

Urgent Crisis Center Performance Improvement Center

Quarterly Report: FY2025 Q2

Urgent Crisis Centers (UCCs) provide full crisis assessments in a safe location for any child and family in Connecticut experiencing a behavioral health crisis. There are three community-based UCCs funded by DCF and operated by Child and Family Agency of Southeastern Connecticut (New London), The Village for Families and Children (Hartford), and Wellmore Behavioral Health (Waterbury). There is an additional UCC at Yale-New Haven Health, currently operating out of their emergency department.

This report provides an overview of UCC services using data entered by the three community-based UCCs into DCF's Provider Information Exchange (PIE) Database. Yale is not currently entering data into PIE; when data becomes available for Yale, it will be analyzed separately due to differences between hospital-based and community-based UCCs.

This report was prepared by the UCC Performance Improvement Center, housed at the Child Health and Development Institute (CHDI). CHDI receives data from DCF, which is analyzed and summarized for this report. For more information, please contact Kayla Theriault at ktheriault@chdi.org.

Urgent Crisis Center Quarterly Report - FY2025 Q2

This report presents data for Connecticut's three community-based Urgent Crisis Centers for children (UCCs), from October 1, 2024 - December 30, 2024.

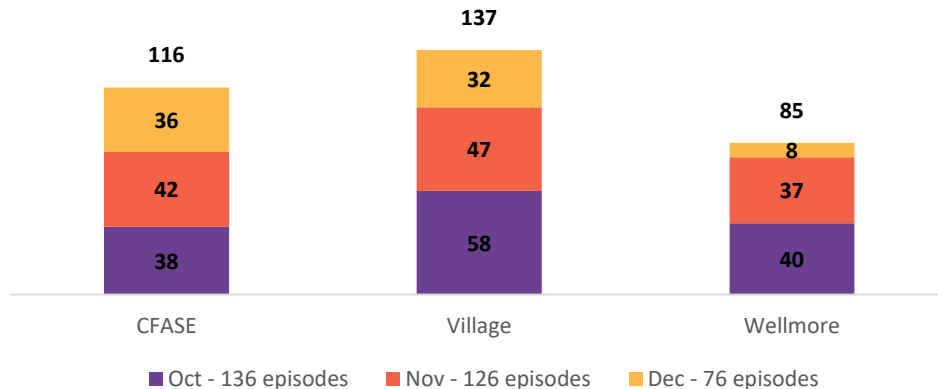
Between January 1, 2024 and December 30, 2024 the UCCs have served 1,781 children

FY2025 Q2 Highlights:

- 338 episodes of care
- Race and ethnicity of children served is consistent with CT's child population - statewide, 14% of children served were Black, 19% were Hispanic, and 53% were White
- Higher rate of female children served
- Harm/risk of harm to self and disruptive behavior are the most common presenting problems statewide
- Schools were the most common referral source
- 100% of children met their treatment goals, which was consistent across major racial and ethnic groups (98% for Black children and 100% for White and Hispanic children)
- 88% of children showed some level of improvement from intake to discharge and 12% stayed the same
- 99% of children were discharged to their homes and communities, which was consistent across racial and ethnic groups (99% White children 100% for Hispanic and Black children)

How much did we do?

UCC Volume by Month



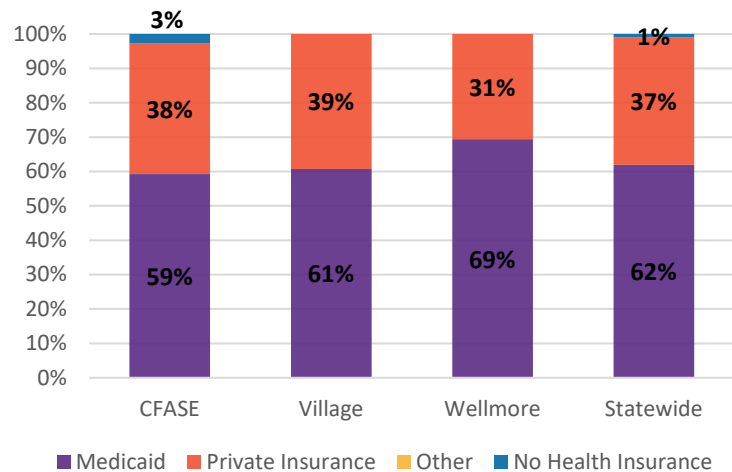
In FY2025 Q2, the three community-based UCCs reported **338 episodes of care**. In total, 392 families reported to the UCC but ultimately 54 of these were evaluation only cases, meaning that the child was not admitted to the UCC for assessment. The most common reasons for an evaluation only case were the family declining services (46%), the child needing a higher level of care (34%), or the child being more appropriate for a lower level of care (7%).

The highest volume was reported by the Village (137) and the lowest volume was reported by Wellmore (85)*. Statewide, November had the highest volume (126).

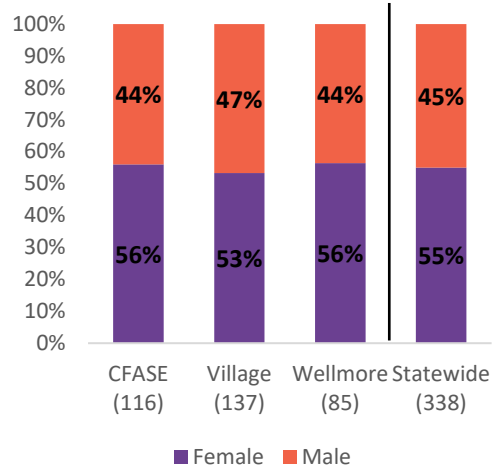
*Low Dec. volume for Wellmore is likely due to delayed data entry.

Who did we serve?

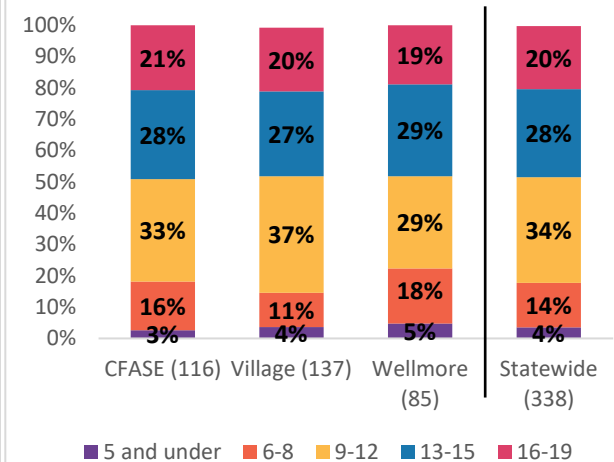
Health Insurance of Children Served



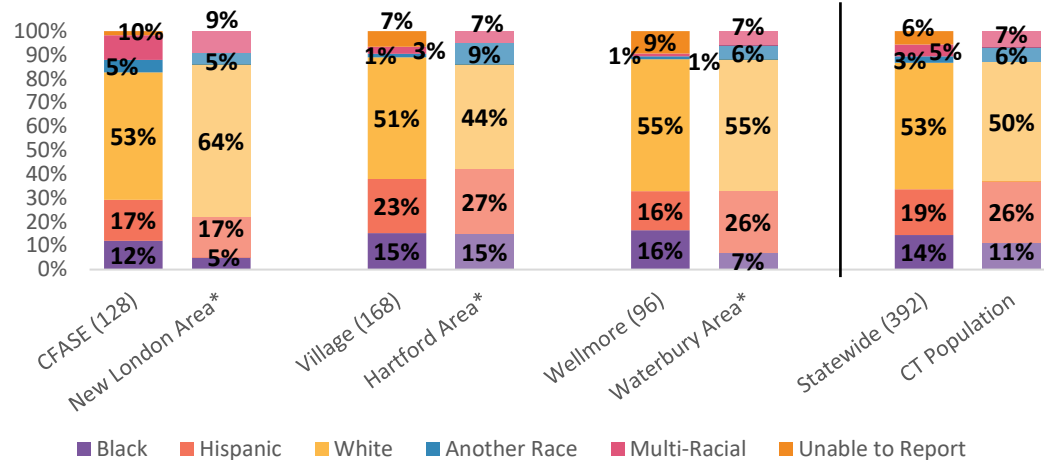
Sex of Children Served



Age of Children Served



Race and Ethnicity of Children Served



*As a walk-in service, families can choose to visit any UCC regardless of where they live. These areas are defined as the city the UCC is located in plus a selection of towns in the surrounding area. There may be overlap between these areas.

Statewide, UCCs served a population that is similar in race and ethnicity to the CT child population. There was some variation within individual regions.* CFA served White youth at lower rates than the regional population (53% vs 64%). Wellmore served Hispanic youth at a lower rate than their regional population (16% vs. 26%).

In Q2, 55% of the youth served were female, and 2.3% of children served reported being transgender. The largest age groups of children served were 9-12 years old (34%) and 13-15 years old (28%).

*Due to small relatively small sample sizes, it is important to interpret differences with caution. We monitor overall trends, and only note differences of 10 percentage points or more.

Who did we serve?

Presenting Problem	CFASE (56)	Village (102)	Wellmore (70)	Statewide (228)
Harm/Risk of Harm to Self	51%	34%	30%	39%
Disruptive Behavior	15%	23%	10%	17%
Depression	5%	13%	18%	12%
Anxiety	8%	11%	15%	11%
Harm/Risk of Harm to Others	2%	9%	4%	5%
School Problems	3%	1%	6%	3%
Trauma	3%	0%	6%	2%
Family Conflict	1%	3%	2%	2%
Running Away	3%	1%	1%	2%
Hyperactive/Impulsive	0%	1%	4%	1%
Other	10%	2%	4%	5%

Statewide, the most common presenting problem was harm/risk to self (39%). This was consistent with all providers with CFA being the highest at 51%.

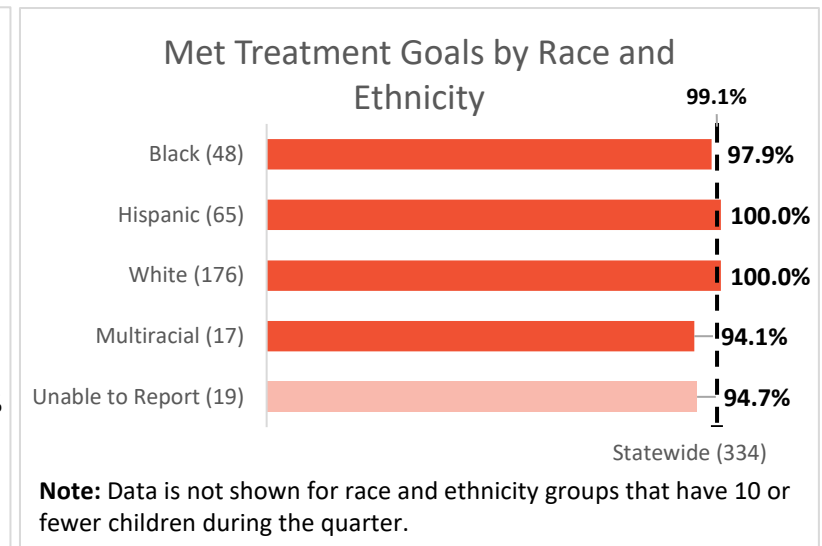
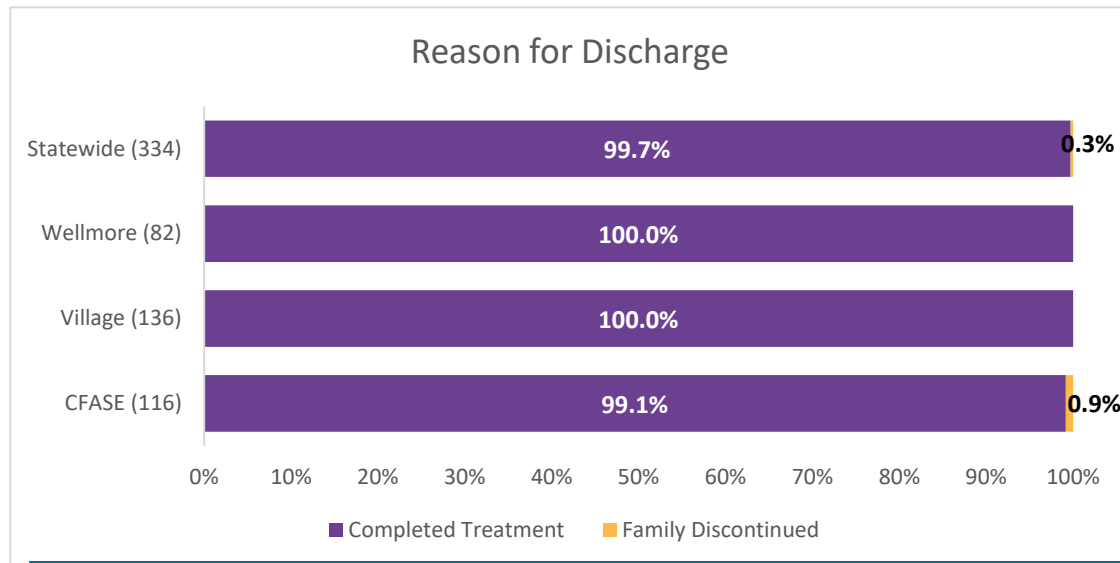
Statewide, the most common referral source was school (50%), with CFA having the highest amount of school referrals at 59%

Referral Source	CFASE (56)	Village (102)	Wellmore (70)	Statewide (228)
School	59%	42%	49%	50%
Self/Family	14%	20%	21%	18%
Other Community Provider Agency	9%	11%	7%	9%
Other Program within Agency	8%	9%	4%	7%
Physician	1%	8%	7%	5%
Info-Line (211)	1%	4%	2%	3%
DCF	2%	1%	4%	2%
Mobile Crisis	0%	2%	5%	2%
Police	4%	1%	0%	2%
Emergency Department	2%	0%	1%	1%
Other Referral Source	1%	1%	0%	1%

How well did we do?

Services Provided	CFASE	Village	Wellmore	Statewide
Medical Clearance	97%	99%	93%	97%
Crisis Assessment and Intervention	97%	99%	94%	97%
Psychiatric Care	96%	99%	75%	92%
Care Referrals	96%	99%	94%	96%
Safety Planning	96%	99%	94%	96%
Written Discharge Instructions	93%	99%	92%	95%
Aftercare Case Management	96%	99%	85%	94%
Total Episodes	116	137	85	338

Most major elements of the model were consistently provided to all children served by the UCC.

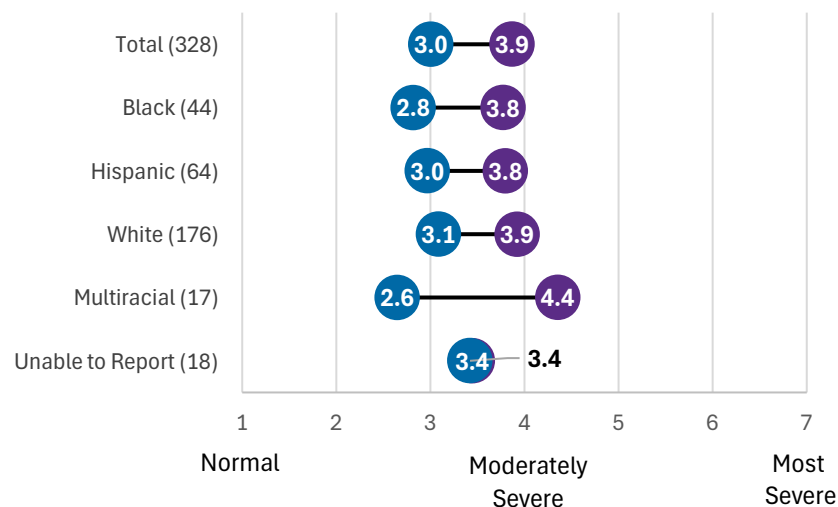


The **average length of stay (LOS)** statewide was 3.4 hours. This number varied by agency with CFA having an average LOS of 2.9 hours, Wellmore 2.7 hours, and the Village having the highest average LOS of 4.1 hours.

Nearly 100% of children statewide were discharged because they completed treatment with the UCC. Statewide, 99.1% of children met treatment goals, varying minimally by race and ethnicity. Lower rates of meeting treatment goals among Multiracial children and children whose race was not reported, when compared to White children, were statistically significant ($p=.037$) with a small effect size ($C=0.185$).

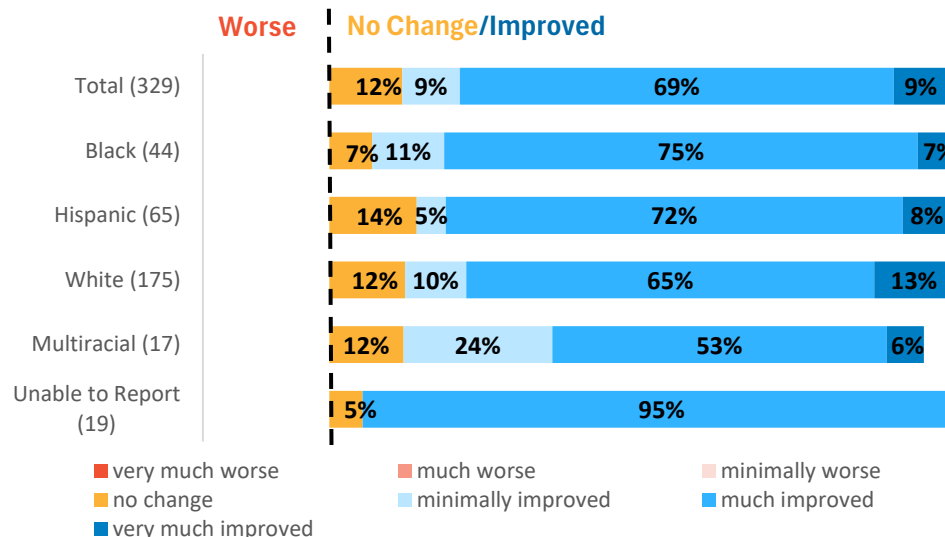
Is anyone better off?

Severity Rating on CGI at **Intake** and **Discharge**, by Race and Ethnicity



Note: Data is not shown for race and ethnicity groups that have 10 or fewer children during the quarter.

Compared to the child's condition at intake, at discharge the child's condition is...

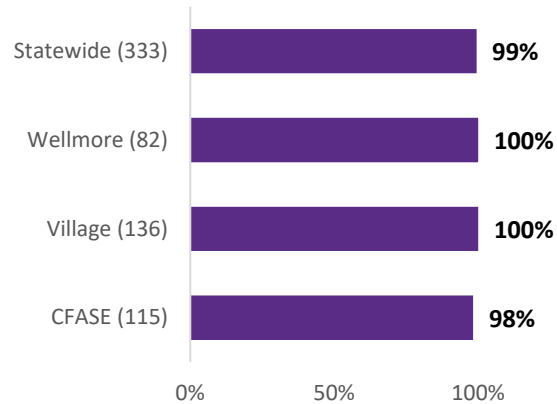


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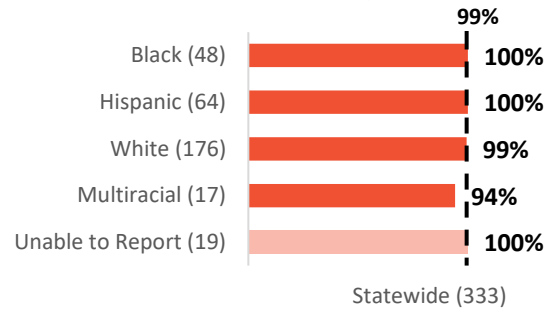
The Clinical Global Impressions Scale (CGI) consists of two questions. The first, asked at both intake and discharge, was "Considering your experience, how severe are the child's emotional, behavioral, and/or cognitive concerns at this time?" Clinicians respond on a scale of 1 to 7, with 1 being "normal" and 7 being "among the most severe symptoms that any child may experience". At intake for the UCCs, the average severity reported on the CGI was 3.9, approaching "moderately severe". There was a change in severity reported between intake and discharge, with the average score at discharge being 3.0. Multiracial children had a significantly higher score when compared to children whose race was not reported ($p=.043$), and children whose race was not reported had significantly lower change in score from intake to discharge compared to all other groups ($p<.001$).

The second CGI question asks "Compared to the child's condition at intake, this child's condition is...", answered on a scale of "very much worse" to "very much improved". Nearly all children (88%) saw some level of improvement, with the most common category being "much improved" (69%). Given the UCC is such a short intervention, a child demonstrating even minimal improvement is considered a positive outcome. Additionally, it is recognized that in some situations helping maintain a child and family is the goal, and that might not result in any change; this was the case for 12% of children. There were no significant differences in improvement level between racial and ethnic groups.

Percent Discharged to Home/Community



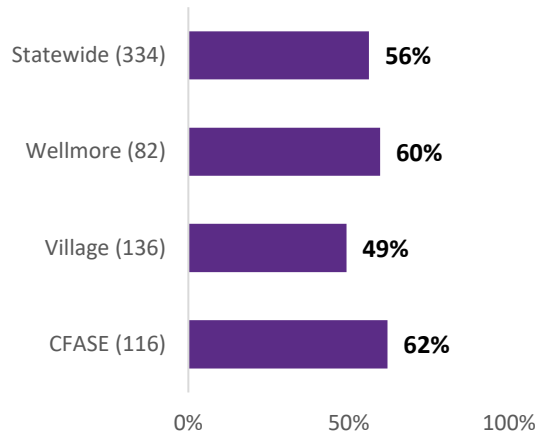
Percent Discharged to Home/Community by Race and Ethnicity



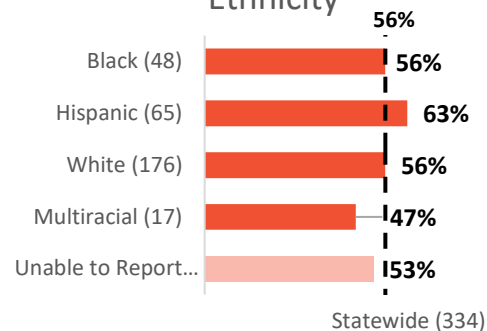
Note: Data is not shown for race and ethnicity groups that have 10 or fewer children during the quarter.

99% of children were able to return to their home/community at discharge. This was consistent across most racial/ethnic groups, with Black & Hispanic youth having a rate of 100%. There were no statistically significant differences between racial and ethnic groups.

Percent of families reporting they would have used the ED if not for the UCC



Percent of reporting they would have used the ED if not for the UCC, by Race and Ethnicity



Note: Data is not shown for race and ethnicity groups that have 10 or fewer children during the quarter.

UCC providers ask families what they would have done if the UCC wasn't available, particularly whether they would have gone to an ED. For 56% of episodes, families reported diversions from the emergency department, indicating a substantial portion of clients being redirected or receiving care outside of the ED. White and Black youth had a diversion rate similar to the statewide rate, while Hispanic youth have a higher rate (63%). Differences between racial and ethnic groups were not statistically significant.

Note: Episodes not considered a diversion did not necessarily end in a visit to the ED - the parents just did not report that they would have gone to the ED if not for the UCC.