families and another 30 referring parties.
- Figure 76 shows the statewide percent of parent/guardian satisfaction with the mental health services their child received, calculated by taking the count for each category divided by the total responses to the survey broken down by service area.
- Figure 77 shows the statewide percent of parent/guardian rating of the extent to which the child’s treatment plan included their ideas, calculated by taking the count for each category divided by the total responses to the survey.

Section XI: Training Attendance

- Table 6 shows the trainings completed by staff employed by the agency as of June 30, 2021

Section XII: Data Quality Monitoring

- Figure 78 calculates the percent of Ohio Scales collected by each provider *at intake* by dividing actual over expected. Only episodes that have a mobile or deferred mobile response with a crisis response type of Face-to-Face or *stabilization plus follow up* are expected to have Ohio Scales collected. Therefore, this criteria is applied to both the actual (numerator) and the expected (denominator) in calculating the percentage collected.
- Figure 79 is the same as Figure 78, but only includes Ohio Scales collected *at discharge*.

Section XIII: Provider Community Outreach

- Table 7 is a count of formal outreach activities performed in the community by each provider during each quarter. The definition of “formal outreach” is included below the table.

⁹ Ogles, B. M., Melendez, G., Davis, D. C., & Lunnen, K. M. (2001). The Ohio Scales: Practical Outcome Assessment. *Journal of Child and Family Studies*, 10(2), 199–212.

Appendix B: List of Diagnostic Codes¹⁰ Combined

Adjustment Disorders:

- F43.21 - Adjustment Disorder w/ Depressed Mood
- F43.22 - Adjustment Disorder with Anxiety
- F43.23 - Adjustment Disorder w/ Mixed Anxiety & Depressed Mood
- F43.24 - Adjustment Disorder with Disturbance of Conduct
- F43.25 - Adjustment Disorder w/ Mixed Disturbance of Emotions & Conduct
- F43.20 - Adjustment Disorder Unspecified

Anxiety Disorders:

- F41.9 - Unspecified Anxiety Disorder
- F41.8 - Other specified Anxiety Disorder
- F41.0 - Panic Disorder
- F41.1 - Generalized Anxiety Disorder
- F40.00 - Agoraphobia
- F93.0 - Separation Anxiety Disorder
- F94.0 - Selective Mutism
- F40.10 - Social Anxiety Disorder (Social Phobia)
- F40.218 - Specific Phobia, Animal
- F40.230 - Specific Phobia, Fear of Blood
- F40.231 - Specific Phobia, Fear of Injections and Transfusions
- F40.233 - Specific Phobia, Fear of Injury
- F40.232 - Specific Phobia, Fear of Other Medical Care
- F40.228 - Specific Phobia, Natural Environment
- F40.298 - Specific Phobia, Other
- F40.248 - Specific Phobia, Situational

Attention Deficit/Hyperactivity Disorders:

- F90.0 - Attention Deficit/Hyperactivity Disorder, Predominantly Inattentive Presentation
- F90.2 - Attention Deficit/Hyperactivity Disorder, Combined Presentation
- F90.1 - Attention Deficit/Hyperactivity Disorder, Predominantly Hyperactive/Impulsive Presentation
- F90.8 - Other Specified Attention-Deficit/Hyperactivity Disorder
- F90.9 – Unspecified Attention-Deficit/Hyperactivity Disorder

Bipolar Disorders:

- F31.0 - Bipolar I Disorder, Current or Most Recent Episode Hypomanic
- F31.9 - Bipolar I Disorder, Current or Most Recent Episode Hypomanic, Unspecified
- F31.9 - Bipolar I Disorder, Current or Most Recent Episode Manic, Unspecified
- F31.11 - Bipolar I Disorder, Current or Most Recent Episode Manic, Mild
- F31.12 - Bipolar I Disorder, Current or Most Recent Episode Manic, Moderate
- F31.13 - Bipolar I Disorder, Current or Most Recent Episode Manic, Severe Without Psychotic Features

¹⁰ World Health Organization. (2015). International statistical classification of diseases and related health problems, 10th revision, Fifth edition, 2016. World Health Organization.

F31.2 - Bipolar I Disorder, Current or Most Recent Episode Manic, Severe With Psychotic Features
F31.71 - Bipolar I Disorder, Current or Most Recent Episode Hypomanic, In Partial Remission
F31.73 - Bipolar I Disorder, Current or Most Recent Episode Manic, In Partial Remission
F31.74 - Bipolar I Disorder, Current or Most Recent Episode Manic, In Full Remission
F31.72 - Bipolar I Disorder, Current or Most Recent Episode Hypomanic, In Full Remission
F31.9 - Bipolar I Disorder, Current or Most Recent Episode Depressed, Unspecified
F31.31 - Bipolar I Disorder, Current or Most Recent Episode Depressed, Mild
F31.32 - Bipolar I Disorder, Current or Most Recent Episode Depressed, Moderate
F31.4 - Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe Without Psychotic Features
F31.5 - Bipolar I Disorder, Current or Most Recent Episode Depressed, Severe With Psychotic Features
F31.75 - Bipolar I Disorder, Current or Most Recent Episode Depressed, In Partial Remission
F31.76 - Bipolar I Disorder, Current or Most Recent Episode Depressed, In Full Remission
F31.9 - Bipolar I Disorder, Current or Most Recent Episode Unspecified
F31.9 - Unspecified Bipolar and Related Disorder
F31.81 - Bipolar II Disorder
F31.89 - Other Specified Bipolar and Related Disorders

Conduct Disorders:

F63.81 - Intermittent Explosive Disorder
F91.1 - Conduct Disorder, Childhood-Onset Type
F91.2 - Conduct Disorder, Adolescent-Onset Type
F91.9 - Conduct Disorder, Unspecified Onset
F91.8 - Other Specified Disruptive, Impulse-Control, and Conduct Disorder
F91.9 - Unspecified Disruptive, Impulse-Control, and Conduct Disorder
F91.3 - Oppositional Defiant Disorder

Depressive Disorders:

F32.9 - Major Depressive Disorder, Single Episode, Unspecified
F32.0 - Major Depressive Disorder, Single Episode, Mild
F32.1 - Major Depressive Disorder, Single Episode, Moderate
F32.2 - Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
F32.3 - Major Depressive Disorder, Single Episode, Severe With Psychotic Features
F32.4 - Major Depressive Disorder, Single Episode, In Partial Remission
F32.5 - Major Depressive Disorder, Single Episode, In Full Remission
F33.9 - Major Depressive Disorder, Recurrent, Unspecified
F33.0 - Major Depressive Disorder, Recurrent, Mild
F33.1 - Major Depressive Disorder, Recurrent, Moderate
F33.2 - Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
F33.3 - Major Depressive Disorder, Recurrent, Severe With Psychotic Features
F33.41 - Major Depressive Disorder, Recurrent, In Partial Remission
F33.42 - Major Depressive Disorder, Recurrent, In Full Remission
F34.1 - Persistent Depressive Disorder, Dysthymia
F32.8 - Other Specified Depressive Disorder

F32.9 - Unspecified Depressive Disorder
N94.3 - Premenstrual Dysphoric Disorder

Diagnosis Due to Medical Condition

F05 - Delirium Due To another Medical Condition
F05 - Delirium Due to Multiple Etiologies
F06.2 - Psychotic Disorder Due to another Medical Conditions, With Delusions
F06.0 - Psychotic Disorder Due to another Medical Conditions, With Hallucinations
F06.33 - Bipolar and Related Disorder Due to another Medical Condition, Manic Features
F06.33 - Bipolar and Related Disorder Due to another Medical Condition, Manic Hypomanic-Like Episodes
F06.34 - Bipolar and Related Disorder Due to another Medical Condition, Mixed Features
F06.31 - Depressive Disorder Due to another Medical Condition, Depressive Features
F06.32 - Depressive Disorder Due to another Medical Condition, Major Depressive-Like Episode
F06.34 - Depressive Disorder Due to another Medical Condition, Mixed Features
F06.4 - Anxiety Disorder Due To another Medical Condition
F06.1 - Catatonic Disorder Due to another Medical Condition
F02.80 - Major Neurocognitive Disorder Due to another Medical Condition, Without Behavioral Disturbance
F02.81 - Major Neurocognitive Disorder Due to another Medical Condition, Behavioral Disturbance
G31.84 - Mild Neurocognitive Disorder Due to another Medical Condition
F06.8 - Obsessive-Compulsive and Related Disorder Due to another Medical Condition
F06.8 - Other Specified Mental Disorder Due to another Medical Condition
F09 - Unspecified Mental Disorder Due to another Medical Condition
F07.0 - Personality Change Due to another Medical Condition
G47.429 - Narcolepsy Secondary to another Medical Condition

Obsessive Compulsive Disorder

F42 - Hoarding Disorder
F42 - Obsessive-Compulsive Disorder
F42 - Other Specified Obsessive Compulsive and Related Disorder
F42 - Unspecified Obsessive-Compulsive and Related Disorder
F45.22 - Body Dysmorphic Disorder
L98.1 - Excoriation (Skin Picking) Disorder
F63.3 - Trichotillomania (Hair Pulling Disorder)

Psychotic Disorder

F06.1 - Catatonia Associated with another Mental Disorder, Catatonia Specifier
F20.81 - Schizophreniform Disorder
F25.0 - Schizoaffective Disorder, Bipolar Type
F25.1 - Schizoaffective Disorder, Depressive Type
F20.9 - Schizophrenia
F22 - Delusional Disorder
F28 - Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
F29 - Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Trauma Disorders

F43.0 - Acute Stress Disorder

F43.10 - Posttraumatic Stress Disorder

F43.8 - Other Specified Trauma and Stressor Related Disorder

F43.9 - Unspecified Trauma and Stressor Related Disorder

F94.2 - Disinhibited Social Engagement Disorder

F94.1 - Reactive Attachment Disorder

Z91.49 - Other Personal History of Psychological Trauma

Other Disorders

F84.0 - Autism Spectrum Disorder

F34.8 - Disruptive Mood Dysregulation Disorder

Appendix C: Tables

Table 8. Percent Type of Health Insurance at Intake (relates to Figure 25)

	HUSKY A	Private	No Health Insurance	Other	HUSKY B	Medicaid (non-HUSKY)	Military Health Care	Medicare
STATEWIDE	57.3%	32.0%	1.4%	6.8%	1.4%	0.4%	0.6%	0.1%
CENTRAL	55.9%	40.6%	0.8%	1.1%	0.9%	0.3%	0.5%	0.0%
CHR/MiddHosp-EMPS	53.4%	42.3%	1.7%	0.4%	1.3%	0.4%	0.4%	0.0%
CHR-EMPS	56.6%	40.1%	0.6%	1.3%	0.8%	0.2%	0.5%	0.0%
EASTERN	57.1%	32.3%	1.6%	3.4%	1.5%	0.3%	3.8%	0.0%
UCFS-EMPS:NE	61.9%	32.6%	1.3%	3.4%	0.8%	0.0%	0.0%	0.0%
UCFS-EMPS:SE	54.8%	32.1%	1.8%	3.4%	1.8%	0.4%	5.6%	0.0%
HARTFORD	62.9%	32.2%	1.0%	2.1%	1.5%	0.1%	0.3%	0.0%
Wheeler-EMPS:Htfd	69.3%	23.7%	1.7%	3.8%	1.3%	0.1%	0.1%	0.0%
Wheeler-EMPS:Meridn	61.3%	35.2%	0.4%	1.1%	1.9%	0.0%	0.0%	0.0%
Wheeler-EMPS:NBrit	58.0%	38.4%	0.6%	1.0%	1.5%	0.0%	0.5%	0.0%
NEW HAVEN	56.7%	33.8%	1.0%	4.7%	2.4%	0.8%	0.3%	0.4%
CliffBeers-EMPS	56.7%	33.8%	1.0%	4.7%	2.4%	0.8%	0.3%	0.4%
SOUTHWESTERN	53.9%	34.3%	4.2%	4.4%	1.6%	1.3%	0.1%	0.1%
CFGC/South-EMPS	50.6%	33.1%	5.3%	9.4%	1.6%	0.0%	0.0%	0.0%
CFGC-EMPS:Nrwk	41.5%	48.9%	2.1%	2.1%	2.1%	2.7%	0.5%	0.0%
CFGC-EMPS	63.9%	26.5%	4.5%	1.9%	1.3%	1.6%	0.0%	0.3%
WESTERN	51.8%	21.1%	1.2%	24.7%	1.0%	0.2%	0.0%	0.0%
Well-EMPS:Dnby	36.4%	33.8%	2.1%	26.2%	1.5%	0.0%	0.0%	0.0%
Well-EMPS:Torr	46.1%	25.6%	0.6%	26.1%	1.1%	0.6%	0.0%	0.0%
Well-EMPS:Wtby	56.5%	17.2%	1.1%	24.1%	0.8%	0.2%	0.0%	0.0%

Table 9. Type of Trauma Reported at Intake (relates to Figure 35)

	Witness Violence	Victim Violence	Sexual Victimization	Disrupted Attachment / Multiple Placements	Recent Arrest of Caregiver (last 30 days)*	Other
STATEWIDE	19.3%	17.9%	15.4%	22.8%	0.3%	24.3%
CENTRAL	20.0%	16.9%	12.6%	22.3%	0.3%	27.9%
CHR/MiddHosp-EMPS	13.1%	6.1%	11.1%	31.3%	0.0%	38.4%
CHR-EMPS	20.7%	18.0%	12.7%	21.4%	0.3%	26.9%
EASTERN	17.4%	16.4%	17.4%	22.8%	0.2%	26.0%
UCFS-EMPS:NE	17.8%	14.1%	20.9%	24.1%	0.5%	22.5%
UCFS-EMPS:SE	17.1%	17.4%	15.7%	22.2%	0.0%	27.5%
HARTFORD	23.1%	22.4%	19.0%	14.1%	0.4%	21.0%
Wheeler-EMPS:Htfd	24.0%	20.9%	21.8%	11.3%	0.0%	22.0%
Wheeler-EMPS:Meridn	17.3%	24.8%	18.0%	14.3%	0.8%	24.8%
Wheeler-EMPS:NBrit	23.8%	23.1%	16.9%	16.5%	0.6%	19.2%
NEW HAVEN	14.9%	11.6%	7.6%	30.0%	0.9%	34.9%
CliffBeers-EMPS	14.9%	11.6%	7.6%	30.0%	0.9%	34.9%
SOUTHWESTERN	18.1%	14.9%	16.6%	21.9%	0.0%	28.5%
CFGC/South-EMPS	11.6%	14.5%	26.1%	17.4%	0.0%	30.4%
CFGC-EMPS:Nrwk	17.8%	17.8%	13.9%	17.8%	0.0%	32.7%
CFGC-EMPS	20.3%	13.7%	15.0%	25.1%	0.0%	26.0%
WESTERN	18.4%	20.5%	18.3%	29.9%	0.2%	12.6%
Well-EMPS:Dnby	12.4%	24.7%	18.6%	26.8%	1.0%	16.5%
Well-EMPS:Torr	17.9%	20.1%	15.7%	32.1%	0.0%	14.2%
Well-EMPS:Wtby	19.5%	20.0%	18.8%	29.9%	0.2%	11.7%

*Included in "Other" category in Figure 35.

Table 10. Reasons for Client Discharge (relates to Figure 73)

	Met Treatment Goals	Family Discontinued	Client Hospitalized: Psychiatrically	Agency Discontinued: Administrative	Agency Discontinued: Clinical	Child Requires Other Out of Home Care	Family Moved	Child Ran Away	Client Incarcerated	Client Hospitalized: Medically	No Payment Source	Age (too old)	Child Is Deceased
STATEWIDE	78.4%	11.9%	5.8%	2.8%	0.2%	0.2%	0.3%	0.2%	0.0%	0.1%	0.0%	0.0%	0.0%
CENTRAL	68.1%	15.3%	5.6%	9.7%	0.1%	0.3%	0.4%	0.4%	0.0%	0.1%	0.0%	0.0%	0.0%
CHR/MiddHosp-EMPS	77.8%	12.7%	7.0%	1.3%	0.2%	0.8%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CHR-EMPS	64.2%	16.3%	5.0%	13.1%	0.1%	0.2%	0.5%	0.5%	0.0%	0.2%	0.0%	0.0%	0.0%
EASTERN	87.4%	9.3%	2.5%	0.2%	0.2%	0.0%	0.2%	0.3%	0.0%	0.1%	0.0%	0.0%	0.0%
UCFS-EMPS:NE	88.3%	9.9%	1.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
UCFS-EMPS:SE	86.9%	9.0%	2.8%	0.3%	0.3%	0.0%	0.3%	0.4%	0.0%	0.1%	0.0%	0.0%	0.0%
HARTFORD	76.1%	16.9%	3.6%	1.9%	0.6%	0.1%	0.5%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%
Wheeler-EMPS:Htfd	49.6%	36.0%	6.2%	5.2%	1.4%	0.4%	0.7%	0.3%	0.0%	0.3%	0.0%	0.0%	0.0%
Wheeler-EMPS:Meridn	89.1%	7.8%	2.2%	0.0%	0.3%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Wheeler-EMPS:NBrit	92.2%	5.1%	2.0%	0.1%	0.1%	0.0%	0.3%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%
NEW HAVEN	79.7%	10.6%	5.6%	2.9%	0.2%	0.1%	0.3%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%
CliffBeers-EMPS	79.7%	10.6%	5.6%	2.9%	0.2%	0.1%	0.3%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%
SOUTHWESTERN	82.5%	11.5%	4.9%	0.0%	0.1%	0.5%	0.1%	0.1%	0.0%	0.1%	0.0%	0.2%	0.0%
CFGC/South-EMPS	81.7%	10.9%	4.8%	0.0%	0.3%	1.9%	0.3%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%
CFGC-EMPS:Nrwlk	82.8%	11.3%	5.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.3%	0.0%
CFGC-EMPS	82.7%	11.9%	4.7%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.2%	0.0%	0.3%	0.0%
WESTERN	82.9%	3.2%	12.1%	1.0%	0.0%	0.1%	0.3%	0.1%	0.1%	0.1%	0.0%	0.0%	0.1%
Well-EMPS:Dnby	89.9%	4.1%	5.0%	0.3%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Well-EMPS:Torr	89.5%	3.3%	6.6%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Well-EMPS:Wtby	79.4%	3.0%	15.4%	1.3%	0.0%	0.2%	0.2%	0.2%	0.1%	0.2%	0.0%	0.0%	0.1%

Table 11. Type of Services Client Referred at Discharge (relates to Figure 75)

	Referred Back to Original Provider	Outpatient Services	Intensive In-Home Services	Other: Community-Based	Inpatient Hospital	Partial Hospital Program	Intensive Outpatient Program	Extended Day Treatment	Care Coordination	Group Home	Other: Out-of-Home	Residential Treatment	None
STATEWIDE	28.9%	33.0%	8.3%	3.8%	4.5%	2.7%	4.0%	0.8%	1.3%	0.1%	0.7%	0.6%	11.2%
CENTRAL	18.9%	34.2%	7.4%	4.8%	3.3%	4.5%	4.9%	1.1%	2.9%	0.2%	0.9%	0.3%	16.5%
CHR/MiddHosp-EMPS	31.8%	35.7%	7.1%	3.6%	4.3%	4.6%	5.0%	2.2%	0.8%	0.1%	0.8%	0.7%	2.9%
CHR-EMPS	12.2%	33.5%	7.6%	5.4%	2.7%	4.4%	4.9%	0.5%	4.0%	0.3%	0.9%	0.1%	23.5%
EASTERN	26.0%	26.7%	9.2%	2.6%	2.5%	11.3%	1.4%	0.0%	0.3%	0.0%	0.4%	0.3%	19.1%
UCFS-EMPS:NE	26.4%	21.7%	10.0%	4.1%	2.0%	10.7%	1.0%	0.0%	0.8%	0.0%	0.0%	0.4%	22.7%
UCFS-EMPS:SE	25.8%	29.3%	8.8%	1.9%	2.7%	11.7%	1.6%	0.0%	0.1%	0.0%	0.6%	0.3%	17.3%
HARTFORD	33.6%	30.9%	10.9%	3.6%	3.7%	1.3%	5.5%	1.7%	1.0%	0.1%	0.6%	0.6%	6.6%
Wheeler-EMPS:Htfd	35.7%	25.3%	8.8%	4.1%	3.0%	1.3%	7.3%	1.4%	1.0%	0.1%	0.3%	1.2%	10.3%
Wheeler-EMPS:Meridn	30.5%	35.1%	12.4%	4.1%	3.8%	1.0%	2.4%	1.7%	0.7%	0.0%	1.0%	0.0%	7.4%
Wheeler-EMPS:NBrit	32.5%	35.0%	12.4%	2.9%	4.3%	1.4%	4.6%	1.9%	1.0%	0.0%	0.9%	0.1%	2.7%
NEW HAVEN	44.5%	28.1%	5.8%	4.0%	1.9%	0.1%	4.3%	0.8%	1.1%	0.1%	0.8%	0.7%	8.0%
CliffBeers-EMPS	44.5%	28.1%	5.8%	4.0%	1.9%	0.1%	4.3%	0.8%	1.1%	0.1%	0.8%	0.7%	8.0%
SOUTHWESTERN	34.8%	38.6%	2.9%	4.9%	3.0%	0.0%	3.2%	0.1%	1.7%	0.1%	0.9%	0.3%	9.4%
CFGC/South-EMPS	38.3%	44.1%	3.2%	2.6%	2.8%	0.0%	1.8%	0.0%	0.2%	0.4%	1.6%	0.2%	4.9%
CFGC-EMPS:Nrwlk	39.1%	31.1%	3.4%	5.4%	4.3%	0.0%	4.0%	0.4%	1.1%	0.0%	0.4%	0.2%	10.5%
CFGC-EMPS	29.2%	39.5%	2.4%	6.3%	2.4%	0.0%	3.6%	0.0%	3.3%	0.0%	0.8%	0.5%	12.0%
WESTERN	17.0%	38.9%	10.9%	3.1%	12.2%	1.0%	3.1%	0.2%	0.5%	0.4%	0.4%	1.3%	11.1%
Well-EMPS:Dnby	18.3%	50.2%	9.3%	2.7%	3.3%	0.9%	3.0%	0.0%	0.3%	0.0%	0.6%	0.3%	11.1%
Well-EMPS:Torr	18.5%	38.9%	10.0%	2.8%	6.6%	3.4%	3.8%	0.9%	0.6%	0.0%	0.0%	1.6%	12.9%
Well-EMPS:Wtby	16.3%	35.9%	11.5%	3.3%	15.9%	0.5%	3.0%	0.1%	0.5%	0.5%	0.5%	1.6%	10.6%

Table 12. Performance Improvement Plan Goals and Results for Fiscal Year 2020-2021

Service Area	Performance Goals and Relevant Quarter(s)	Goal Achieved	Positive Progress Toward Goal	No Positive Progress
Central	Continue to outreach to schools to support with kids transitioning back (Q1)	Q1		
	Improve rate of completed Parent Discharge Ohio's by 25% (Q1,Q2)		Q4	Q1 ,Q2,Q3
	Continue to fill staff vacancies and train new staff (Q1,Q2,Q3)		Q2,Q3	Q1
	Increase mobility since schools are back in session and utilize telehealth as appropriate if COVID rates increase (Q2,Q3)	Q3	Q2	
	Work on recruitment and hiring of staff (Q4)		Q4	
	To Improve follow up care related to high risk and frequency of kids that need stabilization while waiting for other services (Q3)	Q3		
	Adjust staffing and to the flow incoming referrals and expected productivity (Q3)		Q3	
	Obtain Worker Ohio's 75% of the time and monitor problem severity (Q4)		Q4	
Eastern	Increase the number of Worker Discharged Ohio's to 80 percent (Q1,Q2,Q3,Q4)		Q1	Q2,Q3,Q4
	Decrease the likelihood of family disruption/placement by utilizing SFIT referrals to increase by 1.5% (Q1,Q2,Q3,Q4)	Q3	Q1,Q2,Q4	
	To increase self-care amongst and with MCI team members (Q1,Q2,Q3,Q4)		Q1,Q2,Q3,Q4	
Hartford	Utilize collection of data to determine areas of focus/strength for MCIS staff and team (Q1)	Q1		
	Increase focus on follow up visits for youth based on acuity (Q1, Q2)		Q1, Q2	
	Meet or exceed statewide benchmark of mobile response time (Q2,Q3,Q4)	Q2,Q3,Q4		
	Focus on Ohio collection to ensure MC is using it as an effective tool to inform MCIS care (Q3,Q4)		Q3,Q4	
	MCIS will enhance delivery standards for clients and their families (Q3,Q4)		Q3,Q4	
New Haven	Increase the number of Parent Discharge Ohio's (Q1, Q2,Q3,Q4)		Q1,Q2,Q4	Q3
	Improve mobility response time (Q1,Q2,Q3,Q4)		Q1,Q2,Q3,Q4	
	Improve diversion and timely discharge from EDs by increasing collaboration and training among MC Programs and schools (Q1,Q2)		Q1,Q2	
	Focus on responses to critical situations (Q4)		Q4	
Southwestern	Increase number of Worker Ohio scales obtained at discharged completion goal of 67% (Q1,Q2,Q3,Q4)	Q1,Q2,Q3,Q4		
	Increase number of Parent Ohio scales obtained at discharged completion goal of 30% (Q1,Q2,Q3,Q4)	Q1,Q3,Q4	Q2	
Western	Increase the number of collected Parent Ohio's (Q1,Q2,Q3,Q4)		Q1,Q2,Q3,Q4	
	Improve training of new hires and supervisors within Mobile Crisis Program (Q1,Q2,Q3,Q4)		Q1,Q2,Q3,Q4	
	Maintain staff morale (Q1,Q2,Q3,Q4)		Q1,Q2,Q3,Q4	

Total Goals=67 (includes duplicate counts of goals if continued across multiple quarters); Number of goals achieved (during at least one quarter): 15 of 67 (22%); Number of goals with positive progress (during at least one quarter): 44 of 67 (66%); Number of goals with no positive progress 8 of 67 (12%)