MOBILE CRISIS
RESPONSE TEAM FOR YOUTH

Mobile Crisis Intervention Services

FISCAL YEAR 2024 ANNUAL REPORT

Mobile Crisis Intervention Services is a program funded by the State of Connecticut in partnership with the United Way of Connecticut 2-1-1 and the Child Health and Development Institute (CHDI).

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Mobile Crisis Performance Improvement Center

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This report was developed by the Mobile Crisis Performance Improvement Center, housed at the Child Health and Development Institute (CHDI). For more information, contact Kayla Theriault at ktheriault@chdi.org.

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Contents

Executive Summary

The Child Health and Development Institute (CHDI) serves as the Performance Improvement Center for Connecticut's Mobile Crisis Intervention Services. Mobile Crisis provides youth and families with a community-based, face-to-face response for behavioral health crises, with the goal of keeping children in their homes and preventing utilization of more restrictive services.

This report summarizes episode-level Mobile Crisis data for State Fiscal Year 2024. The report presents data and progress on key indicators of access, quality, and outcomes for Mobile Crisis in Connecticut. Equity is cross-cutting theme, addressed throughout each section of the report, and is a central focus of our work both in Mobile Crisis services and in our quality improvement activities.

During FY2024, Mobile Crisis continued to exceed major performance benchmarks, providing services for children and families all across the state. Though volume has declined, the data shows that the service continues to meet the high standards that have been established in the past 15 years.

In addition to a comprehensive overview of data, this report outlines the activities undertaken by CHDI, Mobile Crisis providers, and DCF to continuously enhance the system. Through our data analysis and quality improvement activities, we have identified a number of areas to focus on in FY 2025:

- Increasing utilization of Mobile Crisis, with a focus on doing so equitably
- Setting goals for improvement that incorporate an equitable lens
- Enhancing training of the Mobile Crisis workforce
- Improving documentation and practices around data collection and entry
- Working with system partners to enhance the relationship between 988, Mobile Crisis, and the overall behavioral health crisis system

KEY FINDINGS FY24:

Mobile Crisis had **11,346** episodes of care serving **8,428** children.

42% of callers to Mobile Crisis were schools, and **41%** were the family or child themselves.

39% of children received ongoing follow-up and stabilization services from Mobile Crisis.

Children were most commonly presenting to Mobile Crisis with **Harm/Risk of Harm to Self (29%)** and **Disruptive Behavior (25%)**.

Mobile Crisis had a **94.4% mobility rate**, and responded to **86.6%** of mobile episodes in **under 45 minutes.**

74.% of children were discharged after completing their treatment with Mobile Crisis

43% of children were referred to **outpatient services**, and **31%**were referred back to an **existing provider. 25%** of children received referrals to **multiple services**.

Introduction

Overview of Mobile Crisis and PIC

Mobile Crisis Intervention Services (Mobile Crisis) is a face-to-face intervention for children and adolescents experiencing a behavioral or mental health need or crisis, where a clinician meets the child and family in their home or community. Mobile Crisis is available to any child and family across the state, free of charge. Mobile Crisis is funded by the Connecticut Department of Children and Families (DCF) and is accessed by calling 2-1-1 or 988. The statewide Mobile Crisis network is comprised of over 200 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 FY2024 Annual Report summarizes Mobile Crisis data entered into Provider Information Exchange (PIE), DCF's web-based data entry system, as well as other activities and results relevant to Mobile Crisis implementation.

Goals of Mobile Crisis

The goals of the PIC are to ensure equitable access, quality, and outcomes in MCIS services as illustrated in Figure 1. Each of these areas is addressed in detail in this report.

- **Access:** Mobile Crisis is available to all children and families across the state providing mobile responses 24/7/365. To help ensure MCIS reaches all in need, access goals are to:
    - Have high volume and service reach rates across demographic groups, referral sources, and geographies.
    - Promote widespread community awareness that a rapid clinical crisis response is available.

- **Quality:** Mobile Crisis services must provide a rapid response and be delivered in-person within homes and communities. Specifically, the quality metrics are:
    - Mobility rate of 90% or higher.
    - At least 80% of episodes have a response time of 45 minutes or less.

- **Outcomes:** Ultimately the goal is to work with the child and family in stabilizing the situation and avoid inappropriate use of restrictive services. Additionally, Ohio scale assessments provide clinical information on changes in child functioning and problem severity. Positive outcomes are seen when there is:
    - Diversion from behavioral health emergency department visits, inpatient care, arrests.
    - Improvement in Ohio scale scores by worker and parent report.

- **Equity:** Equity is a consideration across all performance goals and outcomes in Mobile Crisis. Increasing access, ensuring quality, and promoting positive outcome each have equity components to ensure the service is working well not just overall but for everyone. There are many subgroups that can be examined, but in Mobile Crisis we focus on examining indicators by racial/ethnic groups, geographic region, age group, and sex.

Figure 1. Goals of the Performance Improvement Center.

The layout of this report follows this format. There are sections on Access, Quality, and Outcomes with Equity considered within each. The report then delves into other key activities of providers and the PIC, including training and workforce development, community outreach, and additional data support and consultation.

Note: Data presented in this report for past years may differ from previously published reports. In the FY2023 Mobile Crisis Annual Report, much of the analysis was split up by new and old hours after moving to 24/7 mobility halfway through the year. In this report, we have recalculated FY2023 data to be inclusive of all episodes. In updating the report formatting, we have also modified a handful of analyses to ensure the clearest representation of the data.

FY2024 Focus

Improving our equity work was the primary focus of PIC activities this year. Key metrics are consistently met in MC, both overall and for subgroups. However, we wanted to examine more closely all decision points for potential differential treatment knowing that how youth and families enter and leave the program are important considerations for access and utilization. At the end of FY2023, we worked with DCF and providers to identify a list of decision points that occur throughout the course of a Mobile Crisis episode. These ranged from someone deciding to call Mobile Crisis to the child being discharged. Decision makers could include the call center, the MCIS team, the caller, family, child, etc. The PIC mapped available data onto each decision points. Of the 19 identified decision points, 12 had data available in PIE. Analyzing data at each of these decision points for disparities by race and ethnicity, we identified a few areas to focus on. We also identified key Mobile Crisis metrics that did not show any disparities but should be monitored on an ongoing basis. We will present data on each of the below elements disaggregated by race and ethnicity in this annual report.

- Overall children served – ***Who is being served?***
- Referral source – ***Are referrers calling consistently for all youth?***
- Presenting problem – ***Are youth being referred for similar reasons?***
- Mobility and response time – ***Are all youth receiving timely, face-to-face responses?***
- Reason for discharge – ***Are youth completing treatment at similar rates?***

As a result of these analyses and based on ongoing work with DCF and providers, we incorporated additional data into our quarterly RBAs at both the state and regional level, disaggregating both referral source and reason for discharge by race and ethnicity. We also updated our quarterly Performance Improvement Plan forms with providers to focus on SMARTIE goals (Specific Measurable, Achievable, Relevant, Time-Bound, Inclusive, and Equitable), rather than SMART goals – ensuring that goals are inclusive and equitable. We will continue working with providers on setting and achieving their SMARTIE goals through FY2025.

How many youth were served?

This year, 15,187 calls came into the Mobile Crisis line at 2-1-1, resulting in **11,346 episodes of care**. This was a 7.0% decrease in call volume compared to FY2023, and an 8.7% decrease in episode volume. Episode volume remained 25.9% lower than FY2019, prior to the pandemic. The 11,346 episodes this year served **8,428 unique children.** Most children served only had one episode of care this year (78.4%), with 21.6% having two or more episodes of care within the year. Most of the youth with multiple episodes of care only had two episodes (66.8%). The pattern of episode volume from month to month was similar to last year, with summer seeing the lowest volume and peak volume being seen in March and May. The largest decline in volume compared to FY2023 occurred in February and March, each month having approximately a 20% decrease.

Figure 2. Call and episode volume over time.

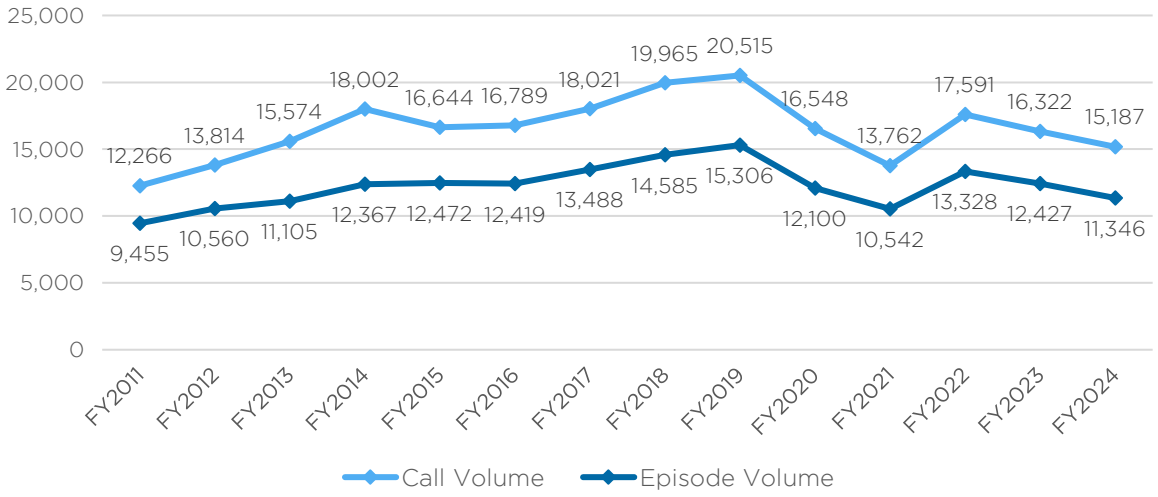
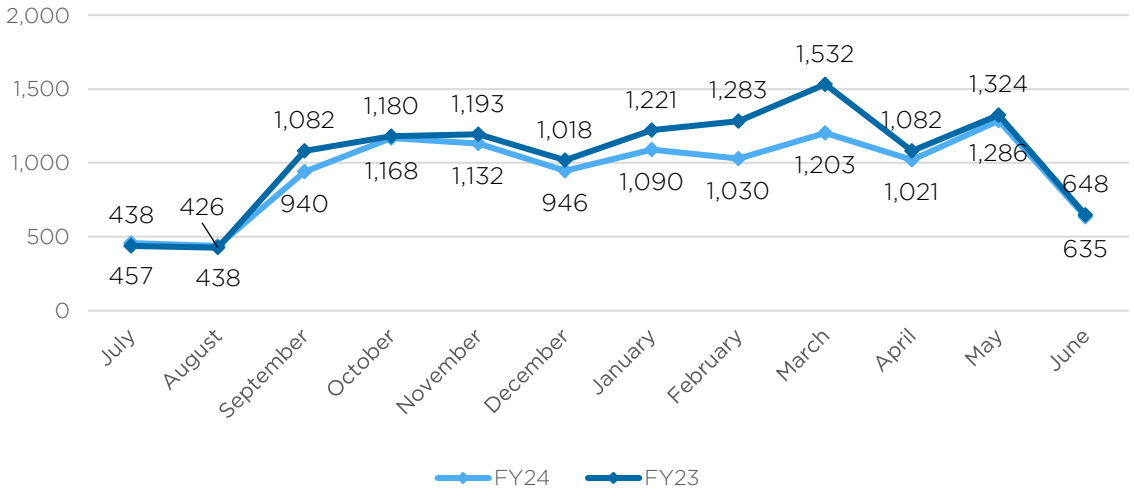


Figure 3. Number of episodes per month.



Episode volume for each region ranged from 1,378 (Eastern) to 2,759 (Hartford). **The statewide service reach rate was 15.4 episodes per 1,000 children in Connecticut**. Four of the six regions were within one standard deviation (3.0) of the statewide average (15.4). The Hartford region was more than one standard deviation above the statewide average, while the Southwestern region was more than two standard deviations below.

Figure 4. Number of episodes by region.

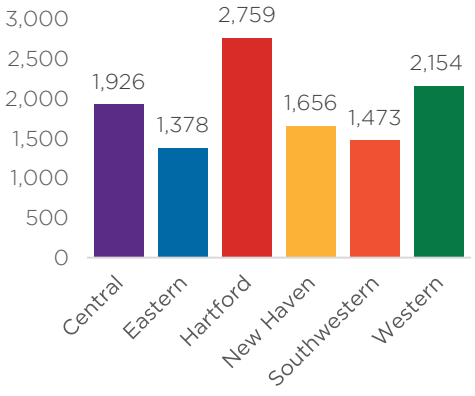


Figure 5. Episodes per 1,000 children.

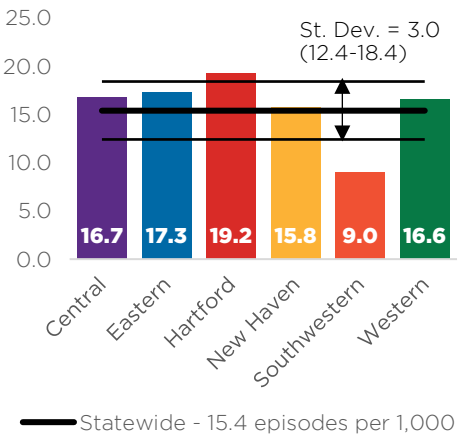
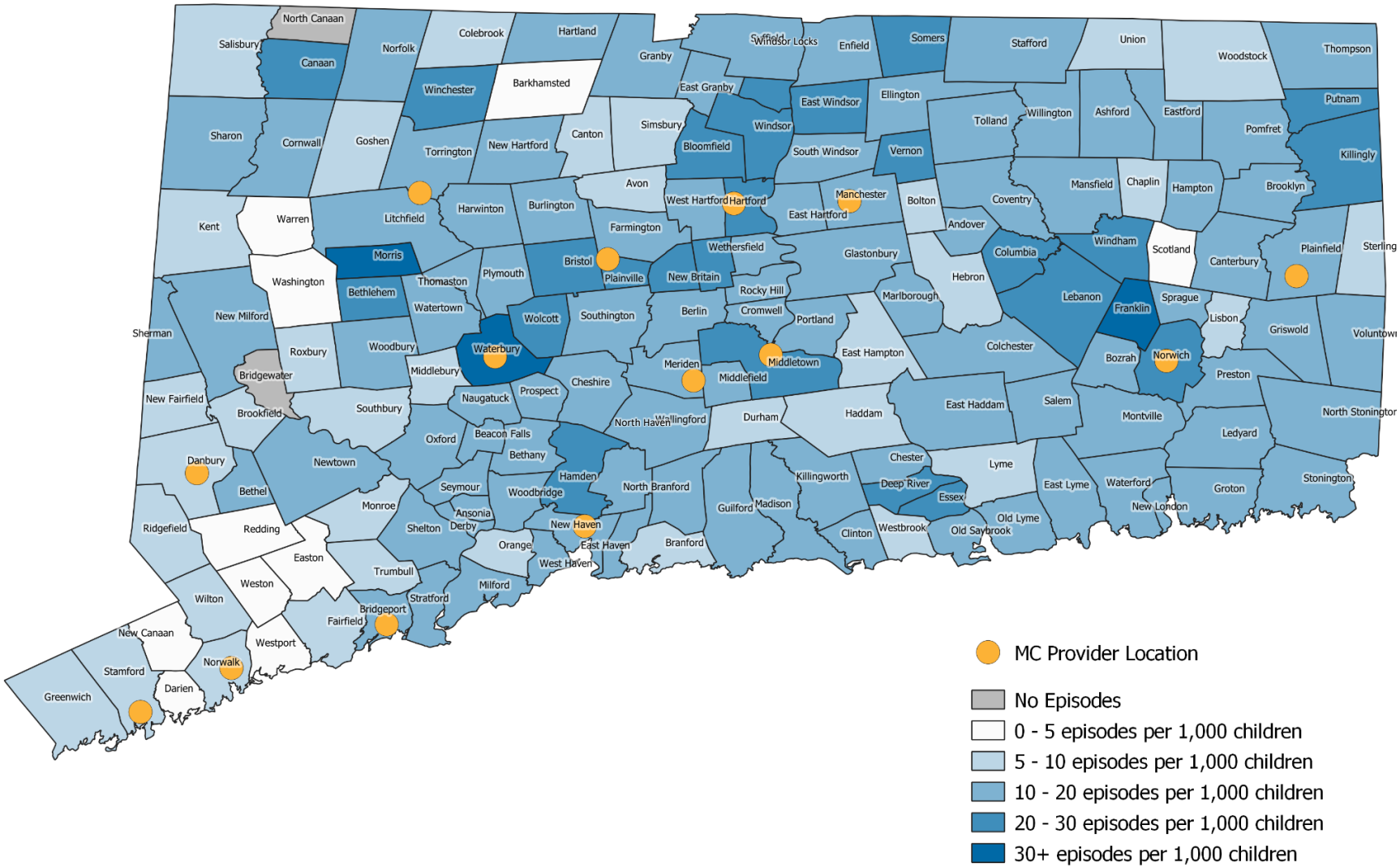


Figure 6 provides a visual representation of Mobile Crisis episode volume across the state. The map indicates the rate of Mobile Crisis episodes in each town during FY2024, relative to each town's child population (episodes per 1,000 children). There were two towns that didn't have a Mobile Crisis episode compared to five towns without an episode in FY2023. The major cities of Hartford and Waterbury each had over 750 episodes this year, while Bridgeport and New Haven each had over 450 episodes.

Figure 6. Episodes per 1,000 children, by town.



When did calls come in?

The majority of episodes (71.0%) resulted from calls that came in Monday-Friday between 7 a.m. and 5 p.m. An additional 16.4% of episodes were initiated on weekdays between 5 p.m. and midnight, and 10.5% came in at any time over the weekend. Only 3% of episodes were initiated between midnight and 7 a.m. In January 2023, Mobile Crisis expanded to 24-hour mobile availability. Previously, mobile hours were from 6 a.m. to 10 p.m. during the week and from 1 p.m. to 10 p.m. on weekends and holidays. In FY2024, 7.8% of all episodes were initiated during these additional mobile hours. Of the calls during these hours, the majority came in either between 10 p.m. and midnight on any day of the week (37.4%) or between 6 a.m. and 1 p.m. on the weekends (37.0%).

Table 1. Mobile Crisis episodes by hour and day of week.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
0:00-0:59	12	15	11	18	11	16	11	**94**
1:00-1:59	10	8	11	6	12	5	8	**60**
2:00-2:59	0	3	3	3	7	4	2	**22**
3:00-3:59	2	2	1	2	1	4	0	**12**
4:00-4:59	2	4	1	2	0	3	1	**13**
5:00-5:59	4	4	3	4	4	4	2	**25**
6:00-6:59	5	17	12	10	13	14	2	**73**
7:00-7:59	2	47	57	64	23	37	6	**236**
8:00-8:59	12	95	139	138	117	117	15	**633**
9:00-9:59	20	191	200	190	186	180	33	**1000**
10:00-10:59	32	216	211	238	263	233	46	**1239**
11:00-11:59	41	215	235	204	248	189	45	**1177**
12:00-12:59	32	223	220	221	229	209	36	**1170**
13:00-13:59	38	190	189	201	194	197	36	**1045**
14:00-14:59	45	149	149	186	197	154	53	**933**
15:00-15:59	54	129	113	98	146	141	39	**720**
16:00-16:59	45	98	95	92	97	96	40	**563**
17:00-17:59	41	72	87	88	99	60	34	**481**
18:00-18:59	47	90	75	76	80	64	29	**461**
19:00-19:59	53	67	75	74	80	44	43	**436**
20:00-20:59	42	58	60	59	56	52	27	**354**
21:00-21:59	36	42	49	36	40	21	25	**249**
22:00-22:59	22	27	20	42	21	31	26	**189**
23:00-23:59	7	21	20	25	28	19	22	**142**
	604	**1983**	**2036**	**2077**	**2152**	**1894**	**581**	**11327**

Who is being served?

Mobile Crisis has consistently served Black and Hispanic youth at higher rates than the Connecticut population. Children served this year were 52% female and 48% male. The rates of each racial and ethnic group served were consistent for both sexes. The majority of children served were between ages 9 and 15. These demographics are all consistent with past years

Figure 7. Race and ethnicity of children served compared to the CT population.

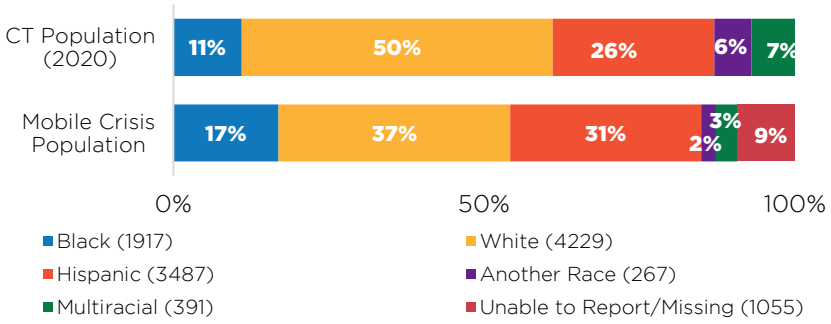
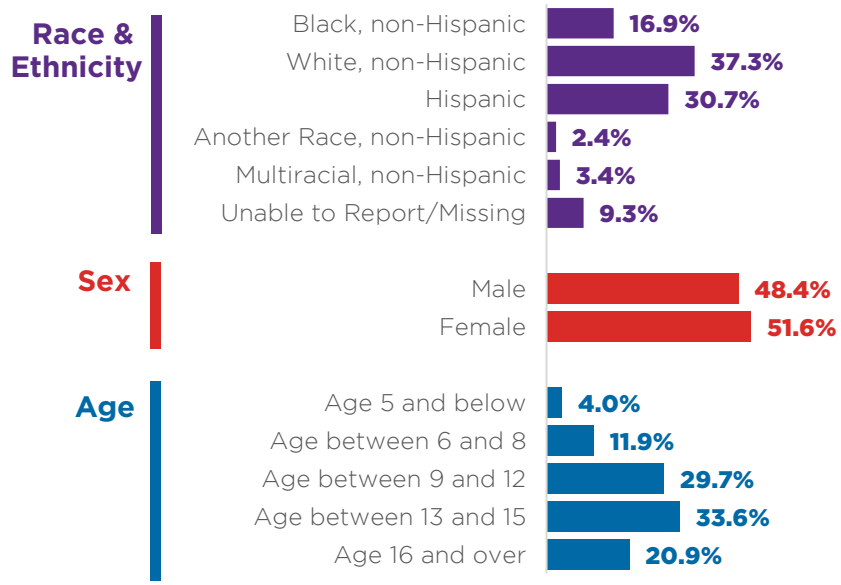


Figure 8. Demographics of children served.



When looking across race and ethnicity, sex, and age, more males were served at a younger age across the three largest racial/ethnic categories, while females were served less at a young age and had a greater spike in episodes approaching adolescence.

Figure 9. Male children served by race/ethnicity and age.

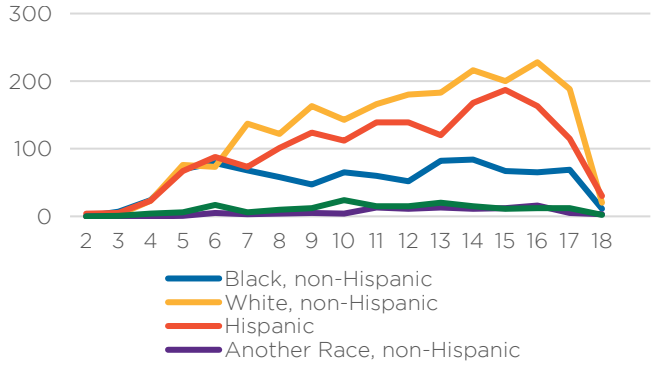
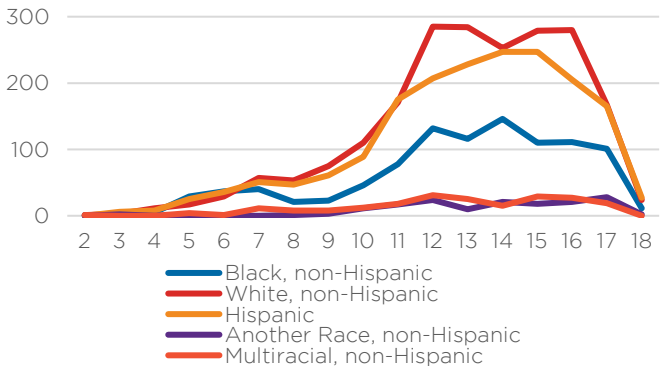


Figure 10. Female children served by race/ethnicity and age.

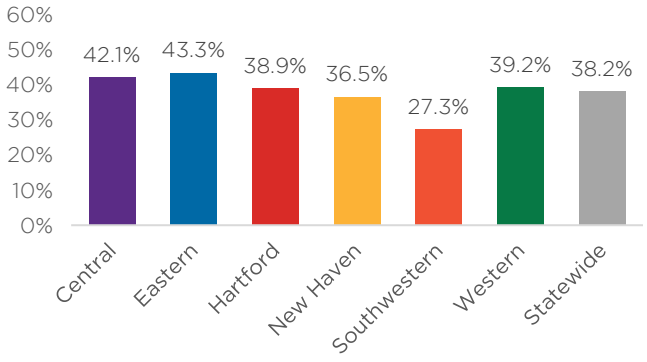


The majority of children served were covered by **Medicaid (59.6%)** or **private health insurance (26.8%)**. Additionally, **86.8% of children did not have an active case with DCF**.

What are the past experiences of children who are served by Mobile Crisis?

Statewide, **38.2% of children[1] served by Mobile Crisis reported a history of trauma**, compared to 36.5% in FY2023. It is important to note that 29.7% were missing data on these variables; it is unclear whether this missing data indicates not having experienced trauma or the question not being asked/answered. The remaining 32.2% of children reported not having experienced trauma. PIE asks about four specific types of trauma. Of the children who reported any type of trauma, the most reported type was disrupted attachment (36%). Twenty-eight percent reported being a witness to violence, 24% reported being a victim of violence, and 18% reported sexual victimization. A small number reported the recent arrest of a caregiver (0.8%). Additionally, 43% of youth who reported trauma indicated experiencing another type of trauma not specified in PIE.

Figure 11. Children reporting a history of trauma at intake.



As part of their assessment, Mobile Crisis providers ask the child and their family about the child's history, particularly surrounding behavioral health crises. In the 6 months prior to the Mobile Crisis episode, 15.5% of children report having visited the emergency department for psychiatric concerns, consistent with 15.6% of children in FY2023. This data was missing for 29.5% of children, while 55.0% reported not having been to the ED. Additionally, 8.5% report an inpatient stay in the last 6 months, slightly higher than in FY2023 (7.7%). This data was missing for 29.4% of children, while 62.1% said no. A small number of children served reported being arrested (1.6%) or detained (0.7%) in the year prior to their episode of care. Alcohol and Drugs were not commonly reported, with 6.8% of children reporting alcohol and/or drug use in their lifetime, and 6.4% reporting use in the prior 6 months. Approximately 10% of children reported having been suspended from school in the past year. Sixty percent of children reported having issues at school, most commonly citing emotional issues (40%), behavioral issues (31%), social issues (28%), and academic issues (20%).

Table 2. Child history.

Child History	Lifetime	Prior 6 months
Emergency Department Psych		15.5%
Inpatient Psych	15.1%	8.5%
Out-of-Home Psych	3.4%	1.6%
Alcohol and Drugs	6.8%	6.4%
		Prior 12 months
Arrested		1.6%
Detained		0.7%
Suspended from School		9.5%

[1] Mobile Crisis data is based on episodes; children with multiple episodes are counted multiple times in "children served".

Who is making the call?

Statewide, **schools were the top caller to Mobile Crisis (42.3%)** followed closely by self/family (40.5%). This varied by region, with Eastern, New Haven, and Southwestern regions having families as the top callers. Only about 5% of self/family calls were from the youth themselves. Emergency Departments are the third most common caller statewide (8.8%), which varies significantly by region, ranging from 23.4% of calls in the Western region to only 0.8% in the Southwestern region.

Table 3. Caller type by region.

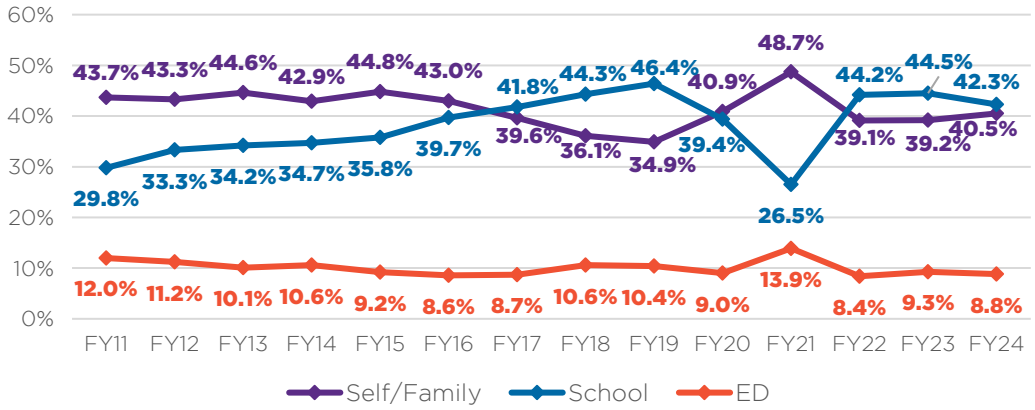
Caller type	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
School	41.6%	43.9%	44.2%	42.4%	45.6%	37.0%	**42.3%**
Self/Family	40.3%	46.2%	39.3%	43.1%	46.1%	33.0%	**40.5%**
Emergency Department	7.5%	1.8%	6.3%	8.6%	0.8%	23.4%	**8.8%**
Psychiatric Hospital	4.1%	3.0%	4.0%	1.4%	0.8%	2.3%	**2.8%**
Other Community Provider Agency	2.8%	1.5%	2.1%	1.9%	2.0%	1.5%	**2.0%**
Other Program Within Agency	0.9%	0.4%	0.8%	0.2%	0.7%	0.4%	**0.6%**
Police	0.4%	0.9%	1.0%	0.4%	0.3%	0.6%	**0.6%**
Foster Parent	0.6%	0.6%	0.4%	0.4%	0.3%	0.1%	**0.4%**
Other Referral Source	1.9%	1.7%	2.0%	1.6%	3.5%	1.6%	**2.0%**

How has caller type changed over time?

The top three caller types are consistent with recent years. Outside of the pandemic, **schools have been the top callers since FY2017**, largely in response to the development of MOAs between Mobile Crisis and Connecticut school districts.

The top referring EDs in FY2024 were St. Mary's Hospital (46.5% of ED referrals), CCMC (26.4%), and Yale-New Haven Hospital (17.3%). This is a departure from previous years, as CCMC is typically the top referring ED – from FY2019 to FY2023 CCMC made up 46% of all ED referrals to Mobile Crisis. Calls from CCMC are down 43% from FY2023, while calls from St. Mary's are up 23%.

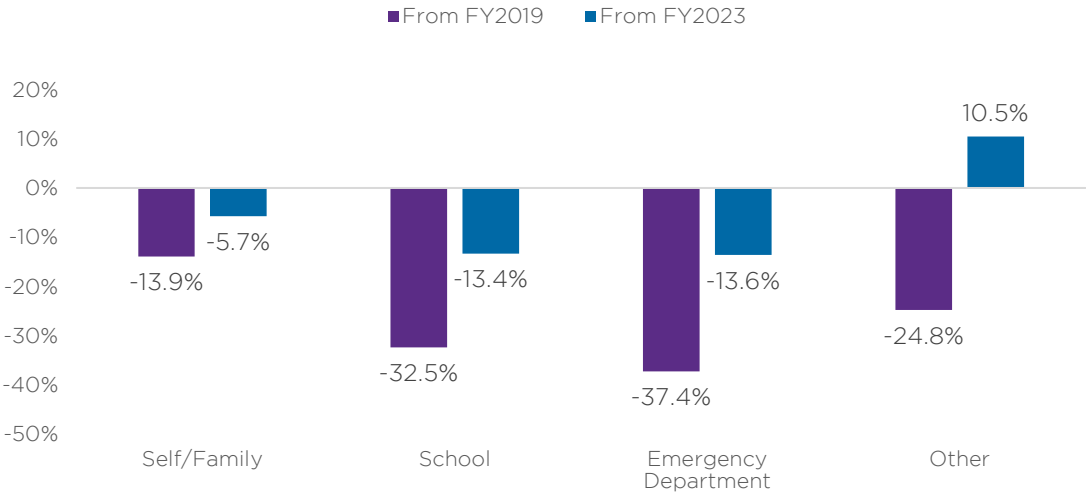
Figure 12. Caller type over time.



How has the decline in volume varied by caller type?

After beginning to rebound from the effects of the pandemic in FY2022, episode volume has declined over the past two years. Compared to last year, **calls from emergency departments and schools showed the highest rate of decline in FY2024**, decreasing 13.6% and 13.4% respectively. Similarly, those callers are down the most from FY2019 (pre-pandemic). Self and family calls were down 5.7% from last year and remain 13.9% lower than FY2019. Calls from all other sources combined remain down 24.8% from FY2019 but increased 10.5% between FY2023 and FY2024. It is important to consider that smaller overall rates of calls from EDs and other sources create more dramatic fluctuations in percentage change.

Figure 13. Decrease in volume by caller type.

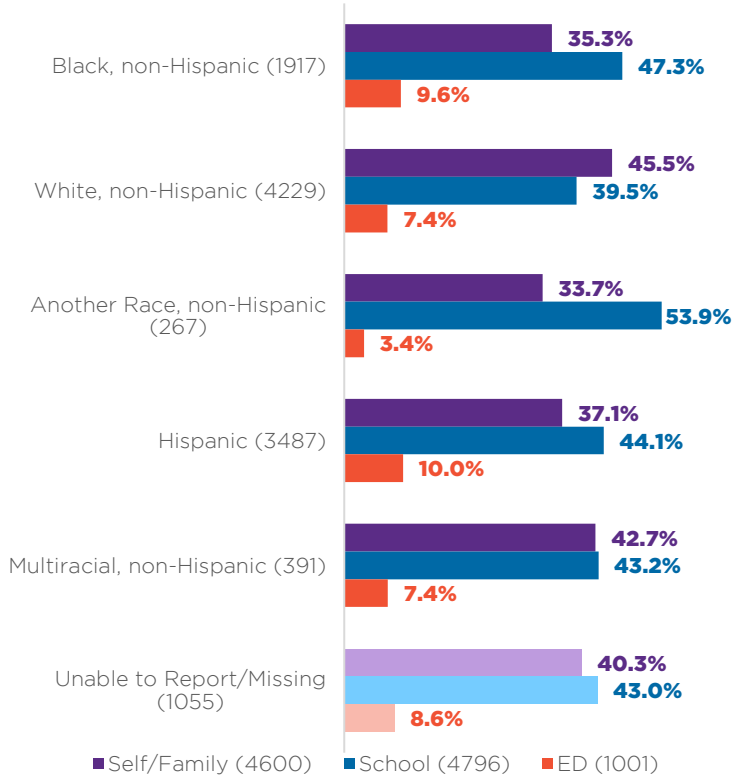


Did different referrers call at the same rates for all youth?

The people making calls to Mobile Crisis are a key determinant of who has access to the service. As such, it is important to monitor whether referrals are being made equitably. Notable findings from FY2024 include:

- White youth had the highest rate of calls from self/family.
- Black youth, Hispanic youth, and youth identifying as another race all receive higher rates of calls from schools than White youth.
- Rates of ED calls for Black and Hispanic youth are slightly higher than for White youth and are lowest for youth identifying as another race.
- These differences are statistically significant, but the effect size[2] is small ($p<.001$; $C=.114$). This means that while the differences can be reliably detected, due in part to large sample sizes, the practical significance (measured by effect size) is limited. Small effect sizes suggest this trend is one to continue to monitor but to be cautious in interpreting as representing meaningful differences, especially as this effect size just crosses the threshold of 0.1 for a small effect.

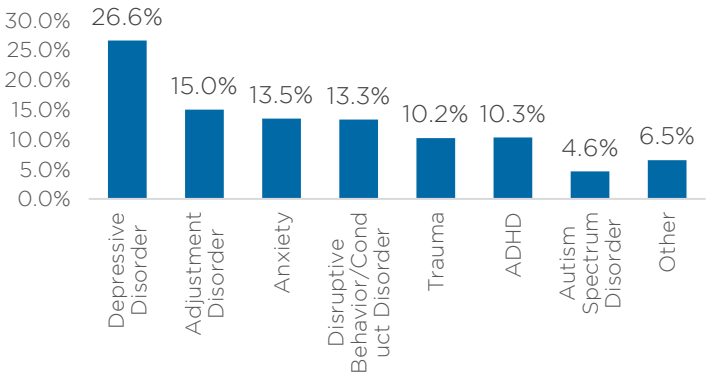
Figure 14. Caller type by race and ethnicity.



Why did they call?

The top presenting problems statewide were Harm/Risk of Harm to Self (29.0%) and Disruptive Behavior (25.0%). These remain the top presenting problems for each of the six regions, though there is variation in proportions. Due to the short nature of a Mobile Crisis episode, data on presenting problem is typically more relevant than diagnosis. The top diagnoses are depressive disorders (26.6%), adjustment disorders (15.0%), anxiety (13.5%), and disruptive behavior/conduct disorders (13.3%).

Figure 15. Top diagnoses.



[2] Effect size represents the magnitude of the relationship between two variables, and will be between 0 and 1, with a higher number indicating a stronger relationship. Using the contingency coefficient (C), effect size is defined by the following thresholds: small (0.1), medium (0.29), large (0.45).

Table 4. Top presenting problems by region.

Presenting Problem	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Harm/Risk of Harm to Self	42.6%	41.3%	23.4%	25.9%	19.8%	25.3%	**29.0%**
Disruptive Behavior	22.7%	20.3%	25.4%	28.0%	25.9%	26.6%	**25.0%**
Depression	8.3%	6.6%	15.2%	11.1%	16.9%	14.3%	**12.5%**
Anxiety	5.6%	4.6%	10.0%	8.3%	6.9%	6.0%	**7.2%**
Harm/Risk of Harm to Others	6.1%	8.8%	4.6%	4.3%	2.7%	5.5%	**5.3%**
School Problems	4.1%	4.1%	4.8%	6.2%	8.2%	4.8%	**5.2%**
Family Conflict	5.0%	4.5%	4.4%	5.6%	6.0%	7.2%	**5.5%**
Other	5.6%	9.9%	12.1%	10.5%	13.6%	10.3%	**10.4%**

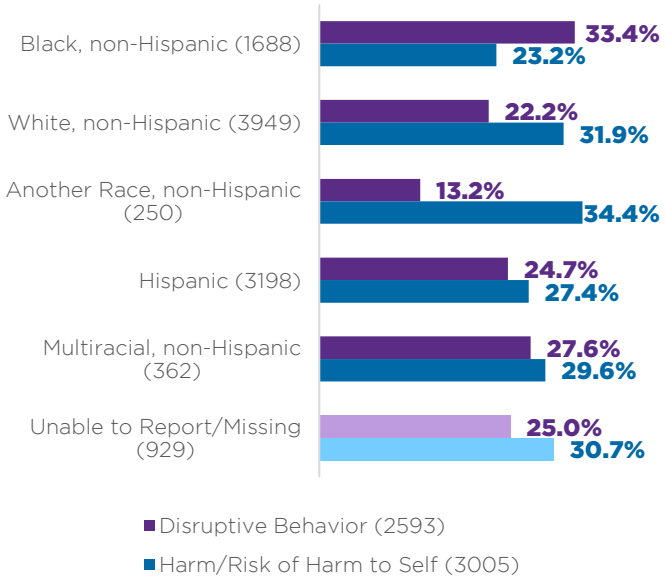
Were children referred for similar reasons across race and ethnicity?

Additional analysis showed that top presenting problem does vary by race and ethnicity.

Notable findings from FY2024 include:

- Harm/risk of harm to self is the top presenting problem among all racial and ethnic groups except for Black children, who are most commonly referred for disruptive behavior.
- Disruptive behavior drives 33.4% of referrals for Black children, compared to 24.7% for Hispanic children and 22.2% for White children.
- Children identifying as a race or ethnicity outside of the three major categories are also far less likely to be referred for disruptive behavior, which only makes up 13.2% of their referrals.
- Differences are statistically significant, but with a small effect size ($p<.001$; $C=.108$)

Figure 16. Most common presenting problem by race and ethnicity.



It is important to monitor this data and to work with the community to ensure that certain groups of children are not being under-identified for certain concerns.

How many youth received a face-to-face response?

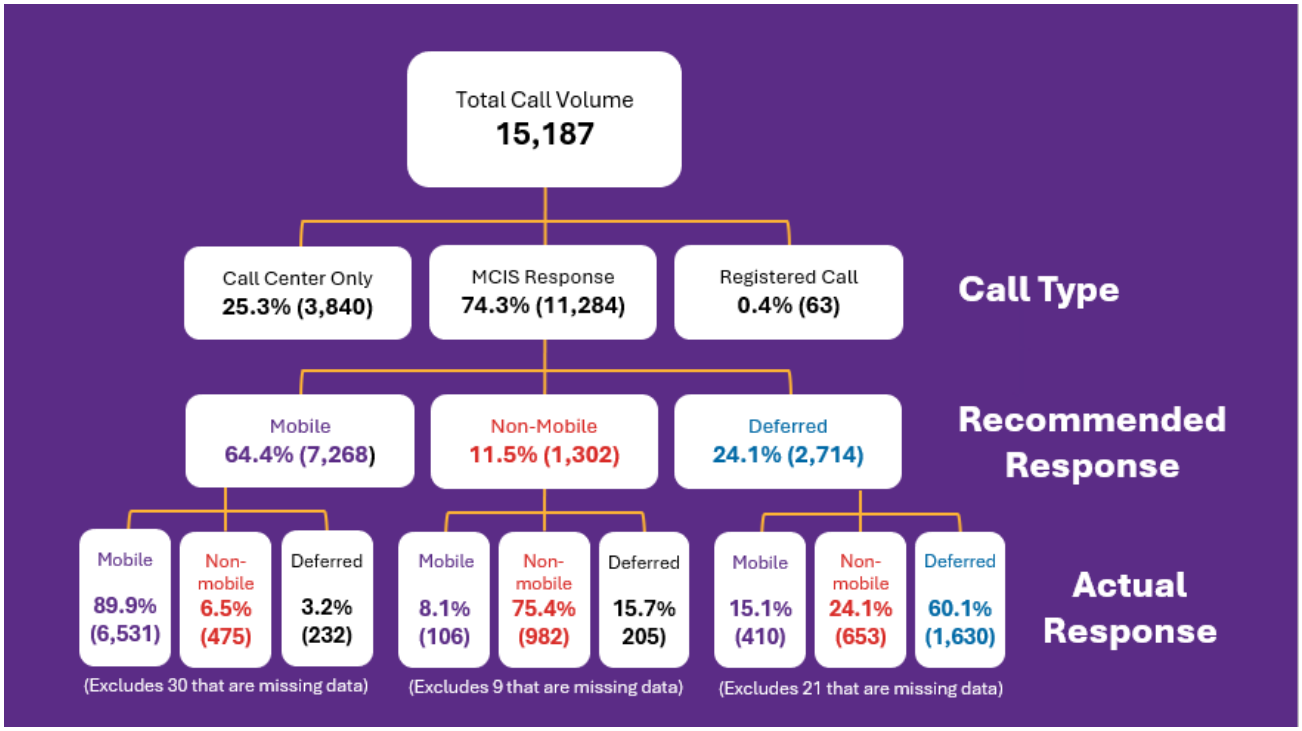
Statewide, the mobility rate in FY2024 was 94.4%, consistent with last year's rate of 94.7% and exceeding the 90% benchmark.

Mobile responsiveness is a key feature of Mobile Crisis service delivery. Since the beginning of PIC implementation, the established mobility benchmark has been 90%. To calculate the mobility rate, the Mobile Crisis PIC has historically examined all episodes for which the recommended response was mobile or deferred mobile, and determines the percentage of those episodes that actually received a mobile or deferred mobile response from a Mobile Crisis provider. Beginning in FY2021, the Mobile Crisis PIC also began excluding episodes where the referral is made by a third party such as a school or ED and is recommended for a mobile or deferred mobile response but the family declines the service or is unable to be reached, as these situations are out of the providers control.

When someone calls 2-1-1 requesting Mobile Crisis support, there are three types of responses from the Mobile Crisis provider:

- A **Mobile** response – the most common – is an immediate face-to-face response in the community that is intended to occur within 45 minutes of the call.
- A **Deferred Mobile** response is a face-to-face response that is scheduled for a later time, typically within 24 hours.
- A **Non-Mobile** response is support provided over the phone.

The 2-1-1 call specialist will discuss the options with the caller to identify the type of response that is recommended to the provider. This recommendation should be based on the needs and wishes of the child and family. The response that is actually provided is typically consistent with the recommendation, though there are some episodes where the response type will change upon further discussion with the family or due to changing circumstances. In FY2024, 88.5% of callers requested a Mobile (64.4%) or Deferred Mobile (24.1%) response. An additional 11.5% requested non-mobile phone support. For the actual response by Mobile Crisis providers, 62.8% received a Mobile response, 18.7% received a Deferred Mobile response, and 18.5% received a non-mobile response.



Most episodes received a response that was consistent with the request of the caller (81.5%), with an additional 6.5% receiving a more enhanced response than what was originally requested. A small number of callers (2.1%) requested a Mobile and received a Deferred Mobile, while 10.0% requested a Mobile or Deferred Mobile response and received a non-mobile response. Of these responses that changed to non-mobile, 92.4% were because the family later declined a mobile response or was unable to be reached. An additional 2.7% involved the original third-party caller cancelling the request.

Table 5. Non-mobile reason by provider.

	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Family Declined Mobile	83.0%	77.7%	78.6%	77.6%	80.0%	80.4%	**79.5%**
Family Not Available	11.4%	12.3%	15.6%	13.3%	10.0%	11.7%	**12.9%**
EMPS Decision	3.0%	7.4%	3.4%	5.5%	6.5%	3.1%	**4.5%**
Third Party Cancelled	2.5%	1.5%	1.5%	3.6%	3.5%	4.8%	**2.7%**
After Mobile Hours	0.0%	1.1%	0.9%	0.0%	0.0%	0.0%	**0.4%**

Did mobility rates vary by provider or region?

All six regions exceeded the benchmark, with performance ranging from 91.9% (New Haven) to 96.0% (Western). Among individual providers, all 14 exceeded the 90% benchmark, with performance ranging from 90.0% (CHR: Middlesex) to 97.9% (CFGC: Bridgeport). **Most mobile responses took place in homes (49.2%) or schools (43.2%)**. A small percentage took place in a hospital emergency department (5.8%) or other community location (1.8%).

Figure 18. Mobility rate by region.

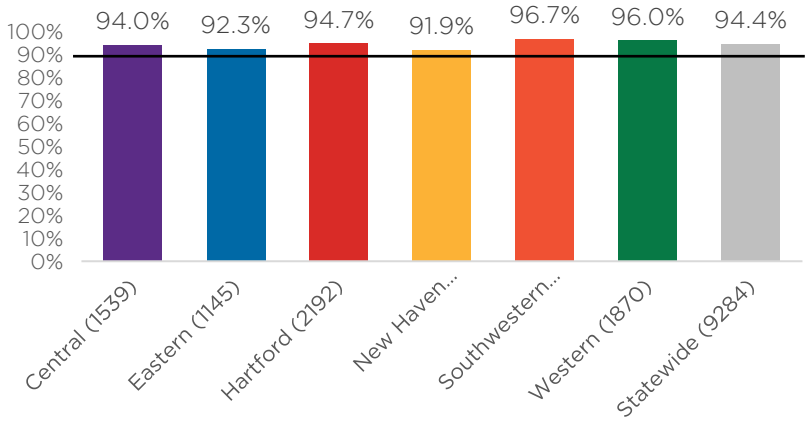
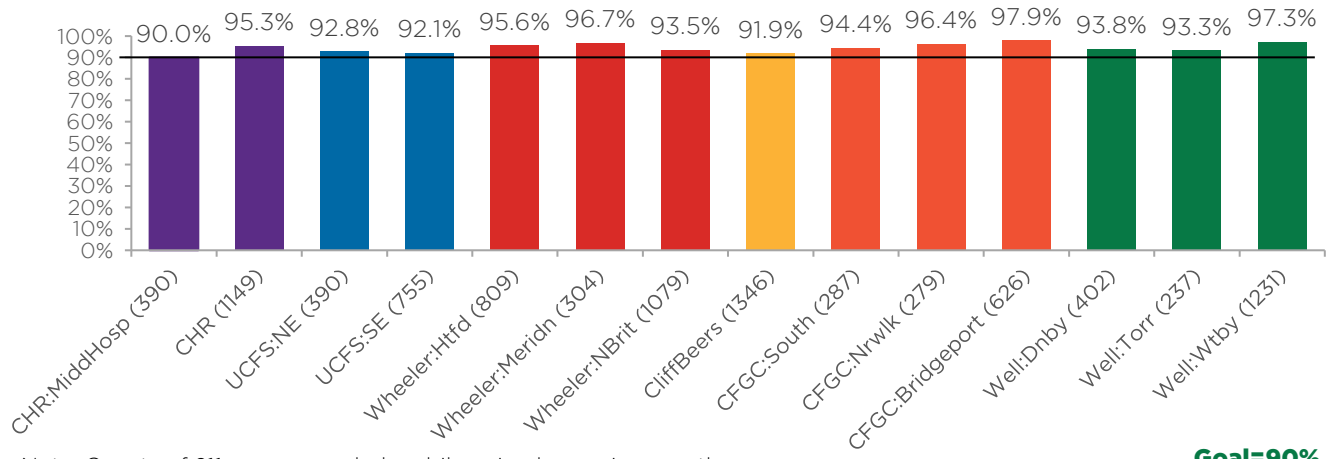


Figure 19. Mobility rate by provider.



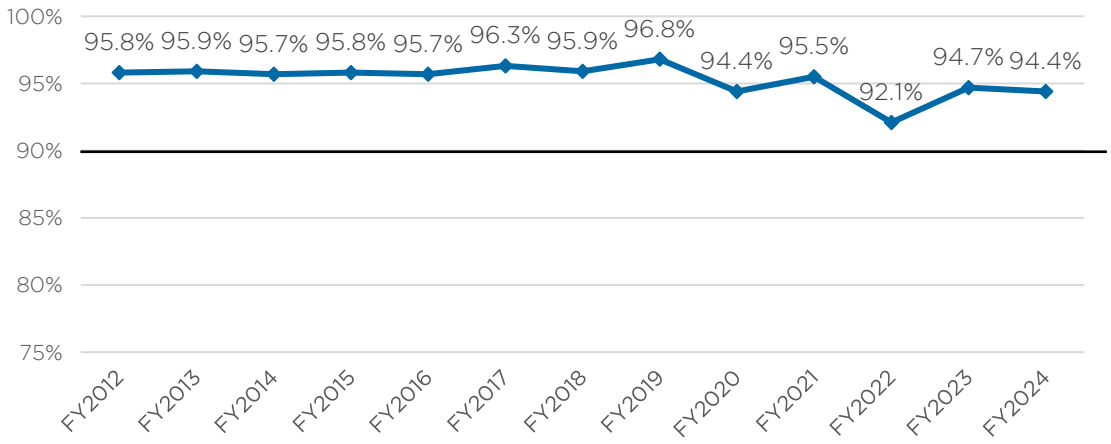
Note: Counts of 211-recommended mobile episodes are in parentheses.

Goal=90%

How have mobility rates changed over time?

Mobility rate has consistently exceeded the 90% benchmark across the state. While still exceeding the benchmark, mobility was at its lowest in FY2022 when Mobile Crisis was facing significant workforce shortages. Since hiring more staff, mobility has increased back to typical rates.

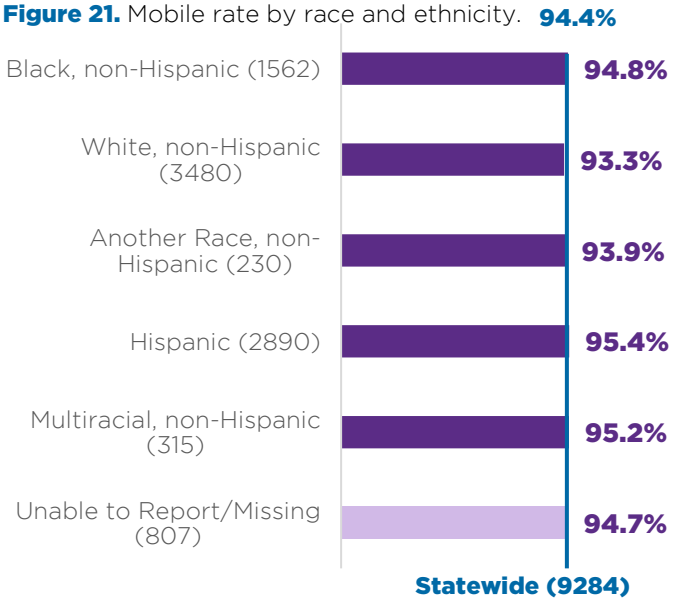
Figure 20. Statewide mobility rate over time.



Do mobility rates vary by race and ethnicity?

While it is a good sign that Mobile Crisis has consistently exceeded the 90% mobility benchmark on a statewide level, it's important to ensure that all children are receiving the same quality service. There is minimal variation in mobility rate between racial and ethnic groups, with the only significant difference being a higher mobility rate for Hispanic youth than for White youth; however, the effect size is negligible. (p=.013; C=.039) suggesting there is no meaningful difference between groups in receipt of mobile responses.

Figure 21. Mobile rate by race and ethnicity.



How long does it take to receive a face-to-face response?

The median response time in FY24 was 29 minutes. This is comparable to FY2023, when it was 30 minutes. Of the 6,783 episodes that received an immediate Mobile response, **86.6% received a response within 45 minutes**, exceeding the 80% benchmark and higher than 84.6% in FY2023. **All six regions exceeded the benchmark**, with performance ranging from 81.9% (Western) to 96.9% (Eastern). Eleven of the fourteen individual providers met or exceeded the 80% benchmark, with performance ranging from 54.3% (Wellmore: Danbury) to 98.6% (UCFS: SE). The median response time for deferred mobile episodes was 3.7 hours.

Figure 22. Response time under 45 minutes by region.

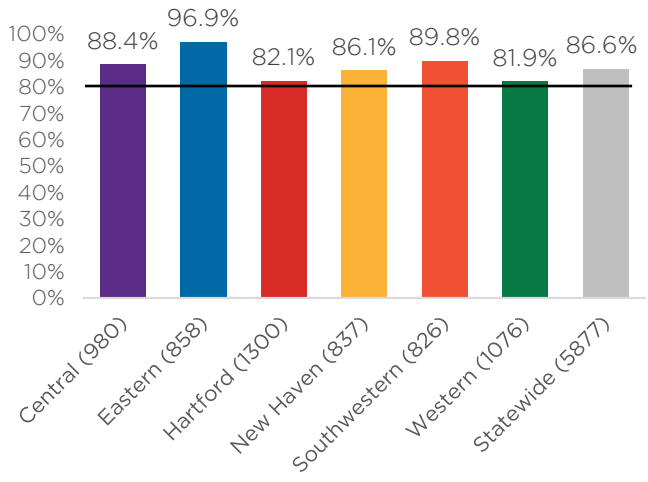
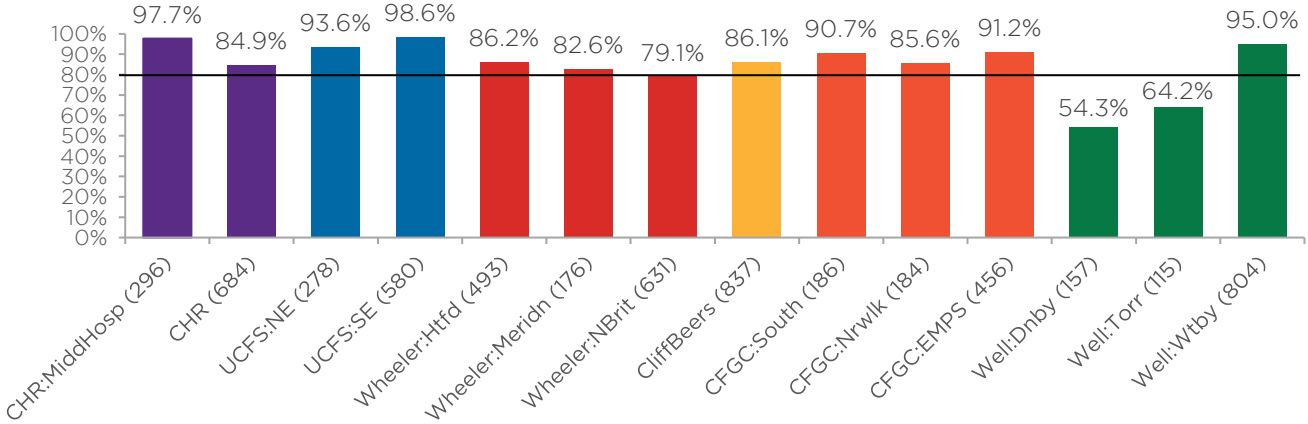


Figure 23. Response time under 45 minutes by provider.

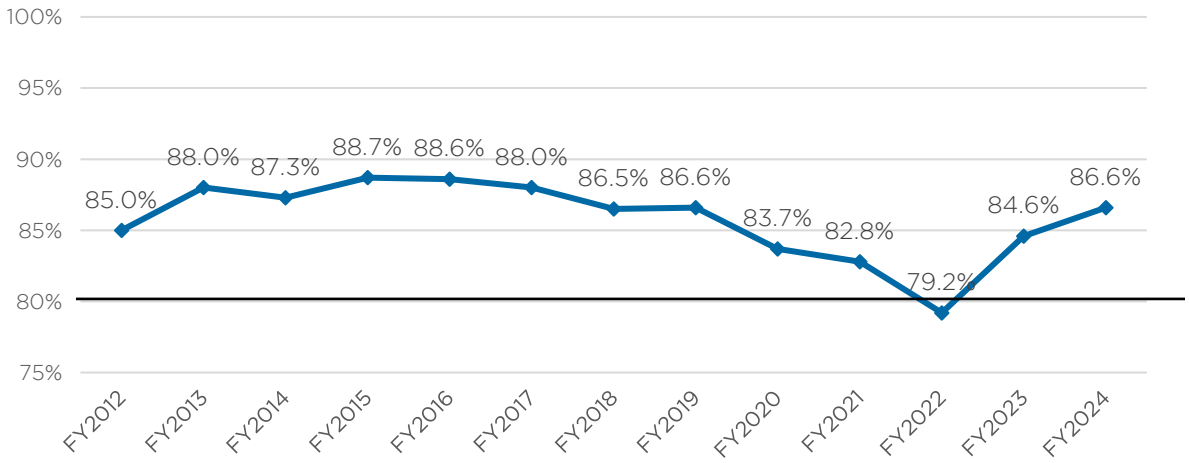


Note: Counts of mobile episodes under 45 minutes are in parentheses.

How has response time changed over time?

The only year that the response time benchmark was not met statewide was FY2022, when it was slightly below 80% due to significant workforce shortages. **The percentage of responses provided in 45 minutes or less has increased over the last two years, with FY2024 having the highest rate since FY2019**.

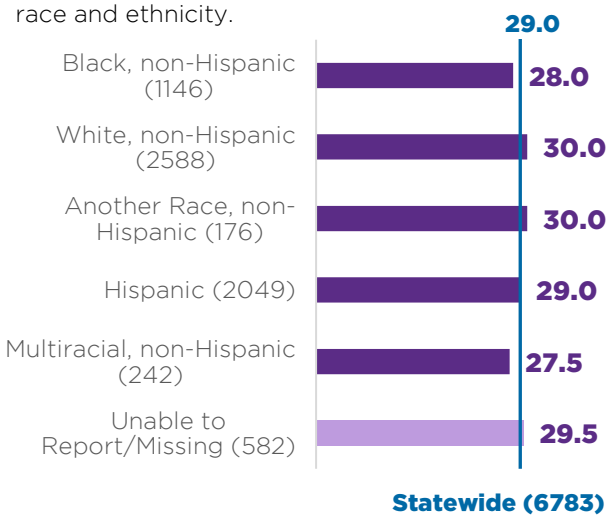
Figure 24. Statewide response time under 45 minutes over time.



Did response time vary by demographic group?

While it is a good sign that Mobile Crisis has consistently exceeded the 80% mobility benchmark on a statewide level, it's important to ensure that all children are receiving the same quality service. There is minimal variation in median response time between racial and ethnic groups. The slight variation that does exist is likely related to the demographics of towns closer to Mobile Crisis offices, which are more likely to have larger populations of Black and Hispanic youth; compared to towns on the outskirts of Connecticut that tend to have larger populations of White youth.

Figure 25. Median response time (minutes) by race and ethnicity.



How often are youth receiving ongoing stabilization services?

Statewide, **38.9% of episode include stabilization services**. Use of stabilization services varied significantly by region, with New Haven providing stabilization services for 6.0% of episodes, and Central providing stabilization services for 69.2% of episodes. This variability suggests this is also a data element that appears to be used inconsistently across providers and needs a clearer definition. Children receiving stabilization services received an average of 1.6 face-to-face contacts per episode.

There are a number of different Mobile Crisis intervention types:

- **Phone Only** – Provides phone consultation and safety assessment of the child, consultation on resources and next steps, and the offer for a face-to-face response in the future. This type of response generally coincides with a non-mobile response, where the family has declined the offer for an in-person response.
- **Face-to-Face** – An initial face-to-face response and assessment, where the family may require ongoing support for up to 5 days. Generally, youth and families receive one or more follow-up visits and telephone check-ins as the youth and family work to resolve the crisis and implement discharge plans.
- **Face-to-Face Plus Stabilization Follow-Up** - Teams may provide an initial mobile crisis response plus stabilization and follow-up services for up to 45 days. During this time, MCIS teams will engage in several treatment activities to help stabilize the crisis, provide further assessment and intervention, and facilitate referral and linkage to ongoing services and supports as needed.
- **Telehealth** – Implemented primarily during the beginning of the COVID-19 pandemic, a telehealth response is a full assessment conducted via a video connection. These are exceedingly rare and would only be provided at the request of the family.
- **Face-to-Face: Consultation Only** – This is a mobile response where the child is not seen by the provider, but consultation is provided to the caller, most often a school. This may occur when they child is picked up prior to the clinician's arrival or when the parent refuses care. In order to be responsive to the needs of the school (or other caller), Mobile Crisis providers will discuss the situation and provide strategies for managing it in the future.

Table 6. Crisis response type by region.

	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Plus Stabilization Follow-Up	69.2%	8.8%	47.0%	6.0%	13.6%	63.5%	**38.9%**
Face-to-Face	6.3%	64.0%	28.5%	64.7%	58.3%	13.8%	**35.4%**
Phone Only	20.7%	26.6%	23.0%	22.5%	15.4%	15.8%	**20.6%**
Face to Face: Consultation Only	3.8%	0.2%	1.3%	6.8%	12.6%	6.9%	**4.9%**
Telehealth	0.0%	0.4%	0.2%	0.0%	0.0%	0.0%	**0.1%**

How long are youth and families involved with Mobile Crisis?

Statewide, the median length of service for discharged episodes was less than one day for a phone only response, 5 days for a face-to-face response, and 16 days for a plus stabilization follow-up response. 20.8% of phone only episodes exceeded one day, 47.6% of face-to-face episodes exceeded 5 days, and **2.3% of plus stabilization follow-up episodes exceeded 45 days, meeting the statewide benchmark of less than 5%**.

Table 7. Length of service for discharged episodes.

		Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Phone Only	N	394	367	619	372	222	322	2296
	Median (Days)	1	0	0	0	0	0	0
	Exceeding 1 day	42.9%	6.3%	27.6%	4.8%	5.0%	26.4%	20.8%
Face to Face	N	121	882	732	1046	816	296	3893
	Median	3	4	4	19	15	2	5
	Exceeding 5 days	19.8%	6.6%	39.3%	83.5%	73.0%	4.7%	47.6%
Plus Stabilization Follow Up	N	1301	115	1229	98	190	1325	4258
	Median	16	16	18	29	35	14	16
	Exceeding 45 days	2.5%	2.6%	0.8%	10.2%	6.8%	2.3%	2.3%

Among open episodes of care, the median length of service was 62 days for phone only episodes, 45 days for face-to-face episodes, and 25 days for plus stabilization follow-up episodes. 95.6% of phone only episodes exceeded the one day benchmark, 92.8% of face-to-face episodes exceeded the five day benchmark, and 34.4% of plus stabilization follow-up episodes exceeded the 45 day benchmark. Cases that remain open for services for long periods of time can impact responsiveness as call volume continues to increase and can compromise accurate and timely data entry. It is also likely that many Phone Only and Face-to-Face cases that are open significantly past benchmarks are due to data entry errors or delays in closing the case in PIE.

Table 8. Length of service for open episodes (as of 6/30/24).

		Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Phone Only	N	4	0	16	1	5	19	45
	Median (Days)	200	N/A	70	2	39	29	62
	Exceeding 1 day	100.0%	N/A	93.8%	100.0%	100.0%	94.7%	95.6%
Face to Face	N	1	0	54	26	43	1	125
	Median	204	N/A	103	17	37	8	45
	Exceeding 5 days	100.0%	N/A	96.3%	76.9%	97.7%	100.0%	92.8%
Plus Stabilization Follow Up	N	32	6	68	1	11	42	160
	Median	18.5	13.5	43	50	30	9	25
	Exceeding 45 days	34.4%	0.0%	48.5%	100.0%	27.3%	16.7%	34.4%

How often were more restrictive services used during the episode?

Mobile Crisis also collects data on how often children utilize a more restrictive crisis services during the episode of care. In FY2024, 7.5% of families reported visiting the ED during their Mobile Crisis episode. No utilization of the ED during the episode was reported by 28.9% of families, while 63.7% were missing data. While it is likely that many of the missing responses represent a lack of ED utilization, we can't be certain. Of the children who did visit the ED during their Mobile Crisis episode, 10.5% received a referral to the ED from Mobile Crisis. Admission to an inpatient psychiatric hospital during the episode was reported by 2.5% of children. No inpatient utilization was reported by 33.8% of families, while 62.7% were missing data. Of the children who did have an inpatient admission, 55.0% received a referral to inpatient from Mobile Crisis.

Did youth experience clinical improvement?

The Ohio Scales are intended to be completed at intake and discharge by parents and Mobile Crisis clinicians, 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.

In FY2024, collection rates[3] of parent Ohio scales at discharge remained stable, while collection rates of all other scales increased compared to FY2023. The Western region had the highest collection rates of worker Ohio scales at both intake and discharge. The Eastern region had the highest collection rate of parent Ohio scales at intake, and the Southwestern region had the highest collection rates of parent Ohio scales at discharge.

Figure 26. Ohio scale collection rates over time.

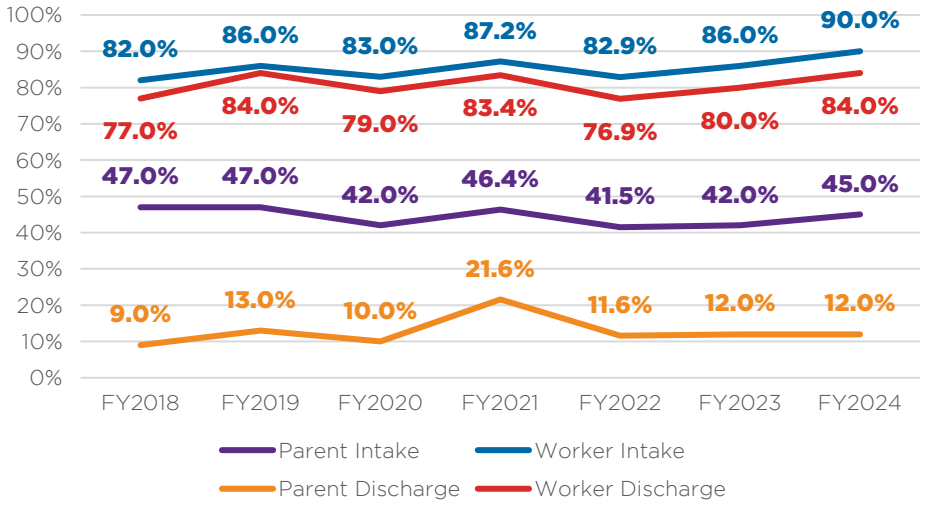


Figure 27. Ohio scale collection at intake by region.

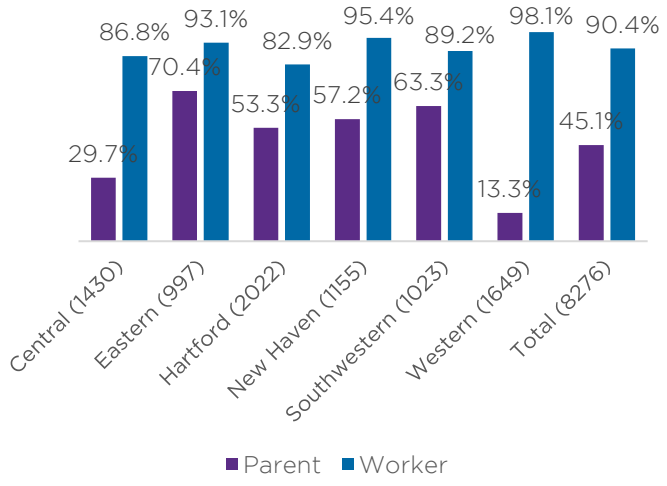
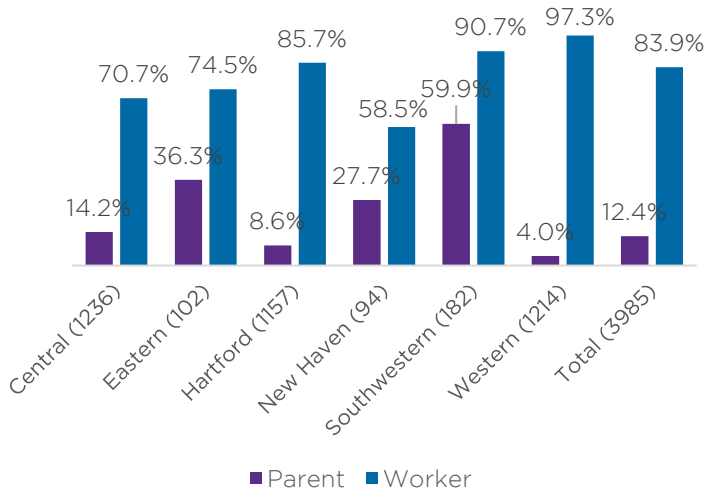


Figure 28. Ohio scale collection at discharge by region.



[3] The percentages of completed Ohio Scales 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.

Even though the Ohio Scales were designed to assess treatment outcomes for longer-term models of intervention such as outpatient care, pre-post changes consistently indicate statistically significant and positive changes on all domains of the Ohio Scales 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.

Compared to FY2023, **rates of improvement[4] from intake to discharge increased across all Ohio scales**. The greatest improvement was seen on worker scales, which also have higher collection rates. Parent problem severity scales showed the lowest improvement in both FY2023 and FY2024. Rates of improvement vary across regions, with the Western and Eastern regions generally seeing the highest rates of improvement. White youth showed the lowest rates of improvement on both parent- and worker-completed functioning scales. Children identifying as a race or ethnicity outside of the three largest racial/ethnic categories had the highest rates of improvement across all scales except for parent-completed problem severity.

Figure 29. FY2023 - Any improvement on Ohio Scales Reliable Change Index.

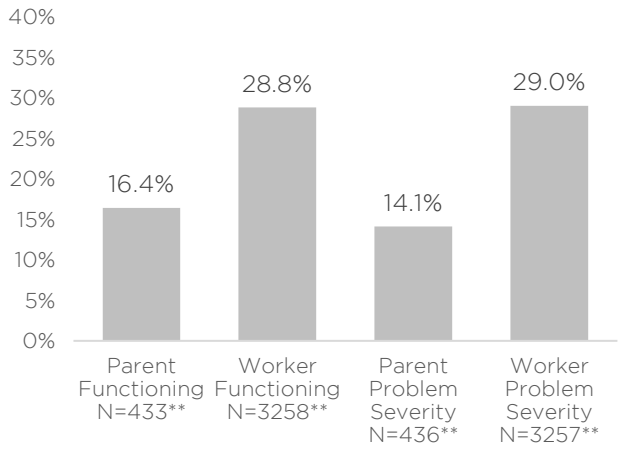


Figure 30. FY2024 - Any improvement on Ohio Scales Reliable Change Index.

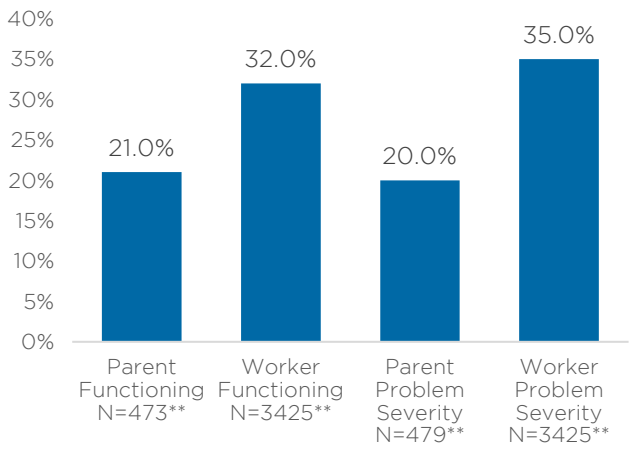


Table 9. Any improvement on Ohio Scales Reliable Change Index by region.

	Central	Eastern	Hartford	New Haven	Southwestern	Western
Parent-Completed Functioning Scale	3.4%	48.4%	23.5%	4.0%	34.3%	44.4%
	N=176	N=34*	N=87*	N=25	N=105†	N=46**
Worker-Completed Functioning Scale	10.2%	37.5%	23.6%	17.3%	28.5%	54.1%
	N=875**	N=80*	N=986*	N=54	N=169**	N=1261**
Parent-Completed Problem Severity Scale	3.4%	45.2%	17.6%	7.7%	39.8%	38.3%
	N=177	N=34**	N=90*	N=26	N=105**	N=47**
Worker-Completed Problem Severity Scale	11.0%	40.5%	27.1%	18.5%	30.2%	56.9%
	N=875**	N=80**	N=986*	N=54*	N=169**	N=1261**

[4]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.

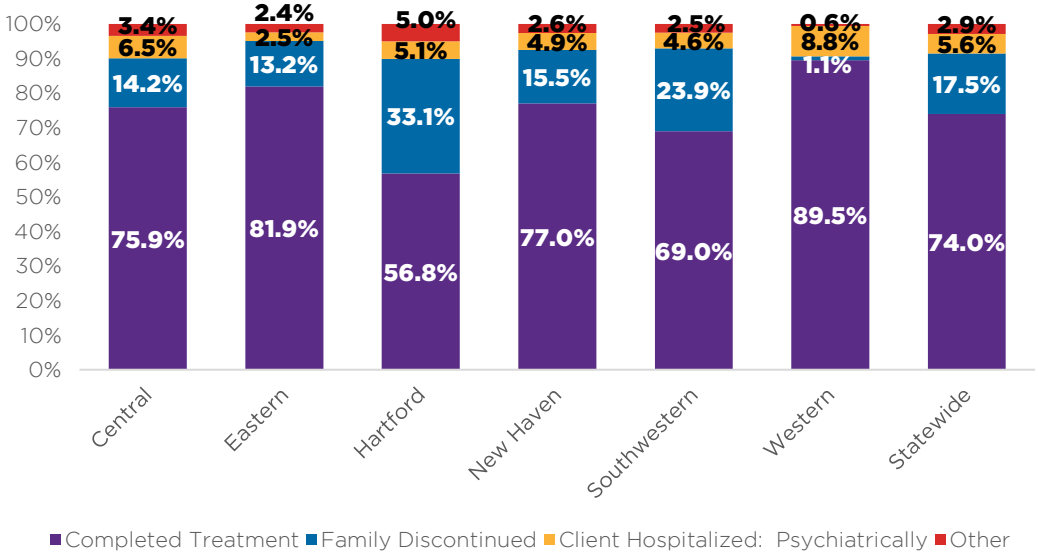
Table 10. Any improvement on Ohio Scales Reliable Change Index by race and ethnicity.

	Black, non-Hispanic	White, non-Hispanic	Another Race, non-Hispanic	Hispanic	Multiracial, non-Hispanic	Unable to Report/Missing
Parent-Completed Functioning Scale	18%	12%	42%	28%	19%	30%
	N=64†	N=186*	N=12	N=134**	N=16	N=61†
Worker-Completed Functioning Scale	33%	29%	40%	33%	39%	32%
	N=531**	N=1275**	N=87**	N=1108**	N=116**	N=308**
Parent-Completed Problem Severity Scale	10%	15%	33%	32%	31%	18%
	N=64†	N=188**	N=12	N=138**	N=16†	N=61
Worker-Completed Problem Severity Scale	32%	33%	46%	37%	38%	30%
	N=531**	N=1275**	N=87**	N=1108**	N=116**	N=308**

Why were youth discharged?

Statewide, **the majority of youth (75.8%) were discharged for completing their treatment with Mobile Crisis.** For Mobile Crisis, completing treatment generally means that the clinician and family worked together to develop a safety plan, follow-up was provided as needed, and the family has been connected with other services or is no longer in need of services. As a short-term intervention, families could be involved with Mobile Crisis for only that initial face-to-face assessment and still have "completed treatment" if their needs were met. Families also sometimes make the choice to discontinue services or stop engaging with Mobile Crisis, which happened 17.5% of the time in FY2024. This varied among regions, ranging from 1.1% in the Western region to 33.1% in the Hartford region. An addition 5.6% of children were discharged because they are hospitalized for psychiatric treatment, and 2.9% are discharged for reasons not previously mentioned. This is another data element where the PIC has identified a need for a clear and consistent definition among providers. As such, some of the variation between regions may be due to differing data definitions rather than differing outcomes.

Figure 31. Reason for discharge by region.



Were there differences in treatment completion rates across groups?

There is slight variation in rate of treatment completion by race and ethnicity. However, while differences were statistically significant the effect size was negligible (p<.001; C=.060).

We also wanted to explore whether reason for discharge, particularly families discontinuing vs. completing treatment, varied when families self-referred or were referred by someone else. This did not appear to be the case, as the rate of families discontinuing services was consistent across the three major referral sources.

Figure 32. Families completing treatment by race and ethnicity.

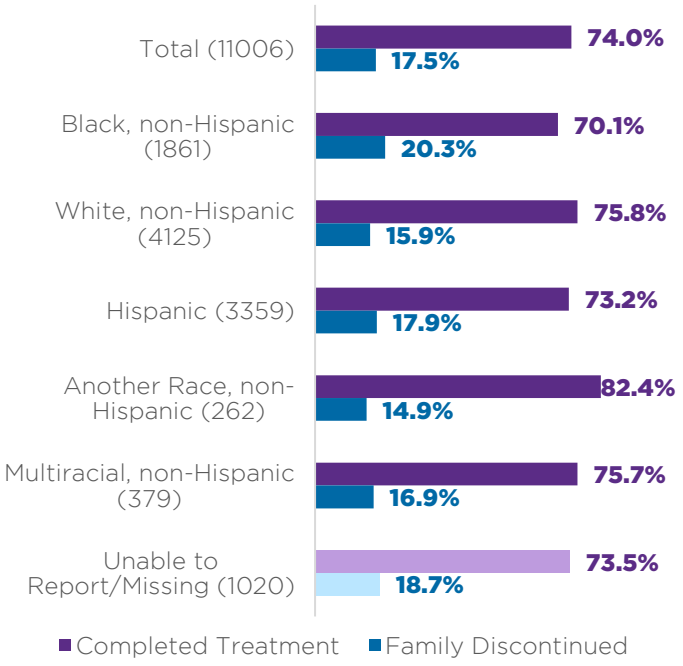
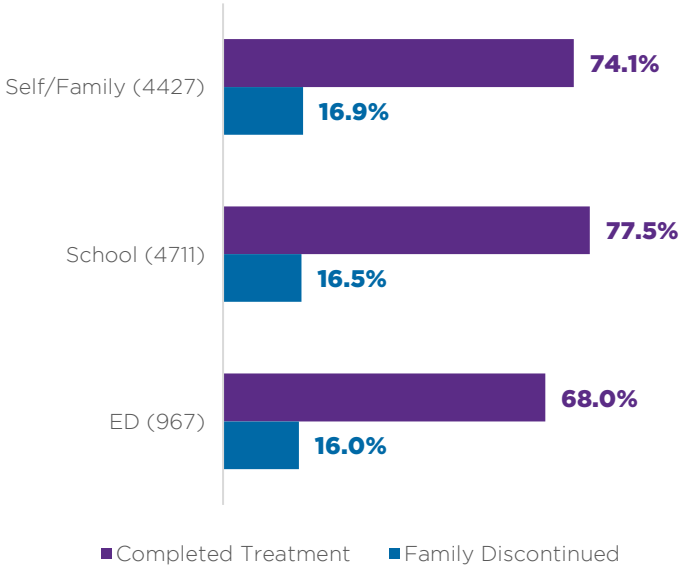


Figure 33. Families completing treatment by referral source.



What other services are youth being referred to?

Statewide, **the most common referrals made upon discharge from Mobile Crisis were to outpatient services (43% of children) and back to an existing provider (31%)**. Mobile Crisis referrals to the ED were rare, occurring for only 4% of children, ranging from 2% (Western region) to 7% (Southwestern region). Children can receive referrals to more than one service and, in fact, 25% of children had multiple referrals. Table 11 displays referrals by region; if children were referred to more than one service, they are duplicated in the table. Fifty-nine percent of children who were referred back to an existing provider also received at least one additional care referral. A small portion of children (14%) did not receive any referrals at discharge. 47% of these children did not complete their treatment with Mobile Crisis. Of the children who completed treatment, 90% received at least one referral. It is also important to note that not all families will need a referral to formal services, and that the data does not capture connections to natural community supports that are frequently made by Mobile Crisis. Statewide, there were 776 episodes of care where at least one desired referral was unavailable. Cumulatively, there were 830 referrals reported as unavailable. The most common unavailable referrals were Outpatient Services (36%), Intensive In-Home Services (29%), and Other: Community-Based (10%).

Table 11. Services referred to by region.

	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Outpatient Services	46%	47%	41%	29%	42%	50%	**43%**
Referred back to original provider	24%	39%	35%	50%	33%	10%	**31%**
Intensive In-Home Services	11%	11%	8%	4%	6%	8%	**8%**
Intensive Outpatient Program	11%	2%	4%	3%	5%	3%	**5%**
Other: Community-Based	9%	4%	5%	4%	3%	3%	**5%**
Emergency Department	5%	6%	3%	5%	7%	2%	**4%**
Inpatient Hospital	3%	1%	3%	2%	3%	9%	**4%**
Care Coordination	3%	2%	3%	1%	3%	1%	**2%**
Psychiatric provider for medication	1%	2%	4%	2%	2%	0%	**2%**
Partial Hospital Program	5%	9%	0%	0%	1%	0%	**2%**
Extended Day Treatment	2%	0%	1%	1%	1%	1%	**1%**
Other: Out-of-Home	1%	0%	1%	0%	0%	0%	**1%**
UCC	0%	0%	2%	0%	0%	0%	**1%**
Residential Treatment	0%	0%	0%	0%	1%	1%	**0%**
Group Home	0%	0%	0%	0%	0%	0%	**0%**
SAC	0%	0%	0%	0%	0%	0%	**0%**
No Care Referral	10%	20%	14%	14%	14%	14%	**14%**

Are families and other referrers satisfied with the service?

Each quarter, 2-1-1 surveys a sample of families and other referrers on their experience with Mobile Crisis. Each question is measured on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree). In FY2024, 124 clients/families and 83 other referrers were surveyed regarding their satisfaction with the service; clients/families gave favorable ratings to 2-1-1 and Mobile Crisis services. On a 5-point scale, clients' average ratings of 2-1-1 and Mobile Crisis were 4.90 and 4.84. Among other referrers (e.g. schools, hospitals, DCF, etc.), the average ratings of 2-1-1 and Mobile Crisis were 4.85 and 4.82, respectively. Qualitative comments (see Section X) varied from very satisfied to dissatisfied. Note that there was a smaller sample of respondents this year due to technical issues in capturing the data during quarters 2 and 3.

Table 11. Satisfaction with Mobile Crisis services.

2-1-1 Items	Clients (n=124)	Referrers (n=83)
The 2-1-1 staff answered my call in a timely manner	4.89	4.87
The 2-1-1 staff was courteous	4.91	4.84
The 2-1-1 staff was knowledgeable	4.93	4.85
My phone call was quickly transferred to the EMPS provider	4.88	4.84
Sub-Total Mean: 2-1-1	4.90	4.85
Mobile Crisis Items		
Mobile Crisis responded to the crisis in a timely manner	4.86	4.76
The Mobile Crisis staff was respectful	4.94	4.89
The Mobile Crisis staff was knowledgeable	4.96	4.87
The Mobile Crisis staff spoke to me in a way that I understood	4.88	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)	4.77	X
The services or resources my child and/or family received were right for us	4.77	X
The child/family I referred to Mobile Crisis was connected with appropriate services or resources upon discharge from Mobile Crisis	X	4.82
Overall, I am very satisfied with the way that Mobile Crisis responded to the crisis	4.72	4.79
Sub-Total Mean: Mobile Crisis	4.84	4.82
Overall Mean Score	4.87	4.84

Client Comments:

- Caller was thoroughly impressed by the high quality of work provided by youth MCI for her son.
- "The clinician was sincere and had a great deal of compassion."
- "I appreciate the evaluation and safety techniques provided for my daughter."
- "My 15yr old did not want to go to school this morning, and MCI was very helpful."
- Caller reports that 211 and MCI should hire more Spanish speaking staff for parents who feel more comfortable speaking Spanish.
- Very grateful for MCI service.
- Feels that being 24/7 is an improvement. Caller reports that she feels the newer clinicians should be sent out with the experienced clinicians.
- Caller expressed tremendous gratitude for MCI service.

Referrer Comments:

- "Dealing with this youth proved quite demanding, as they exhibited resistance in responding to the guidance provided by adults. Your assistance is appreciated!"
- "Your clinicians' dedication is truly admirable, they make a meaningful impact every day. It's a pleasure collaborating with your team."
- "45 minutes for a clinician to respond when a youth is in crisis is not ideal."
- "Navigating the complexities of this youth's case required a collaborative effort, and we are grateful for [MCIS Agency's] invaluable support in addressing the unique challenges presented"
- Caller reports very positive experiences with MCI; however, as she usually requests deferred she doesn't have feedback on response time or additional referrals.
- Would like more communication with MCI and to be told which clinician is assigned to the case.

Another way that satisfaction data is collected is through the Ohio satisfaction scales. Of the 821 responding parents and guardians, 82% feel somewhat to extremely capable of dealing with their child's problems. Of the 738 responding parents and guardians, 89% felt that their ideas were included in their child's treatment plan either "a great deal", "moderately", or "quite a bit". Of the 773 responding parents and guardians, 94% felt somewhat to extremely satisfied with the services their child received.

Figure 34. Upon discharge, how capable of dealing with the child's problems does the parent/guardian feel?

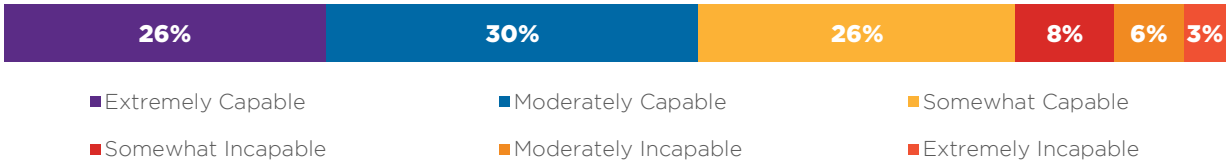


Figure 35. How does the parent/guardian rate the extent to which the child's treatment plan included their ideas about their child's treatment needs?

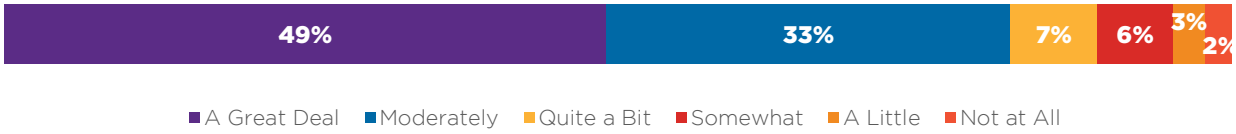


Figure 36. How satisfied is the parent/guardian with the mental health services the child has received?

Mobile Crisis Workforce

How many staff were trained?

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 FY2024, 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. All module trainings were held online with one offering of each training in person. Evaluation findings continue to be used to inform changes for FY2025 Highlights from the Mobile Crisis PIC training component include the following:

- 26 training modules were held in FY2024 (24 were held in FY2023).
- There were 483 attendees across all Mobile Crisis trainings in FY2024, representing 163 unique individuals that attended at least one training this fiscal year.
- There have been 438 trainings in the ten years of Mobile Crisis PIC implementation, and 768 Mobile Crisis staff members have completed one or more trainings during that time.

In addition to the standard training curriculum, CHDI, DCF, and providers work together to identify additional needs and offer ad hoc trainings throughout the year. One example of this is the coordinating of two suicide prevention trainings – an introductory course and an advanced course – to help prepare staff in light of increasing rates of suicide in the state. A key element of these trainings is a focus on being culturally responsive in suicide prevention and management. These trainings are being offered in early FY2025.

When looking across all Mobile Crisis staff, rates of completing all 13 trainings are low (6% statewide; 10% of full-time staff). However, this doesn't take into account the amount of time staff have been employed. Half of staff who have been employed at least one year but less than 2 years have completed at least 6 trainings. Only 13% of staff who have been employed longer than two years have completed all of the trainings. This indicates a need to provide clear, realistic standards for training completion and to track data more closely throughout the year.

Table 12. Trainings completed by region.

	Total Staff	Completed all 13 trainings	Full Time Staff	Completed all 13 trainings	Staff Employed between 1 and 2 years	Completed 6+ trainings	Staff employed 2+ years	Completed all 13 trainings
Central	42	5%	23	9%	15	33%	14	7%
Eastern	22	23%	13	38%	7	71%	11	45%
Hartford	52	0%	37	0%	22	41%	20	0%
New Haven	30	20%	22	23%	6	67%	16	38%
Southwestern	23	0%	13	0%	8	38%	9	0%
Western	47	0%	18	0%	12	67%	18	0%
Statewide	218	6%	127	10%	70	49%	104	13%

In FY2024, the PIC began to track training attendance more closely and work with providers to increase training completion rates. For many years, the PIC has been providing quarterly incentives to providers with the highest collection rates of parent Ohio Scales. This year, we moved to incentivizing training completion. Each quarter we determined the number of full-time staff, employed longer than 6 months, in each region who had completed more than half of the trainings. Over the course of the year, we went from 56% of these staff having completed more than half of the trainings to 64% statewide. Additionally, the Eastern region has achieved 100% of eligible staff having completed more than half of the trainings.

The PIC also worked with DCF to establish clear training standards, which will be implemented in FY2025. Newly hired MCIS full-time staff will complete 6 identified trainings within the first year of employment:

- Emergency Certificate
- Crisis Assessment, Planning and Intervention
- Assessing Violence Risk in Children and Adolescents
- Columbia Suicide Severity Rating Scale
- 21st Century Culturally Responsive Mental Health Care
- Traumatic Stress and Trauma-informed care

Part-time or per-diem staff will complete the 6 identified trainings by 18 months of employment. The remaining trainings must be completed by the end of year 2 for full-time staff and by 2.5 years for part-time or per-diem staff. Each subsequent year, staff will attend a minimum of 2 trainings per year. We will move to tracking and incentivizing training completion in accordance with these standards.

CHDI assisted DCF, the Department of Developmental Services (DDS), and the Department of Mental Health and Addiction Services (DMHAS) with a federal grant application for the Transformation Transfer Initiative (TTI) for the state of Connecticut, which was awarded. DCF has asked CHDI to develop some training modules for Mobile Crisis, and perhaps other services. CHDI has attended some meetings with TTI grantees and provided updates to DCF. CHDI is currently working with DCF to enhance 2 existing MCIS trainings, developing advanced trainings on Autism and Intellection Developmental Disabilities and Positive Behavioral Supports. We are also working to develop two new trainings - one on Family Engagement and another on The Impact of Racism and Mental Health: Uncovering the Links to Enhance Clinical Treatment Effectiveness. These trainings will be live and virtual.

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.

How did providers educate the community about Mobile Crisis?

Mobile Crisis providers play a significant role in creating awareness and increasing utilization of the service by conducting outreaches and building relationships in their communities. Providers conduct a variety of formal outreach activities, including presentations at schools, police departments, and hospitals, as well as participation in community events to reach families. **In FY2024, providers conducted 149 formal outreaches to the community**. Performance ranged from 9 outreaches (Hartford region) to 47 outreaches (Eastern region).

Table 13. Formal outreaches completed by region and provider.

	Q1 FY24	Q2 FY24	Q3 FY24	Q4 FY24	Total
Central	7	4	3	8	22
CHR: Middlesex Health	2	2	3	2	9
CHR	5	2	0	6	13
Eastern	13	13	6	15	47
UCFS:NE	1	6	4	2	13
UCFS:SE	12	7	2	13	34
Hartford	5	0	1	3	10
Wheeler: Hartford	2	1	1	3	7
Wheeler: Meriden	0	0	0	0	0
Wheeler: New Britain	3	0	0	0	3
New Haven	5	3	2	4	14
Clifford Beers	5	3	2	4	14
Southwestern	3	8	10	11	32
CFGC: South	3	4	4	6	17
CFGC: Norwalk	0	0	0	0	0
CFGC: Bridgeport	0	4	6	5	15
Western	11	6	3	5	25
Wellmore: Danbury	1	0	0	0	1
Wellmore: Torrington	1	0	0	0	1
Wellmore: Waterbury	9	6	3	5	23
Statewide	**44**	**35**	**25**	**46**	**150**

How did providers engage in continuous quality improvement with the PIC?

In FY2024, 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.mobilecrisisempsct.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 practices 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 FY2024 there were a total of 60 performance improvement goals developed (includes goals duplicated across more than one quarter). **Of those goals, 25% were achieved and an additional 63% of the goals saw improvement**. Only 12% of goals developed had no positive progress.

Performance Improvement Center Activities

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.

Suicide Prevention: The PIC provided Mobile Crisis data to DCF for use with suicide prevention partners in guiding prevention efforts. This data included information on demographics of children using Mobile Crisis, the prevalence of "harm/risk of harm to self" as a presenting problem, school and ED utilization of Mobile Crisis, and Mobile Crisis utilization by zip code.

Call Volume Analysis: In response to declining call volume since FY2022, the PIC has conducted ongoing analysis to identify any trends in this decline to guide potential strategies for increasing volume. The PIC also provided DCF and providers with data on school utilization, ED utilization, and DCF utilization of Mobile Crisis to guide more targeted outreach efforts. This work is ongoing and will continue into FY2025.

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. Beginning in FY2024 and continuing into FY2025, CHDI will be piloting SBDI-E, a version of SBDI that has been adapted for use with elementary schools. This initiative will use Mobile Crisis data in a similar way to SBDI.

This year, Mobile Crisis data was also used to support Connecticut's participation in Project AWARE and other comprehensive school mental health initiatives, which work within specific school districts and communities to provide or enhance services in support of the mental and behavioral health of youth and families.

Juvenile Justice: CHDI continues to be part of the Juvenile Justice Policy and Oversight Committee (JJPOC) and continues to provide data on Mobile Crisis as needed. 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: Beginning in FY2022, the Mobile Crisis PIC is now providing quarterly data to the Racial and Ethnic Disparities (RED) Committee, formerly known as Disproportionate Minority Contact (DMC) Committee. This data summarizes Mobile Crisis referrals for schools with high rates of exclusionary discipline, with a focus on identifying potential disparities and promoting the use of Mobile Crisis in schools. Staff from DCF and Mobile Crisis provide ongoing participation in the CT Disaster Behavioral Health Response Network which supports the work of the Northeast Terrorism and Disaster Coalition.

Model Development and Promotion

Mobile Crisis stakeholders continue to work toward standardized Mobile Crisis practice across the provider network and present to various system stakeholders to ensure awareness of Mobile Crisis throughout the state. Mobile Crisis partners have also continued to work throughout the year to establish Connecticut's Mobile Crisis service as a recognized national best practice. Staff at the PIC made a number of contributions in these areas which are summarized below.

Connecticut Mobile Crisis stakeholders engage in efforts to leverage Mobile Crisis to reduce behavioral health emergency department (ED) volume as recommended in a 2018 report published by CHDI and Carelon. Mobile Crisis providers continue outreach to schools, communities, and EDs to support youth and defer referrals to the ED whenever it is safe and clinically appropriate. The PIC continues to respond to data requests and provide information on ED referrals to Mobile Crisis. Mobile Crisis is still envisioned as playing a critical role in a continuum of crisis-oriented services in Connecticut, including 988 and two new levels of care procured in FY 2023: Urgent Crisis Centers (UCCs) and Sub-Acute Crisis Stabilization units (SACs). This work has continued to evolve throughout FY2024 as four UCCs opened in Connecticut. CHDI, DCF, and providers for both programs are having ongoing discussions about the role of each service, the partnership between them, and the needs of children and families in crisis.

PIC staff completed work this year in partnership with The Innovations Institute at UConn School of Social Work on the **Mobile Response & Stabilization Service Quality Learning Collaborative (MRSS QLC).** CHDI and UConn co-developed the initiative and engaged in consultation and technical assistance to 4 states (Kansas, New Mexico, Washington, and West Virginia), each of which was interested in launching, expanding, or improving delivery of MRSS services for youth. Through this collaboration, Connecticut's Mobile Crisis service, and its approach to data collection and quality improvement, will continue to influence the development of similar approaches in other states. CHDI staff contributed to the development of MRSS for youth best practice standards, as well as a separate data best practice guide for youth MRSS.

Additionally, CHDI continued consultation to the state of Louisiana through a contract with the Louisiana State University Center for Evidence to Practice. Louisiana is now moving more directly into child and adolescent MRSS services and CHDI will contribute to their development of the state's infrastructure for training, data collection, performance measurement, and quality improvement.

CHDI began a new contract with Meadows Mental Health Policy Institute to consult on the early implementation of Youth Crisis Outreach Teams (YCOT) in Texas. In June, CHDI participated in a best-practice implementation summit where we provided training on the fundamental values and principles underlying YCOT based on national MRSS best practices, using data for quality improvement, considerations for safety planning with children and families, and strategies for a confident and competent workforce. The work will continue into FY2025, CHDI will be working with Meadows to develop a virtual learning community for the eight YCOT teams focused on implementation support.

Individual states continue to reach out to CHDI for consultation on MRSS for youth including our approaches to data collection and QI. Additional states that CHDI spoke with throughout the year about Connecticut's mobile system included Texas, Nevada, and California.

Collaboration 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 Carelon, 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, Carelon, and other stakeholders. The meetings are held to review Mobile Crisis practice and policy issues. Since COVID-19, meetings have continued to be held virtually.

Suicide Postvention: Whenever there is a death by suicide of a youth 24 and under, the regional Mobile Crisis provider is notified so they can provide postvention support to the school and community. A number of other entities also are notified, including the Regional Crisis Teams (RCTs) our of the CT Center for School Safety and Crisis Preparation and the Regional Suicide Advisory Boards (RSABs). Up to this point, Mobile Crisis providers often collaborated with these groups in providing postvention, but there was no formal statewide partnership. In FY2024, Mobile Crisis Providers, DCF, and the Mobile Crisis PIC have worked with the RCTs and the RSABs to develop a formal school postvention protocol. This will be finalized and implemented in FY2025.

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.

Annual Meetings: Typically, Mobile Crisis Providers, clinicians, DCF and other stakeholders attend a year-end annual meeting. This year's annual meeting was held at Central Connecticut State University and our Keynote speaker was Dr. Cecilia Frometa. She presented on Becoming Culturally and Racially Attuned: Reflecting on Self in Clinical Work with Diverse Clients. The purpose of the annual meeting is to recognize Mobile Crisis's accomplishments throughout the year.

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 shifted in 2017 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. In FY2024, there were discussions about updating the MOAs with school districts given the decline in school calls and evolving behavioral health needs of youth. This process will begin in FY2025.

Recommendations and Goals for FY2025

Improving Utilization and Equity

1. CHDI, DCF, and providers will work to increase utilization of Mobile Crisis, with a particular focus on those who are currently underutilizing the service.
    - Routinely analyze data to identify underserved groups and measure the success of outreach efforts towards those groups.
    - Target outreach efforts to reach the identified groups.
        - DCF/Foster Parents
        - Faith-based communities
        - Community organizations and events that could help reach families
        - Schools that do not utilize Mobile Crisis
        - Working with schools to communicate with families about Mobile Crisis
2. CHDI will work with MCIS staff on their SMARTIE goals to continue to look at their goals through and equitable lens.

Data Quality and Documentation

3. CHDI will work with DCF and providers to establish a formal data dictionary to ensure consistent and accurate data entry across all Mobile Crisis providers.
4. CHDI will work with providers to reduce rates of missing data for questions around client history.
5. CHDI will work with MCIS staff on updating the Practice Standards, which were last updated in 2013.
    - CHDI and DCF will meet with supervisors from each agency to review the Practice Standards and edit the document to ensure accuracy to current practices.

Workforce

6. CHDI will continue to work with MCIS trainers to enhance and improve training content through an equitable lens. CHDI will monitor training completion by MCIS staff in accordance with the updated training standards.

System Development

7. CHDI will leverage its role as the Performance Improvement Center for both Mobile Crisis and the UCCs, working with DCF, providers, and United Way (call center for both 211 and 988) to identify both successes and areas for improvement in Connecticut's youth crisis continuum.