MOBILE CRISIS
RESPONSE TEAM FOR YOUTH

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).

2-1-1 Connecticut

United Way of Connecticut

MOBILE CRISIS INTERVENTION SERVICES

Performance Improvement Center (PIC)

ANNUAL REPORT

FY2023

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is housed at the Child Health and Development Institute

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Fiscal Year 2023 Annual Report

Note: As of January 2023, Mobile Crisis providers are available for a mobile response 24 hours a day, 7 days of the week. Prior to January 2023, a mobile response was only available Monday – Friday 6:00 AM to 10:00 PM and from 1:00 PM to 10:00 PM on weekends. At this time, the majority of this report only reflects calls that took place during the previous mobile hours. Relevant data specific to the new overnight hours is reported at the end of each section, in charts titled "expanded hours". Additionally, the "Call and Episode Volume" and "24/7 Expansion and Comparisons to Traditional Hours" sections at the start of this report include data on both the traditional and expanded hours.

Mobile Crisis Intervention Services (Mobile Crisis) is a mobile intervention for children and adolescents experiencing a behavioral or mental health need or crisis. Mobile Crisis is funded by the Connecticut Department of Children and Families (DCF) and is accessed by calling 2-1-1 or 988. The statewide Mobile Crisis network is comprised of over 150 trained mental health professionals who can respond in-person within 45 minutes when a child is experiencing an emotional or behavioral crisis. The purposes of the program are to serve children in their homes, schools, and communities; reduce the number of visits to hospital emergency rooms; and divert children from high-end interventions (such as hospitalization or arrest) if a lower level of care is a safe and effective alternative. Mobile Crisis is implemented by six primary contractors, most of whom have satellite offices or subcontracted agencies. A total of 14 Mobile Crisis sites collectively provide coverage for every town and city in Connecticut.

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

Over the past year, a number of supports and resources stemming from 2022 legislation have been developed or expanded. Mobile Crisis was expanded to be available for children 24/7 statewide. As of January 2023, Mobile Crisis Providers are available for a mobile response 24 hours a day, 7 days of the week. Prior to January 2023, a mobile response was only available Monday – Friday 6:00 AM to 10:00 PM and from 1:00 PM to 10:00 PM on weekends.

The FY2023 Annual Report summarizes results from Mobile Crisis data entered into the Provider Information Exchange (PIE), DCF's web-based data entry system, as well as other activities and results relevant to Mobile Crisis implementation. This year, mobility and response time benchmarks were both met. Mobility was 94.9% during the traditional mobile hours and 94.7% when including calls during the expanded hours, an increase from last year's rate of 92.1%. Additionally, 84.8% of mobile episodes initiated during traditional hours received a response within 45 minutes (84.6% when including expanded hours), the highest rate since the start of the COVID-19 pandemic and exceeding the benchmark of 80%. This marks a positive trend in response time, as in FY2022 the benchmark was not met for the first time in several years. Achievement of positive results is due to strong collaborations among various partners including DCF, Mobile Crisis providers, the PIC and its subcontractors, the CT Clearinghouse at Wheeler Clinic, 211-United Way, the Connecticut Behavioral Health Partnership (CT BHP), Carelon, Data Silo Solutions, family members and advocates, and other partners and stakeholders.

This report reviews data and activities from Fiscal Year 2023 (FY2023; July 1, 2022 to June 30, 2023), and when appropriate, includes comparisons to previous years. Given the rollout of the 24/7 expansion in the middle of the year, much of the report excludes calls initiated during those hours to allow for more accurate comparisons to previous years. The "Call and Episode Volume" section includes call volume totals for calls during all 24 hours, as well as the totals for calls that came in

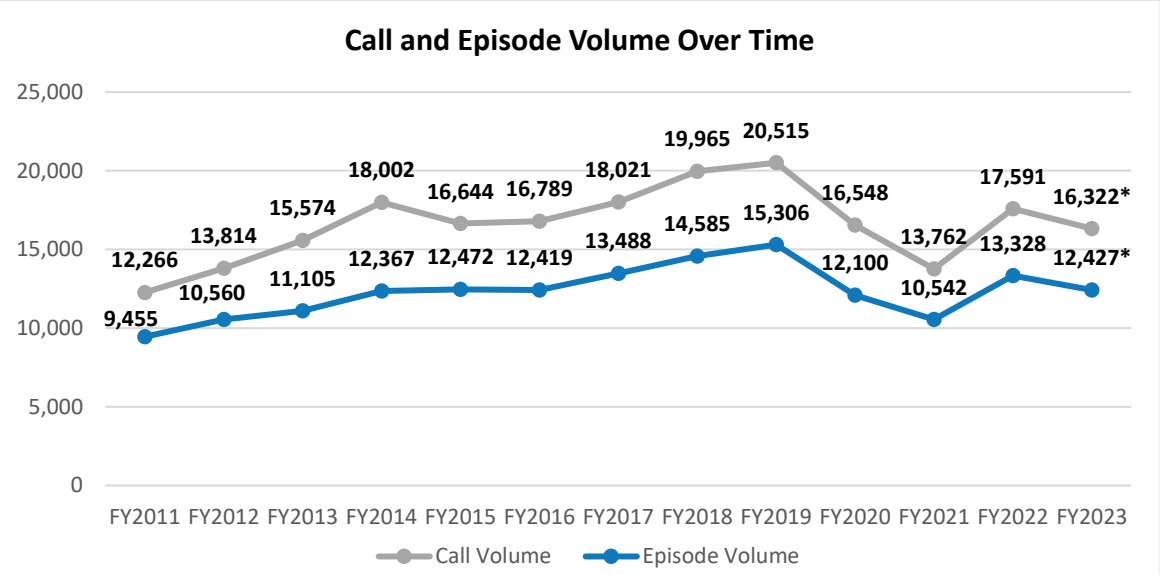
only during the traditional hours. The section titled "24/7 Expansion and Comparison to Traditional Hours" provides a detailed overview of key metrics including the expanded hours that began in January. Unless otherwise noted, the other sections of the report focus on the traditional mobile hours. The report is organized according to the following sections:

- Call and Episode Volume
- 24/7 Expansion and Comparison to Traditional Hours
- Characteristics of Children and Families Served
- Performance Measures and Quality Improvement
- Standardized Workforce Development and Technical Assistance
- Collaboration among Mobile Crisis Intervention Services Partners
- Model Development and Promotion
- Goals for Fiscal Year 2024

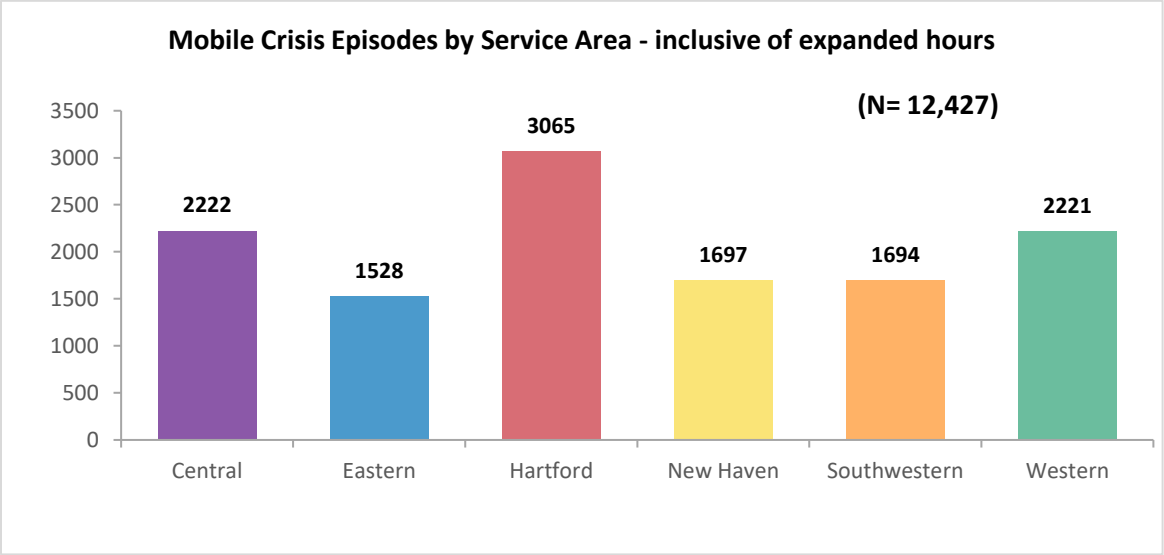
Call and Episode Volume

The 24/7 expansion has had a direct impact on call and episode volume. Inclusive of these new hours, **there were 16,322 calls to 2-1-1 requesting crisis intervention**, which is a 7.2% lower call volume than FY2022 (17,591 calls). In FY2022, volume had increased for the first time since the start of the COVID-19 pandemic in March 2020. However, both call and episode volume declined again this year, even with the expanded hours (see below). Of the 16,322 calls this year, 12,427 resulted in opened episodes of care with Mobile Crisis Intervention Services providers, a 6.8% decrease from FY2022 (13,328). Episode volume remains 18.8% lower than the highest annual episode volume to date in FY2019 (15,306 episodes). There were 661 calls during expanded hours this year, resulting in 431 episodes of care. It should also be noted that youth and families may have sought help by calling 988, which was implemented at the start of FY2023. In Connecticut, United Way operates as the call center for both 211 and 988, both of which can be used to access Mobile Crisis. Calls for youth that come through 988 can be transferred to a Mobile Crisis provider as appropriate. Any 988 calls that resulted in a Mobile Crisis episode are included in this data, though there is not currently data available to indicate which calls came through 988 and which came through 211.

Excluding calls and episodes during expanded hours in FY2023 would allow an equivalent comparison to volume in prior years. Doing so would result in FY2023 call volume of 15,661 (11.0% lower than FY2022) and episode volume of 11,996 (10.0% lower than FY2022).



*Includes calls that came in during expanded hours beginning in January



24/7 Expansion and Comparison to Traditional Hours

This section of the report will summarize utilization and performance metrics for all calls and episodes during FY2023, including the calls that came in during the expanded hours beginning in January. There will also be comparisons to the episodes initiated during traditional hours and discussion of any differences for episodes initiated during the expanded hours. This will provide a full picture of Mobile Crisis during FY2023 and allow for this report to be used to make comparisons in future years.

The majority of referrals to Mobile Crisis during FY2023 came from schools (44.5%) and self/family (39.2%). An additional 9.3% of referrals came from emergency departments. These percentages are consistent with past years. Inclusion of referrals during expanded hours has a very slight impact.

Referral Sources by Service Hours

	All Hours	*Traditional Hours*	*Expanded Hours*
Self/Family	39.2%	38.1%	70.5%
School	44.5%	46.0%	2.8%
Emergency Department	9.3%	8.8%	23.0%
Other Community Provider	1.7%	1.7%	0.7%
Foster Parent	0.8%	0.8%	1.6%
Police	0.5%	0.5%	0.2%
Other	4.0%	4.1%	1.2%

Referral sources vary significantly during the new hours, given that schools are not open. 70.5% of episodes initiated during these hours were referred by self/family and an additional 23.0% were referred by emergency departments. The small number of school referrals are assumed to be data entry errors (e.g., entering AM instead of PM). Referrals from emergency departments varied among service areas. The Eastern and Southwestern regions had very few referrals from emergency departments (2% and 6% of total referrals during these hours). For other regions, emergency department referrals made up between 20% (Hartford) and 42% (Western) of total referrals during the expanded hours.

Response types did vary between expanded and traditional hours, though changes during the expanded hours had little impact on the overall breakdown of response type. During the expanded hours, 2-1-1 recommended 41.5% of episodes for a mobile response, and an additional 27.0% for a deferred mobile response. 31.5% of episodes were recommended as non-mobile episodes, compared to 11.3% during traditional hours. During the expanded hours, 32.6% of episodes received a mobile response, 25.3% received a deferred mobile response, and 42.2% received a non-mobile response. Of the 247

mobile and deferred mobile episodes initiated during expanded hours, 107 received a face-to-face assessment with additional 115 receiving stabilization services.

Responses and Recommendations by Service Hours

	All Hours		*Traditional Hours*		*Expanded Hours*	
	Recommended Response	**Actual Response**	**Recommended Response**	**Actual Response**	**Recommended Response**	**Actual Response**
Mobile	65%	62%	66%	64%	42%	33%
Deferred Mobile	23%	19%	22%	19%	27%	25%
Non-Mobile	12%	19%	11%	17%	32%	42%

Inclusive of all hours, the statewide mobility rate was 94.7%, only a slight decrease from the 94.9% mobility rate during traditional hours. Similarly, **84.6% of mobile episodes received a response within 45 minutes**, compared to 84.8% during the traditional hours.

Key Benchmarks by Service Hours

	All Hours	*Traditional Hours*	*Expanded Hours*
Mobility Rate	94.7%	94.9%	84.9%
Response Time	84.6%	84.8%	68.5%

The mobility benchmark for the expanded hours is consistent with regular hours – 90% of recommended mobile responses should receive a mobile response. Statewide, the mobility rate was 84.9% during the expanded hours, with performance ranging from 52.0% (Southwestern) to 94.9% (Central). Two of the six regions met the 90% benchmark. It should be noted that small Ns can lead to greater fluctuations in these percentages.

As with mobility, the response time benchmark is consistent with traditional hours – 80% of mobile episodes should receive a response within 45 minutes. Statewide, 68.5% of episodes received a response within 45 minutes, with performance ranging from 50.0% (Southwestern) to 100.0% (Eastern). One of the six regions met the 80% benchmark. Again, small Ns can lead to greater fluctuations in these percentages. The median response time during the overnight hours was 35.0 minutes.

Primary presenting problem did not change notably when including expanded hours – the top presenting problems were harm/risk of harm to self (34.2%), disruptive behavior (23.1%), and depression (12.1%). Primary presenting problems during the expanded hours were also similar to traditional hours, though disruptive behavior (31.3% compared to 22.8% during traditional hours) was slightly more common than harm/risk of harm to self (29.3% compared to 34.4% during traditional hours).

The demographics of children served were also very similar regardless of when the initial call came in. Inclusive of all hours, the majority of children served were White, non-Hispanic (39.8%), Hispanic (32.8%), or Black, non-Hispanic (16.0%). Females (52.5%) were served slightly more than males (47.5%).

In any given month or quarter, performance during the expanded hours has the potential to impact overall performance metrics. During the first six months of the expansion, monthly and quarterly reports analyzed these hours separately to account for that impact as providers worked to get the system up and running. Given the high volume of episodes during a full year, the expanded hours had less of an impact on performance.

Characteristics of Children and Families Served

Beginning with this section, all data reported focuses on episodes initiated within the traditional Mobile Crisis hours unless otherwise noted.

Demographic Characteristics

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

Sex[1]: Among all Mobile Crisis episodes of care, 52.4% were for females and 47.6% were for males. This marks the third consecutive year where females were served more than males, where previously males have made up a slight majority of children served.

Age: The highest percentage of children served by Mobile Crisis were 13 to 15 years old (35.5%) and 9 to 12 years old (30.6%). An additional 19.5% of children were 16 years old or older and the remaining 14.3% of children were 8 years old or younger.

Ethnic Background: Most episodes (61.8%) were for children who identified as having a non-Hispanic[2] ethnicity. An additional 5.5% of episodes served children who did not disclose their ethnicity. Of the 32.7% of episodes serving children from a Hispanic ethnic background, most reported their ethnicity as "Other Hispanic/Latino" (22.4%) or "Puerto Rican" (9.1%).

Racial Background: The PIE data system allows for more than one race to be selected. In FY2023, the majority (56.5%) of Mobile Crisis episodes were for children who reported "White" as their racial background, 19.4% for those who reported "Black/African-American", and 2.8% for those who reported another race. Another 4.7% of episodes were for a child who selected more than one race, and 15.4% of episodes did not report racial background.

Health Insurance Status: **For the majority of Mobile Crisis episodes, children were covered by public insurance sources** including Husky A (55.2%) and Husky B (0.8%). Private insurance coverage was reported for 27.6% of episodes and 2.6% of episodes this year served children who had no insurance coverage, which is similar to FY2022 (2.8%).

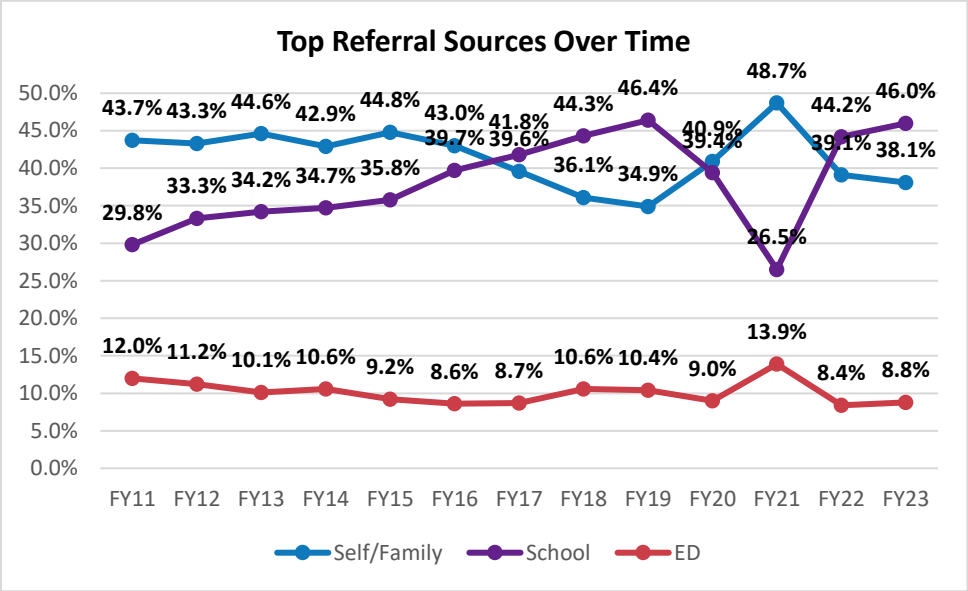
Temporary Assistance for Needy Families (TANF) eligibility: Statewide, **46.1% of Mobile Crisis episodes served children whose families were eligible for TANF**. Across all 14 Mobile Crisis sites, the percentages of episodes serving TANF eligible families ranged from 14.3% (Wellmore: Torrington) to 77.5% (CHR). It should be noted that TANF eligibility is reported as "unable to determine" for most (53.3%) episodes.

Case Characteristics

Referral Source: **Most children were referred by schools (46.0%), self or family members (38.1%), or emergency departments (8.8%).** Though school referrals to Mobile Crisis had decreased in FY2020 and FY2021 as a result of the pandemic, they have returned to being the top referral source since FY2022.

[1] Sex assigned at birth

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



Mean Mobile/Office Visits: In FY2023, the average Mobile Crisis episode included 1.56 mobile contacts (by site, the average number of sessions ranged from 1.13 to 3.23), in which the provider traveled to the child. The average number of in-office sessions was 0.15 sessions (by site, the average number of in-office sessions ranged from 0.01 to 0.55). In comparison, there was an average of 0.04 in-office sessions per episode of care statewide in FY2022. Consistent with the Mobile Crisis model and practice standards, all 14 Mobile Crisis provider sites had a higher average number of mobile sessions per episode than in-office sessions.

Length of Stay (LOS): In FY2023, the median LOS was 15.0 days, and the mean LOS was 18.5 days among discharged episodes of care coded as *stabilization plus follow-up*. In FY2023, Mobile Crisis providers continued to manage LOS and ensure that data on start and end dates were accurately entered into PIE. Among episodes classified as *stabilization plus follow-up,* **3.3% exceeded a 45-day LOS, meeting the benchmark of less than 5% of episodes exceeding 45 days.** This percentage is lower than rates in FY2022 (8.3%). In FY2023, the median LOS for episodes coded as "Face-to-Face" was 5.0 days, and for "Phone Only" episodes the median LOS was less than 1 day.

Clinical and Functional Characteristics at Intake

Primary Presenting Problems: The six most common primary presenting problems at intake were **Harm/Risk of Harm to Self (34.4%); Disruptive Behavior (22.8%); Depression (12.2%); Anxiety (6.6%)**; **Harm/Risk of Harm to Others (6.2%); and Family Conflict (4.5%).** All other presenting problems combined accounted for 13.3% of referrals. These percentages are fairly similar to prior years.

Diagnosis: The five most common primary diagnoses at intake in FY2023 were Depressive Disorder (28.6%); Adjustment Disorder (15.0%); Anxiety Disorder (14.7%); Conduct Disorders (14.2%); Trauma Disorders (9.2%); and Attention Deficit/Hyperactivity Disorder (8.8%).

Trauma exposure: Statewide, **61.4% of children served by Mobile Crisis reported exposure to one or more traumatic events**, which was higher than FY2022 (53.6%). Across service areas this year, the percentage of youth reporting trauma exposure ranged from 52.2% (Hartford area) to 70.8% (Central service area). Among those with trauma exposure, the most common types were disrupted attachment/multiple placements (25.9%), witnessing violence (17.9%), being a victim of violence (15.7%), and sexual victimization (13.0%).

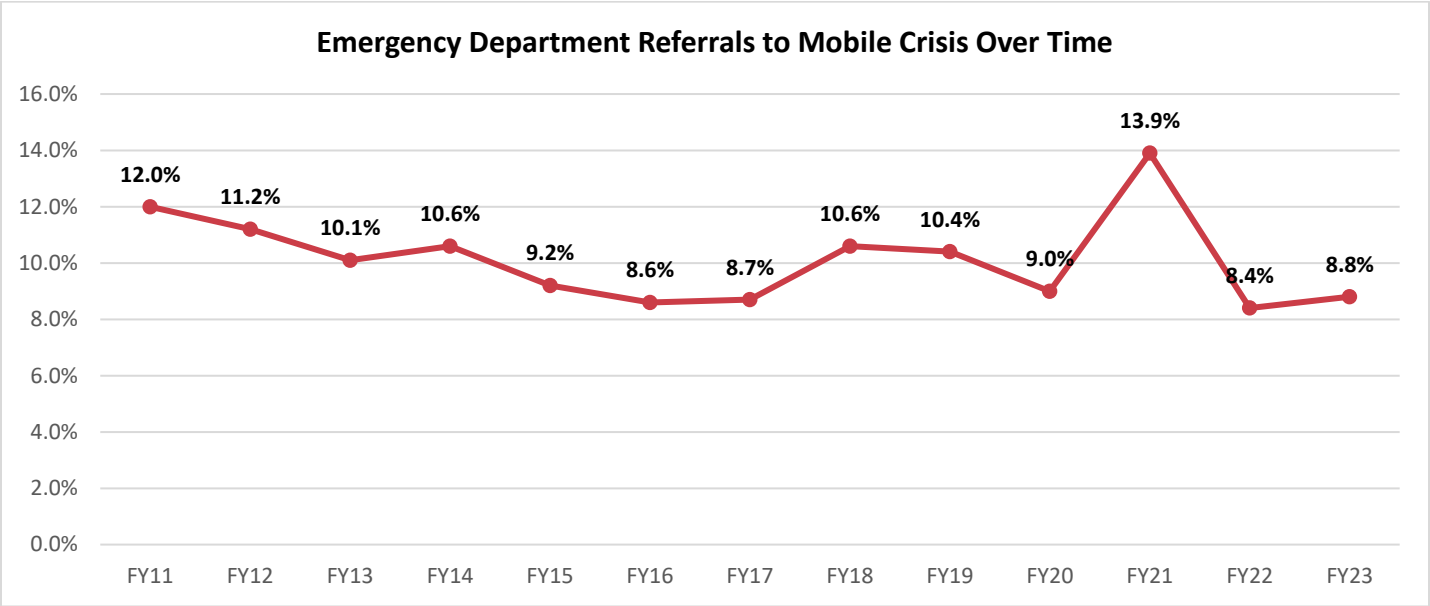
DCF Involvement: At intake, **most children (87.8%) served by Mobile Crisis were <u>not</u> involved with DCF**, similar to FY2022 (88.9%). For those families involved with DCF, the most common types of involvement at intake were CPS in-home services (5.1%), CPS out-of-home services (2.8%), and Family Assessment Response (2.0%). These rates are similar to results from FY2022.

Juvenile Justice Involvement: Statewide, 1.9% of children served by Mobile Crisis had been arrested in the six months prior to the Mobile Crisis episode, similar to FY2022 (1.8%) and FY2021 (2.1%). Moreover, 1.2% of youth were arrested during the Mobile Crisis episode, which is approximately double the rate in FY2022 (0.6%).

School Issues: Across the state, the top four issues at intake that had a negative impact on the youth's functioning at school were emotional (32.5%), behavioral (24.6%), social (23.0%), and academic problems (17.4%). Statewide, 13.0% of youth served by Mobile Crisis had been suspended or expelled in the six months prior to the Mobile Crisis episode. This is higher than the percent suspended or expelled in FY2022 (9.0%).

Alcohol and Other Drug (AOD) Use Problems: In terms of lifetime prevalence of AOD use, 0.5% reported alcohol use, 6.4% reported other drugs, and 2.0% reported both alcohol and other drug use. These are similar to numbers in FY2022.

Emergency Department and Inpatient Hospital Utilization: Statewide, 8.8% of all referrals to Mobile Crisis came from hospital EDs, compared to 8.4% in FY2022. FY2021 saw an increase in both percent and number of ED referrals (1,461 compared to 1,091 in FY2020), likely due to the impact of COVID. During FY2022 and FY2023, ED referrals returned to typical, if not slightly lower, rates. Figure 49 in the report (also shown below) demonstrates trends in this rate over the past several years. In FY2023, 20.4% of episodes were evaluated in an ED one or more times during the given Mobile Crisis episode of care, a rate similar to FY2022 (21.0%). In FY2023, 6.5% of Mobile Crisis episodes had an inpatient admission during the episode, which is similar to FY2022 (6.9%).



Performance Measures and Quality Improvement

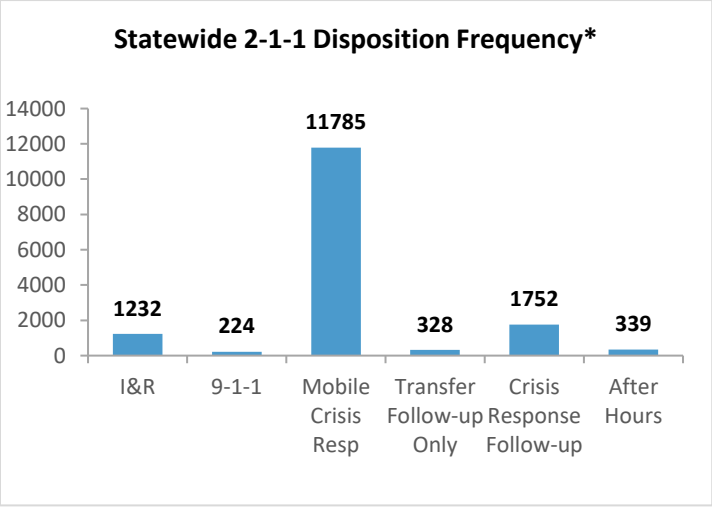
In FY2023, the PIC worked with collaborators to produce monthly reports, quarterly reports, and this annual report summarizing indicators of access, service quality, performance, and outcomes (visit www.chdi.org or www.mobilecrisisempsct.org for all reports). Site visits were conducted with providers 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 FY2023 there were a total of 74 performance improvement goals developed (includes goals duplicated across more than one quarter). Of those goals, 27% were achieved and an additional 61% of the goals saw improvement. Only 12% of goals developed had no positive progress. The continued impact of the pandemic, the focus on the expansion of Mobile Crisis to 24/7, and ongoing behavioral health workforce shortages may have affected providers' ability to meet their goals. See Table 14 for a summary of sites' performance improvement plans.

Data on performance measures and quality improvement activities are reviewed below along with clinical outcomes and special data analysis requests in FY2023.

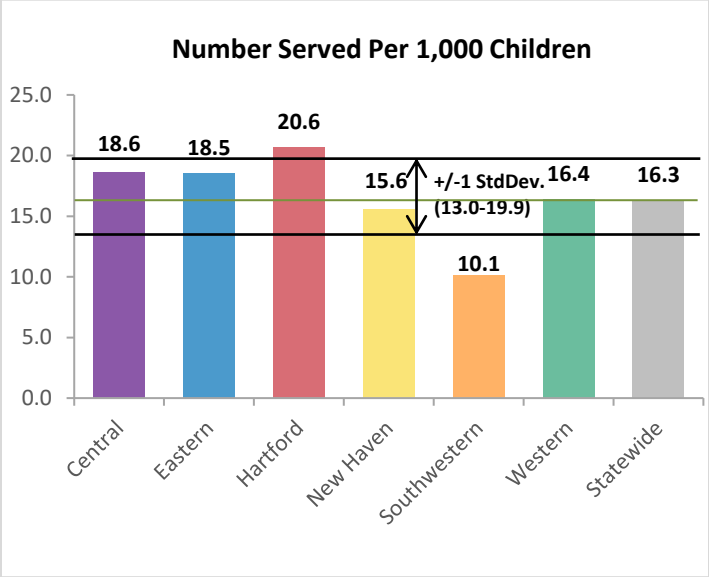
Call Volume: As noted previously, **in FY2023 there were 16,322 calls to 2-1-1 and Mobile Crisis for intervention,** resulting in **12,427 Mobile Crisis episodes of care,** both decreases from FY2022. These 12,427 episodes of care served a total of **9,456 unique children**. Of these children, 20.1% had more than one episode with mobile crisis, compared to 20.8% in FY2022. These numbers are based on total call and episode volume, inclusive of those during the expanded 24-hour access that started in January 2023. When looking only at the traditional hours there were 11,996 episodes of care. These are the episodes used in analyses for the bulk of this report for meaningful comparisons to past years and to understand the overall performance of MC outside of the implementation of the new hours.

Figure 13 (Section III) provides a visual representation of Mobile Crisis episode volume across the state. The map indicates the rate of Mobile Crisis episodes in each town during FY2022, relative to each town's child population (episodes per 1,000 children). There were five towns that didn't have a Mobile Crisis episode compared to only one town without an episode in FY2022. The major cities of Hartford and Waterbury each had over 700 episodes this year, while Bridgeport and New Haven each had over 500 episodes.

Most calls (n=11,785) were transferred to a Mobile Crisis provider for a response. Additionally, 1,752 calls in FY2023 were sent to Mobile Crisis for crisis response follow-up (follow up on an open episode of care), 339 were transferred to Mobile Crisis for after-hours follow-up, and 328 were transfer follow-up (follow up without a crisis in process). The remaining calls were handled by 2-1-1 only as information and referral (n=1232) or as transfers to 9-1-1 (n=224).



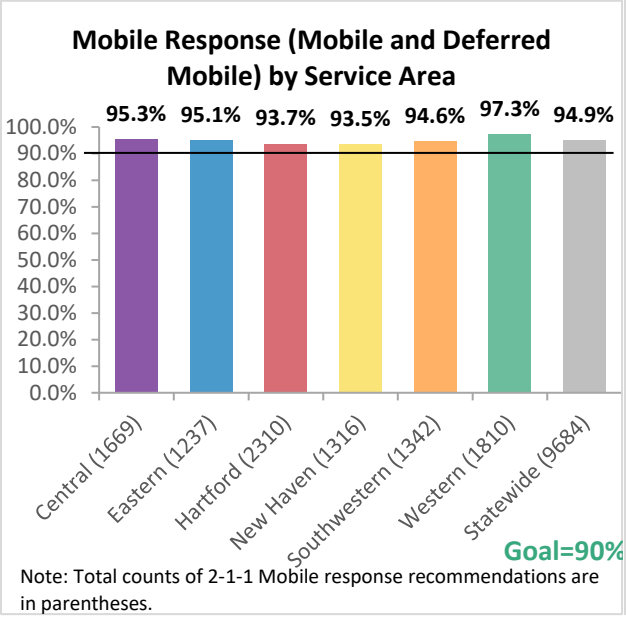
A “service reach rate” examines total episodes relative to the population of children (based on 2020 U.S. Census data) in a given catchment area (see below). Service reach rates are calculated statewide, for each service area, and for each individual provider. The statewide service reach rate for FY2022 was 16.3 episodes per 1,000 children compared to 18.8 in FY2022 and 19.9 in FY2019 (pre-pandemic). The Hartford service area had the highest service reach rate (20.6 per 1,000 children) which was slightly more than one standard deviation above the statewide mean. The lowest service reach rate was in the Southwestern service area (10.1 episodes per 1,000 children), which was more than one standard deviation below the statewide mean.



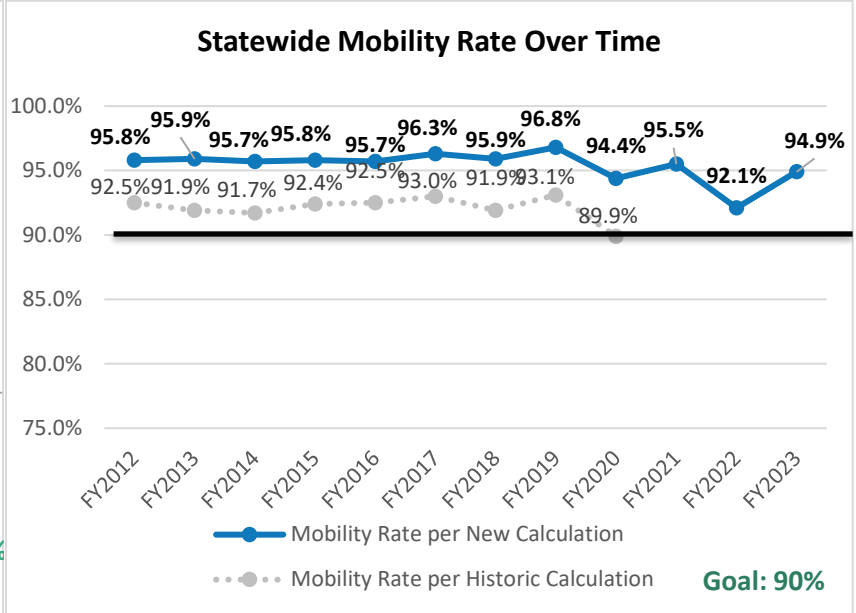
Mobility Rate: Mobile responsiveness is a key feature of Mobile Crisis service delivery. Since PIC implementation, the established mobility benchmark has been 90%. To calculate mobility, the Mobile Crisis PIC has historically examined all episodes for which 2-1-1 recommended a mobile or deferred mobile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

Since the start of the pandemic, a handful of episodes received video telehealth response. Full assessments completed via video telehealth were considered to be “mobile” episodes. At the beginning of FY2022, a data element was added to PIE to track episodes that were conducted via telehealth. During FY2023, there were 52 episodes conducted via telehealth, down from 342 in FY2022. Though there is no available data for FY2021, it is expected there were more telehealth episodes occurring during the height of the pandemic.

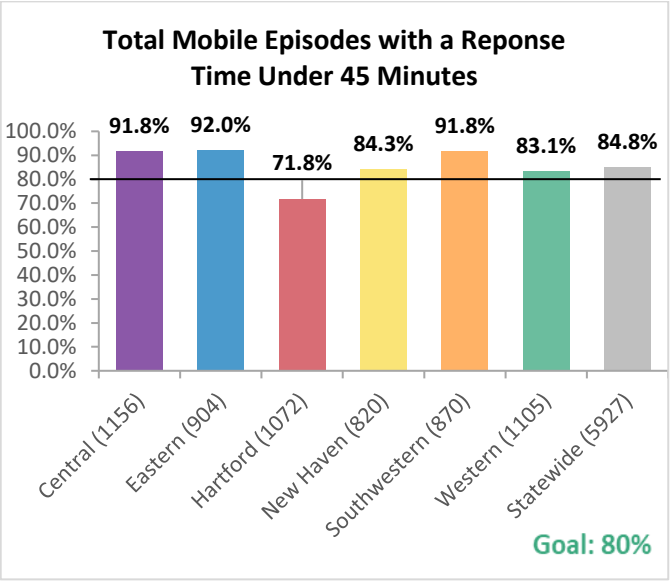
In FY23, the statewide mobility rate was 94.9%, exceeding the 90% benchmark. The statewide mobility rate this year was higher than FY2022 (92.1%). The baseline mobility rate in FY2009, prior to PIC implementation, is estimated at 50%. **All six service areas had an annual mobility rate above the 90% benchmark this year.** The highest rate was in the Western region (97.3%) and the lowest was in the New Haven service area (93.5%). The range in mobility rates across all six service areas was 3.8 percentage points, which was similar to FY2022 (3.7 percentage points) and slightly lower than pre-pandemic (4.9 percentage points in FY2019). High utilization rates impact sites’ abilities to respond to requests for mobile responses; however, the Mobile Crisis program continues to demonstrate excellent overall mobility.

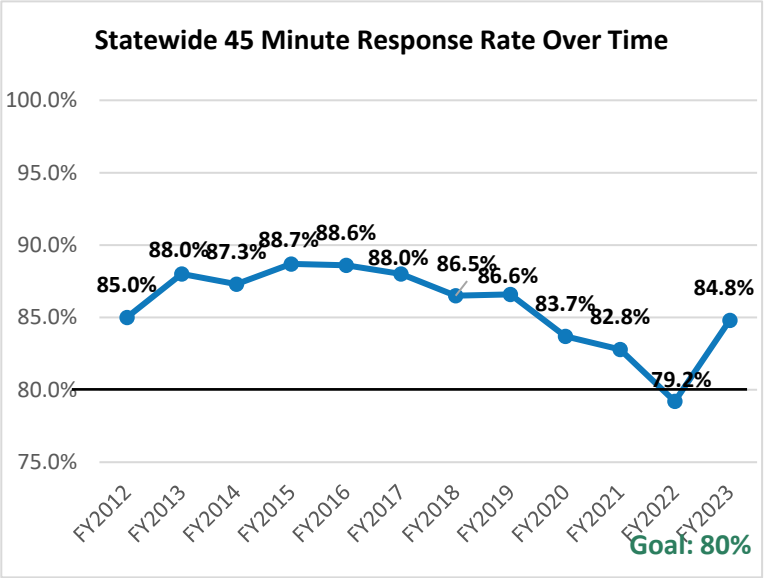


Note: Total counts of 2-1-1 Mobile response recommendations are in parentheses.



Response Time: The benchmark for response time is that a minimum of 80% of all mobile responses be provided in 45 minutes or less. **This year, 84.8% of all mobile responses were made within the 45-minute benchmark.** This is an increase from the rate in FY2022 (79.2%). Five of the six service areas were above the 80% benchmark, with service area performance ranging from 71.8% (Hartford) to 92.0% (Eastern). **The median response time this year was 30.0 minutes, which was two minutes less than FY2022**.





Clinical Outcomes

Ohio Scales: The Ohio Scales are intended to be completed at intake and discharge by parents and Mobile Crisis clinicians, typically for stabilization plus follow-up episodes in which children are seen in person for multiple sessions over a timeframe of at least 5 and up to 45 days. Statewide, 3,178 clinician-report and 421 parent-report Ohio Scales were completed at both intake and discharge[3]. **In FY2023, Mobile Crisis clinicians completed the Ohio Scales for 86.3% of episodes at intake and 80.4% at discharge[4].** Clinician completion rate at both intake and discharge was higher than in

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

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

FY2022. In FY2023 **parents completed the Ohio Scales at the rate of 41.2% at intake and 11.9% at discharge,** both of which were similar to the rates in FY2022. Throughout the year, providers have been working with their clinicians to improve their parent Ohio Scale completion rate. By including Ohio Scale completion as a part of every provider's performance improvement plan, additional training provided by DCF and providers, and consistent emphasis on the importance of these scales, increasing these numbers will continue to be a goal for Mobile Crisis providers.

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

Examining "clinically meaningful change" is one way to view change in Ohio Scales from intake to discharge. Clinically meaningful change on the Ohio Scales Functioning Scale, for the purposes of the Mobile Crisis program, is an increase of at least 8 points and a score of 50 or higher at discharge; and on the problem severity scale, a decrease of at least 10 points and a score of 25 or lower at discharge. Using these definitions, there was clinically meaningful change in Functioning for 8.6% of youth according to parent-report and 7.9% of youth according to clinician-report. None of the parent-reported scales met the criteria for clinically meaningful change on Problem Severity, while 8.5% of youth attained clinically meaningful change according to clinician-report.

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

For FY2023, in addition to the clinically meaningful change noted above, 18.2% of children as measured by parent completion of scales and 30.2% as measured by clinician-completed scales demonstrated either partial or reliable improvement in Functioning. On Problem Severity, 5.8% of children per parent-completed scales and additional 30.8% per clinician-completed scales demonstrated either partial or reliable improvement. It's important to note that the primary goal of Mobile Crisis is to stabilize the child and then connect the child to appropriate longer-term care. It is expected that children make additional improvement in functioning and problem severity within the context of the longer-term care.

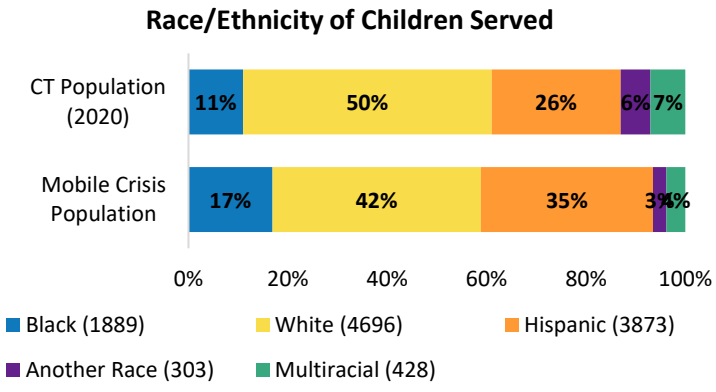
[5] Jacobson, N. S., & Truax, P. (1991). Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research. *Journal of Consulting and Clinical Psychology*, *59*(1), 12–19.

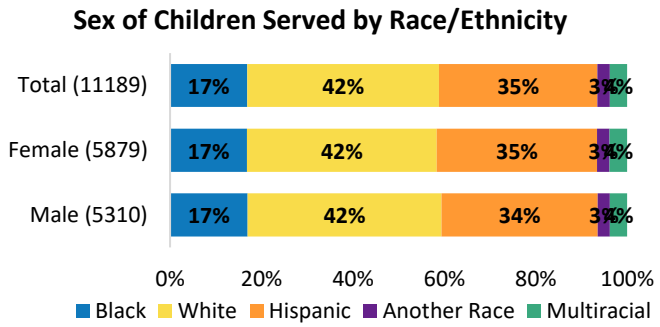
Statewide Ohio Scale Scores (based on paired intake and discharge scores)	**N**	**Mean (intake)**	**Mean (discharge)**	**t-score**	**Sig.**	**% Clinically Meaningful Change**	**% Reliable Improvement**	**% Partial Improvement**	**% Demonstrating Improvement[6]**
Parent Functioning Score	421	42.00	43.85	1.85	4.62	8.6%	2.9%	6.7%	18.2%
Worker Functioning Score	3178	44.85	47.21	2.36	20.87	7.9%	3.7%	18.6%	30.2%
Parent Problem Severity Score	424	29.51	27.66	-1.85	-3.95	0.0%	0.0%	5.8%	5.8%
Worker Problem Severity Score	3177	28.26	25.22	-3.04	-24.77	8.5%	2.8%	19.5%	30.8%

Equitable Access, Quality, and Outcomes

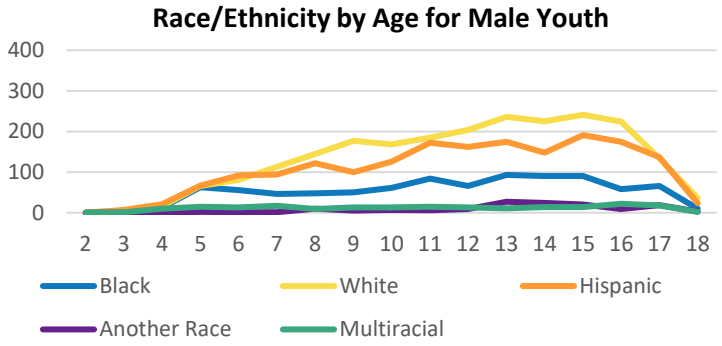
As part of both CHDI and DCF's efforts to improve equity in behavioral health care for children in Connecticut, the Mobile Crisis PIC has been conducting more in-depth analyses to assess whether racial or ethnic disparities exist across a variety of indicators including referral source, presenting problem, discharge status, and behavioral health outcomes. In past years, the PIC created a standalone report specific to exploring potential racial and ethnic disparities, planned to be completed annually. This year, efforts have focused on creating plans for looking at this data on a regular basis and working with providers to identify any areas of concern.

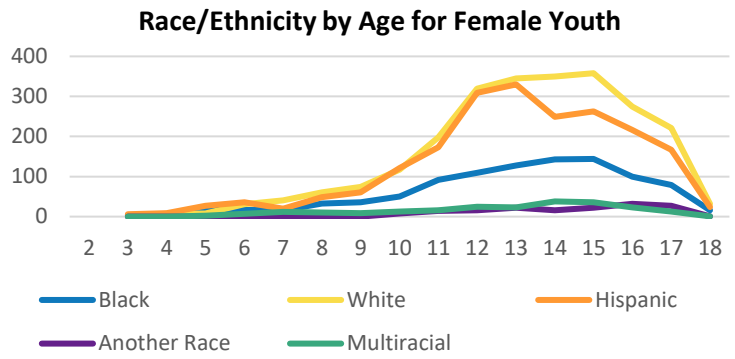
Data from FY2023 is consistent with past years when looking at overall trends in the children served by Mobile Crisis compared to the child population of Connecticut. Mobile Crisis continues to serve Black and Hispanic youth at a higher rate than they appear in the Connecticut population. This is not considered to be a negative disparity, particularly if Mobile Crisis is able to reach children and families who are typically underserved by other services. It has also been a consistent trend that the sex of children served is consistent across racial/ethnic groups. When looking across age, across the three largest racial/ethnic groups, males are referred more consistently across all ages while referrals to Mobile Crisis for females increased significantly as they approached adolescence.





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





In recent years, CHDI, DCF, and Mobile Crisis providers have been increasing efforts to look beyond potential disparities in the population served, and explore whether there are disparities in the quality or outcomes of the service. During FY2023, the PIC worked with DCF and providers to identify a list of decision points that take place during a Mobile Crisis episode. This included decisions made at all levels – the decision made by the caller to seek out Mobile Crisis services, decisions made by 211 and Mobile Crisis staff in responding to the call, and decisions made by the family and providers throughout the course of the initial response and any ongoing treatment that is needed. Each decision point was looked at using a disproportionality index[7] in order to identify where disparities by race and ethnicity may exist. Looking at data from FY2019-FY2022, the decision points that showed the greatest disproportionality between racial/ethnic groups were referral source, presenting problem, and reason for discharge. These findings were presented to DCF and to Mobile Crisis managers in June 2023, and will be used to plan next steps for this work.

This project will continue into FY2024, with the aim of more regular analysis and discussion of disparities data. The PIC and DCF will establish a statewide health equity goal around consistent analysis and discussion of equity data by CHDI and Mobile Crisis providers. This will be accomplished by adding an equity section into each agency's quarterly RBA and creating a standing agenda item to review this data and discuss equity at quarterly site visits. CHDI will also be working to increase the use of equity data in monthly, quarterly, and annual reporting for Mobile Crisis.

Special Data Analysis Requests

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

Results Based Accountability (RBA): Historically, the Mobile Crisis PIC has helped identify appropriate indicators for RBA reporting and has reported on these indicators in the annual report. Beginning in Q2 FY2016, Mobile Crisis PIC integrated the statewide RBA report card into quarterly and annual reports to enhance the capacity for DCF and statewide stakeholders to monitor performance on a more regular basis. In FY2023, the Mobile Crisis PIC continued to provide each regional Mobile Crisis provider with their own RBA with site specific data.

Cross-Project Data Analysis: Continuing a project from FY2022, the Mobile Crisis PIC was able to link Mobile Crisis data to data for Outpatient Psychiatric Clinics for Children (OPCC) and Care Coordination. Mobile Crisis is a short-term stabilization service with the goal of linking children and families to ongoing treatment and supports, and one of the most common referrals made upon discharge is to outpatient services. As such, linking these data provides valuable information on the

[7] The disproportionality index was calculated based on information from the following sources:
https://secureapp.dhs.state.ia.us/PublicROMReports/report_help/default.htm#!Documents/rd2through7disproportionalityindexdi.htm
https://portal.ct.gov/-/media/DCF/RACIAL-JUSTICE/2023/FINALSFY2022CGS17a6e2.pdf

way children move between the two services. Initial results had been reported to DCF in FY2022, and a TTI grant was used to fund more in depth work. This project is ongoing and will continue in FY2024, adding another year of data and working on previously identified next steps.

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.

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 continue 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.

Standardized Workforce Development and Technical Assistance

The Mobile Crisis PIC is responsible for designing and delivering a standardized workforce development and training curriculum that addresses the core competencies related to delivering Mobile Crisis services in the community. Providers are required by contract to ensure that their clinicians attend these trainings. CHDI contracts with Wheeler Clinic's CT Clearinghouse to coordinate the logistics associated with implementing training events throughout the year. There were thirteen regular training modules offered in FY2023, including:

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

Evaluation forms indicated that participants were generally highly satisfied with the training modules and that the learning objectives were consistently met. Due to restrictions on in-person meetings resulting from COVID-19, all module trainings for the year were online. Evaluation findings continue to be used to inform changes for FY2023. Highlights from the Mobile Crisis PIC training component include the following:

- 24 training modules were held in FY2023 (24 were held in FY2022).
- There were 193 attendees across all Mobile Crisis trainings in FY2023, representing 82 unique individuals that attended at least one training this fiscal year.
- There have been 412 trainings in the ten years of Mobile Crisis PIC implementation, and 736 Mobile Crisis staff members have completed one or more trainings during that time.

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

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

Collaborations among Mobile Crisis Partners

There were numerous collaborations among DCF, the Mobile Crisis PIC, Mobile Crisis provider organizations, the Connecticut Behavioral Health Partnership (CTBHP) and 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. Due to COVID-19, all meetings continued to be held online during FY2023.
- *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 at Carelon. The purpose of the annual meeting is to recognize Mobile Crisis accomplishments throughout the year. The annual meeting was held virtually this year due to gathering restrictions related to COVID-19.
- *MOA Development with School Districts*: Mobile Crisis PIC staff provided technical assistance and support to Mobile Crisis managers to develop MOAs with school districts as one element of Connecticut Public Act 13-178. To date, the PIC has collected MOAs from 201 of 206 districts. Staff from 211-United Way sent outreach mailings to school administrators, and the Mobile Crisis PIC facilitated contact between Mobile Crisis providers and school personnel. The responsibility for acquiring the remaining MOAs 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.

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). Additional work will be needed in the coming year to formalize the role and function of Mobile Crisis in this continuum of services as well as the broader service continuum.

CHDI assisted DDS/DCF/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. MC clinicians and managers were given a survey to get feedback on the current MC trainings for potential enhancements. CHDI is currently working with DCF to enhance the current MC trainings and develop two 200 level trainings. These trainings will be live and virtual.

PIC staff continued 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 5 states and one county, 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.

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, Michigan, Rhode Island, Montana, and California.

Numerous state and national presentations on Mobile Crisis occurred this year, including in the following venues:

- National Dialogues conference (New Orleans, LA)
- TTI virtual meeting on CT Mobile Crisis trainings and model development
- Mobile Response and Stabilization Services Learning Community – "Planning for Sustainability: Data and Quality Metrics"

One manuscript relating to youth Mobile Crisis services was accepted for publication this year in a peer-reviewed journal. Although the data came from New York, CHDI staff were contributing authors and leveraged Connecticut experience to inform the manuscript. Another similar publication was submitted in FY23 and is currently under review.

Hutchison, M., Theriault, K., Seng, K., Vanderploeg, J., & Conner, K.R. (under review). The influence of COVID-19 on youth mobile response stabilization service use. *Journal of Psychiatric Research.*

Hutchison, M., Theriault, K., Seng, K., Vanderploeg, J., & Conner, K.R. (in press). Youth mobile response and stabilization services: Factors associated with multiple episodes of care. *Community Mental Health Journal*.

Goals for Fiscal Year 2024

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

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

A. Quality Improvement

1. Continue to maintain volume by engaging in outreach activities, meetings, presentations.
2. Continue to focus on reaching schools, local police, and families that may benefit from Mobile Crisis.
3. Each service area will post mobility at or above the 90% benchmark.
4. Each service area will respond to crises in 45 minutes or less for at least 80% of mobile episodes.
5. Increase Ohio Scales completion rates, particularly the parent discharge measure.
6. Mobile Crisis providers will submit Performance Improvement Plans each quarter with goals in service access, service quality, and outcomes, as well as goals relating to efficient and effective clinical and administrative practices.
7. Continue to monitor changes in episode volume and service delivery that have occurred since the start of the COVID-19 pandemic.
8. Continue to analyze service delivery and outcomes by race and ethnicity and incorporate into regular reporting.
9. Expand upon linkage of Mobile Crisis, OPCC, and Care Coordination datasets to explore trends in connection to care.
10. Continue to amend reports to include data relevant to the 24/7 expansion and support providers during this transition.
11. Support expansion of the mobile crisis workforce and focus on self-care activities for Mobile Crisis clinicians.

B. Standardized Training

1. Maintain or increase the number of training modules that are led by Mobile Crisis managers or supervisors.
2. Continue to review and enhance Mobile Crisis training modules, using TTI funding to:
    - Development of new content and revision of existing content to ensure trainings prepare clinicians to work with TTI populations
    - Explore the use of self-paced online courses for flexibility and expansion beyond Mobile Crisis workforce as appropriate
3. Consider alternative training approaches to ensure that clinicians complete all training modules in a timely manner.
    - Continuation of Mobile Crisis Training Institute Week during which time most or all modules will be offered during this lower-volume time of year. This will supplement, not replace, existing offerings.
    - Continuation of a web-based Mobile Crisis training module to improve access and decrease cost for service providers.

C. Developing the Mobile Crisis Clinical Model

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

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

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

SFY 2023 Annual RBA Report Card: Mobile Crisis Intervention Services

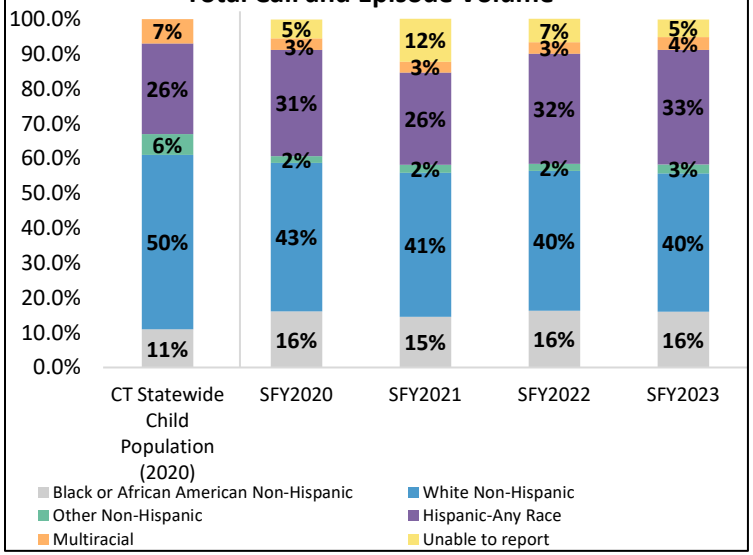
Quality of Life Result: Connecticut's children will live in stable environments, safe, healthy and ready to lead successful lives.

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

Program Expenditures: Estimated SFY2022	State Funding: $13,549,091

How Much Did We Do?

Total Call and Episode Volume



	FY2020	FY2021	FY2022	FY2023
Mobile Crisis Episode	12,100	10,542	13,328	11,996
2-1-1 Only	4,442	3,213	4,258	3,660
Total*	16,548	13,762	17,591	15,661

Story Behind the Baseline: In SFY 2023, there were 15,661 total calls to the 211 Call center, which was 11.0% less than SFY 2022. The number of Mobile Crisis episodes in SFY 2023 was 11,996*, 10.0% less than SFY 2021 (13,333). Though volume increased in FY2022, it still did not reach pre-pandemic levels, and has declined again this year. This year the percentage breakdown of race/ethnicity was similar to FY2022.

Trend: ↓

*Totals may include a small number of crisis-response follow-up calls coded as episodes or calls missing disposition information that were excluded from the episode count.

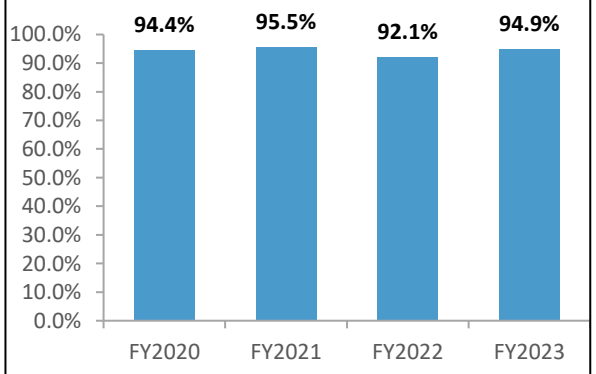
Episodes per Child			
FY2020	**DCF Child**	**Non-DCF Child**	**Total**
1	562 (71.2%)	4210 (81.1%)	**4772**
2	126 (16.0%)	670 (12.9%)	**796**
3	61 (7.7%)	202 (3.9%)	**263**
4 or more	40 (5.1%)	107 (2.1%)	**147**
FY2021	**DCF Child**	**Non-DCF Child**	**Total**
1	390 (72.0%)	3791 (82.0%)	**4181**
2	96 (17.7%)	570 (12.3%)	**666**
3	37 (6.8%)	153 (3.3%)	**190**
4 or more	19 (3.5%)	109 (2.4%)	**128**
FY2022	**DCF Child**	**Non-DCF Child**	**Total**
1	435 (72.7%)	5230 (81.4%)	**5665**
2	103 (17.2%)	839 (13.1%)	**942**
3	36 (6.0%)	226 (3.5%)	**262**
4 or more	24 (4.0%)	128 (2.0%)	**152**
FY2023	**DCF Child**	**Non-DCF Child**	**Total**
1	551 (77.6%)	5284 (82.0%)	**5835**
2	100(14.1%)	823 (12.8%)	**923**
3	34 (4.8%)	197 (3.1%)	**231**
4 or more	25 (3.5%)	138 (2.1%)	**163**

Story Behind the Baseline: In SFY 2023, of the 7,152* children served by Mobile Crisis, 81.6% (5,835) had only one episode of care, 94.5% (6,758) had one or two episodes. These are similar rates to SFY2022 – 80.7% (5,665) and 94.1% (6,607) respectively. This data indicates the effectiveness of Mobile Crisis in reducing the need for additional mobile crisis services. The proportion of children with 3 and 4 or more episodes of care were proportionally similar to last year.

Trend: →

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

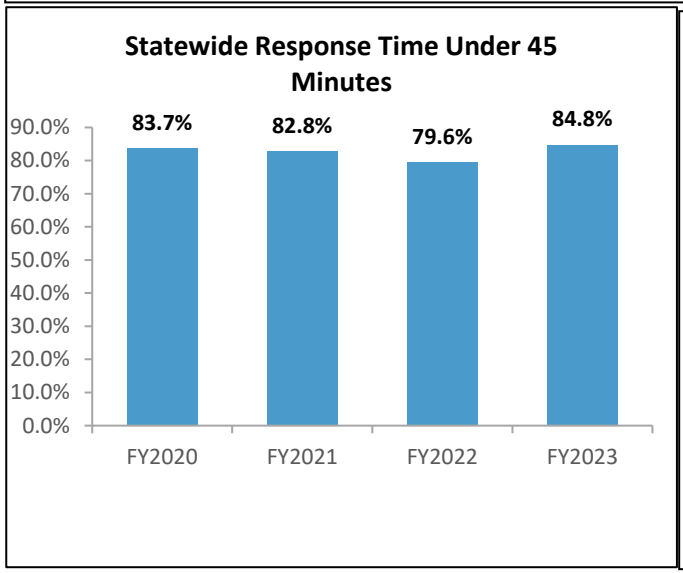
Statewide Mobility Rate



Story Behind the Baseline: Mobile responsiveness is a key feature of Mobile Crisis service delivery which has a 90% mobility benchmark. The statewide mobility rate was estimated at 50% prior to re-procurement of the service. In FY2023, the statewide mobility rate was 94.9%, which is higher than in FY2022.

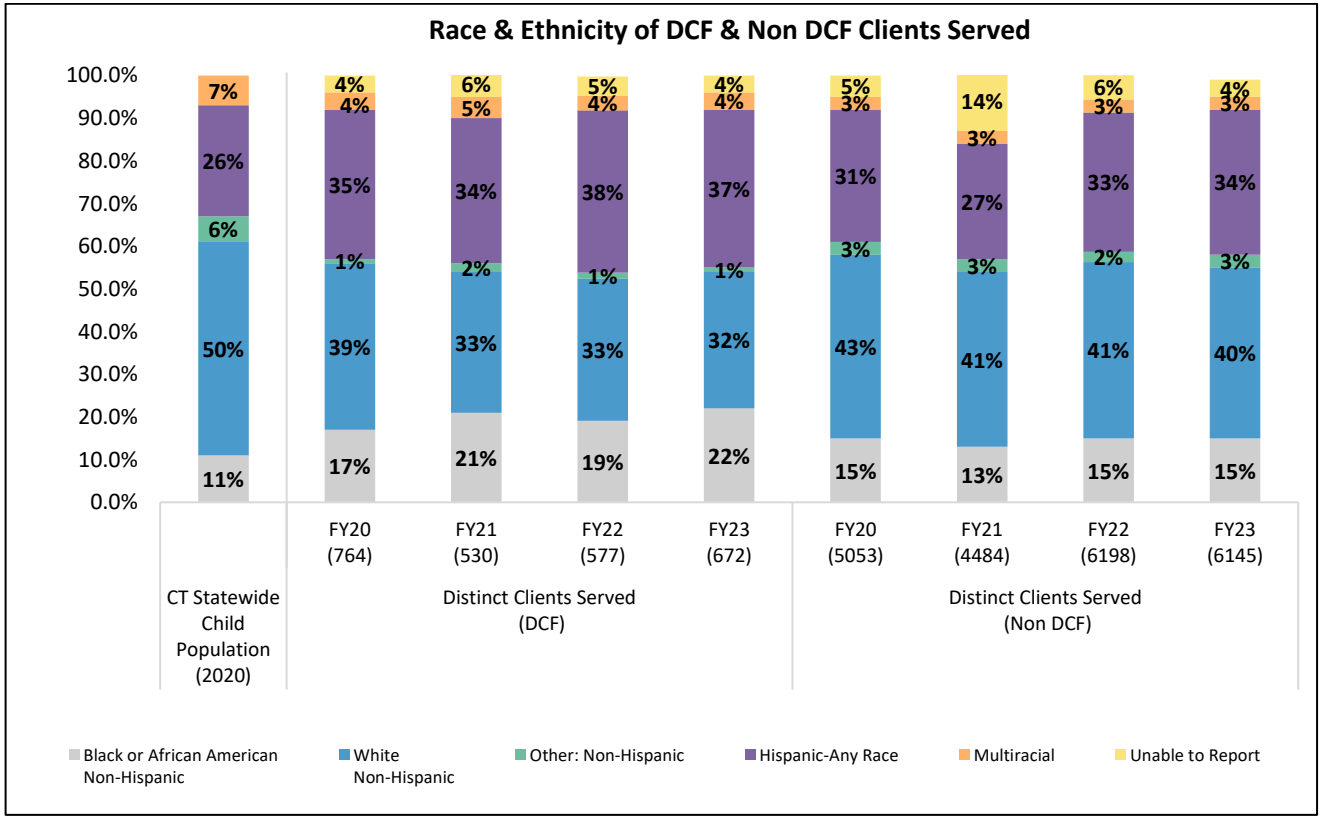
Trend: ↑

How Well Did We Do?



Story Behind the Baseline: Since SFY 2011 mobile crisis has consistently exceeded the 80% benchmark for a 45 minute or less mobile response to a crisis. For SFY 2023, 84.8% of all mobile responses were achieved within the 45 minute mark. This is an increase in the percent of episodes receiving a response in less than 45 minutes when compared to FY2022, and is again exceeding the 80% benchmark. **The median response time for SFY 2023 was 30 minutes**, compared to 32 minutes in FY2022. Mobile Crisis continues to be a highly responsive statewide service system that is immediately present to engage and deescalate a crisis and return stability to the child and family, school or other setting they are in.

Trend: ↑

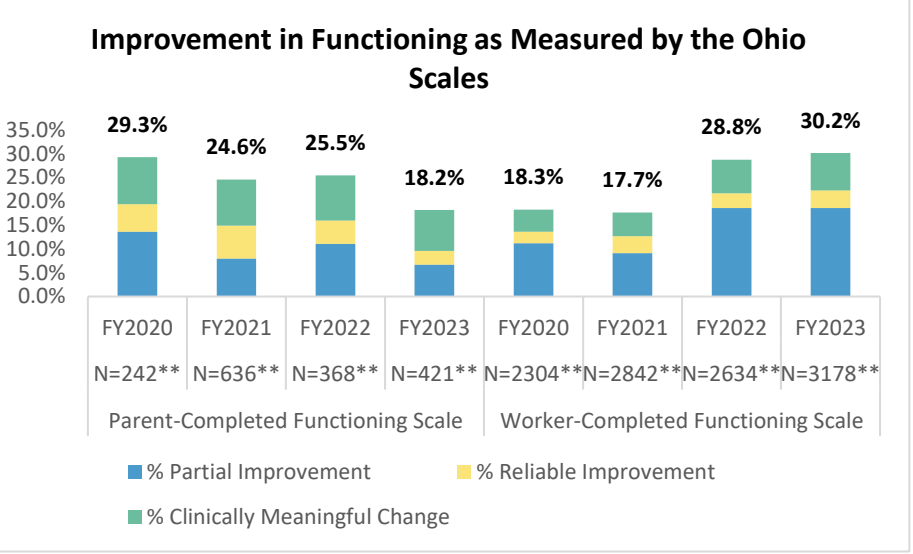


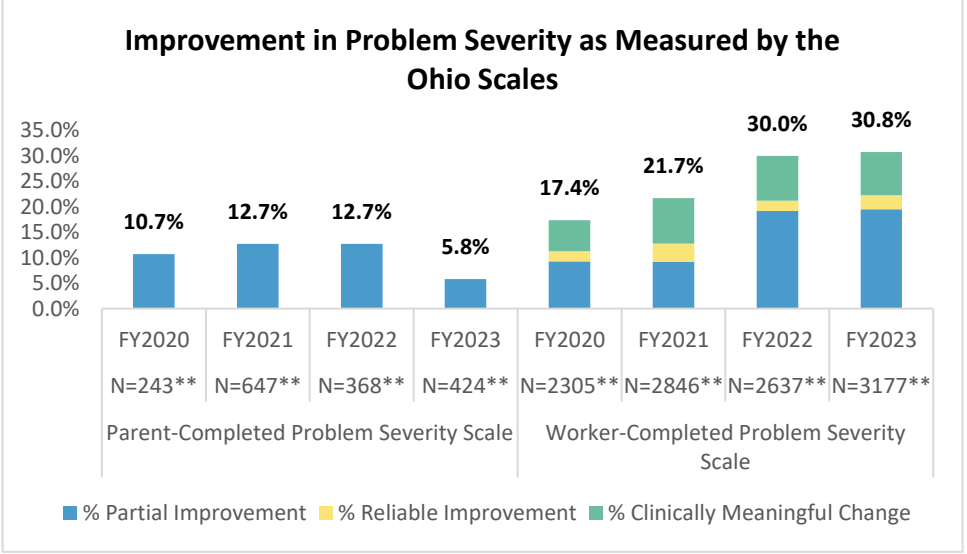
Story Behind the Baseline: Over the 4 years reviewed, slightly higher proportions of Hispanic and Black children are served by Mobile Crisis than are reflected in the overall state population (for both DCF and Non-DCF involved children[1,2]), while White children (both DCF and Non-DCF involved) utilize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

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

Trend: →

Is Anyone Better Off?





Story Behind the Baseline: The Ohio Youth Problems, Functioning, and Satisfaction Scales (Ohio Scales) assesses behavioral health service outcomes. In FY2023, statistically significant changes were observed in both functioning and problem severity as measured by both parent and worker-completed Ohio Scales following a child's episode of care. The proportion of children demonstrating some level of change in symptoms or functioning, from partial improvement to clinically meaningful change, ranged from 5.8% as measured by the parent-completed Problem Severity Scale to 30.8% as measured by the worker-completed Problem Severity Scale.

Trend: →

Proposed Actions to Turn the Curve:

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

Data Development Agenda:

- Work with providers to develop data regarding school, emergency department, police department utilization of Mobile Crisis.
- Work with providers to identify and accurately capture continued changes in volume since COVID-19.
- Identify trends in utilization and quality of episodes initiated during new overnight hours and work with DCF and providers to improve services during these hours

Section II: Mobile Crisis Statewide/Service Area Dashboard

Figure 1. Total Call Volume by Call Type and Old and New Hours

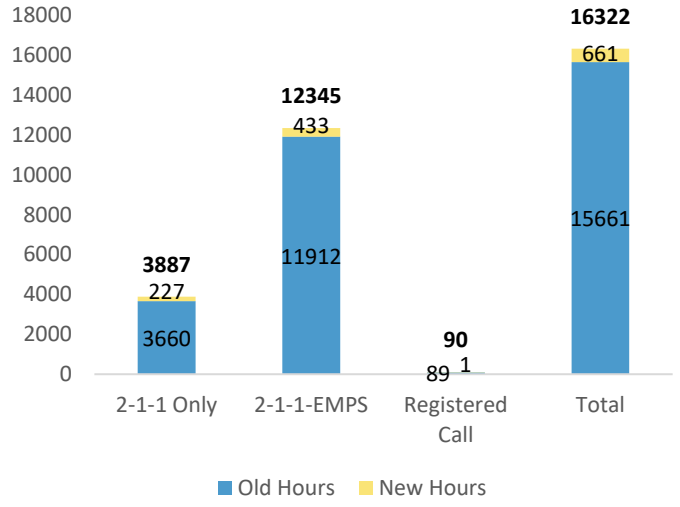


Figure 2. Total Call Volume per Quarter by Call Type

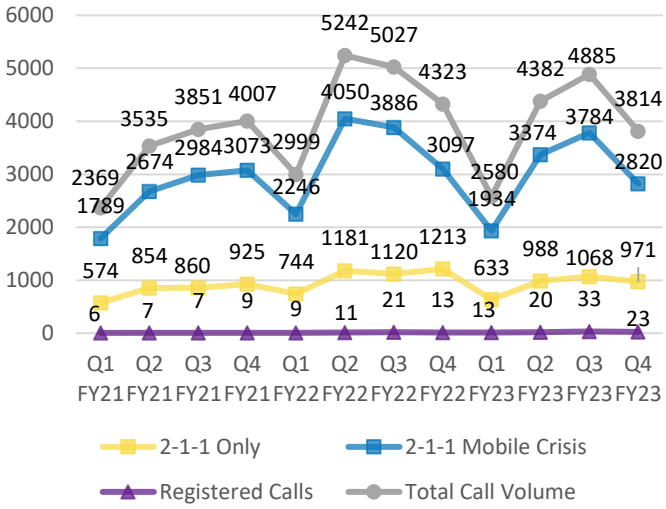
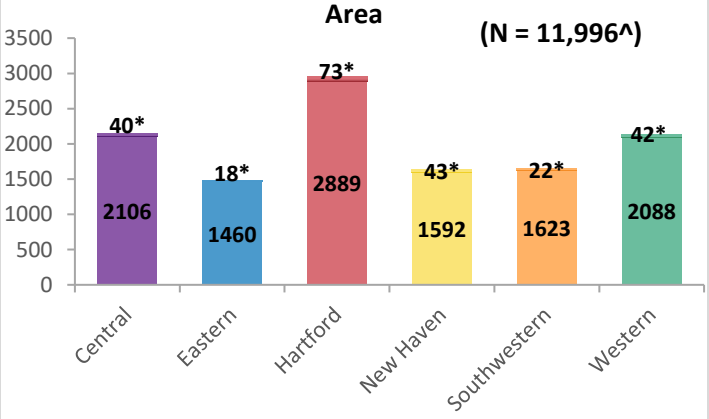


Figure 3. Mobile Crisis Episodes by Service Area

(N = 11,996^)



*After Hours Calls that resulted in episodes – only applies to pre-January 2023

^Excludes 4 Crisis Response Followup calls, 1 call missing disposition information

Figure 4. Mobile Crisis Episodes per Quarter by Service Area

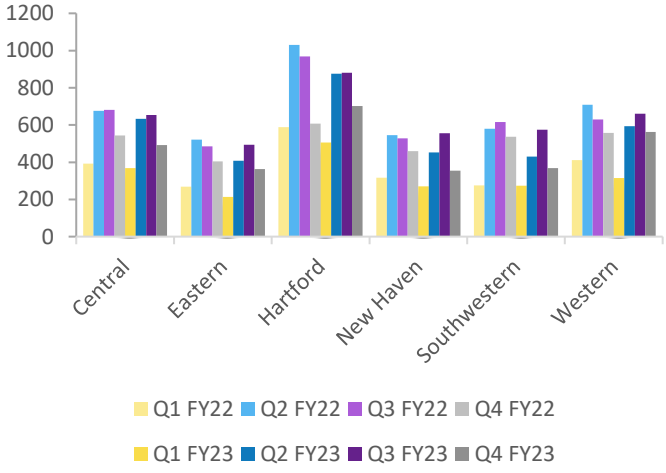


Figure 5. Number Served Per 1,000 Children

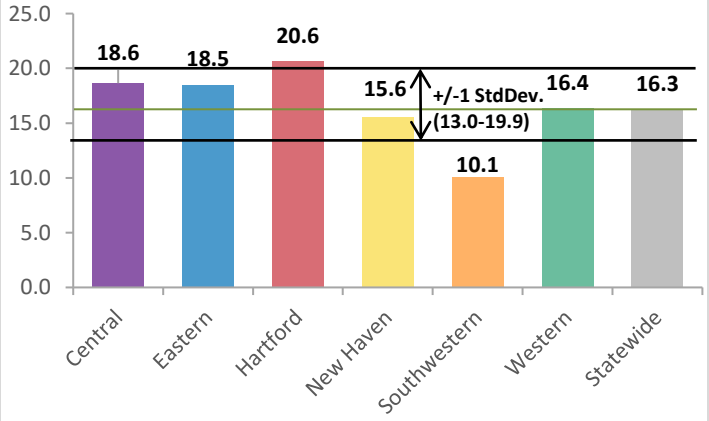


Figure 6. Number Served per 1,000 Children per Quarter by Service Area

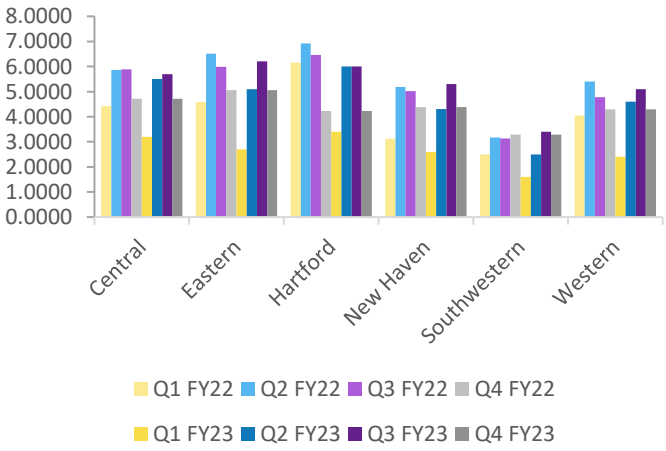


Figure 7. Number Served per 1,000 Children in Poverty

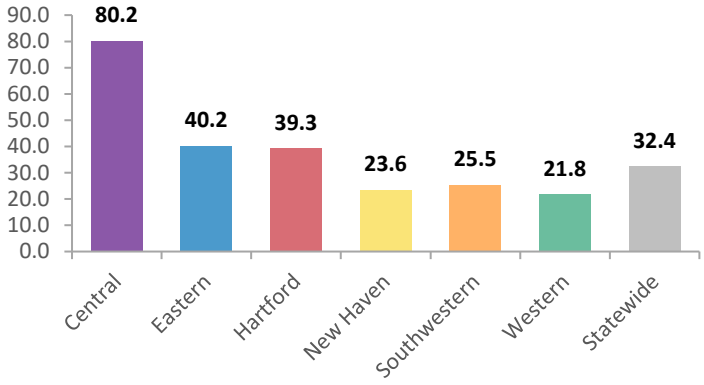


Figure 8. Number Served per 1,000 Children in Poverty per Quarter by Service Area

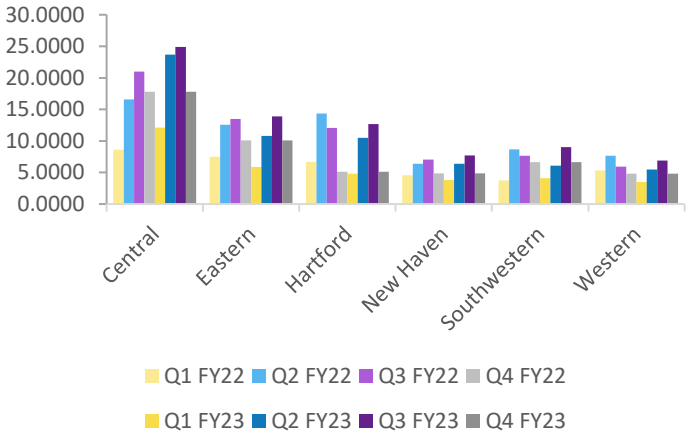
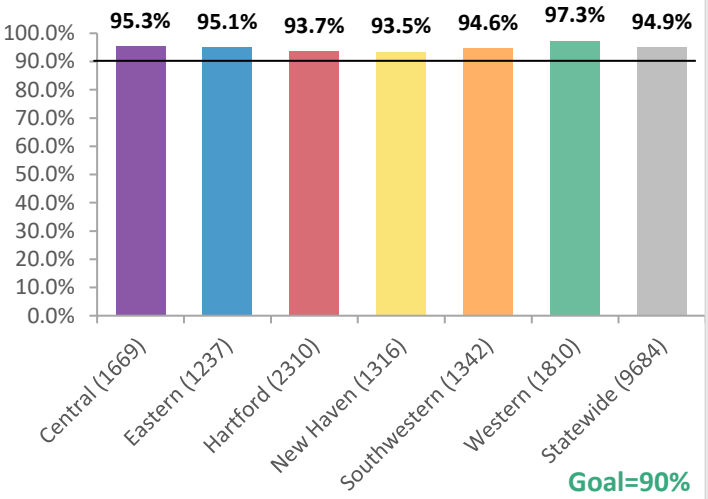


Figure 9. Mobile Response (Mobile and Deferred Mobile) by Service Area



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

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

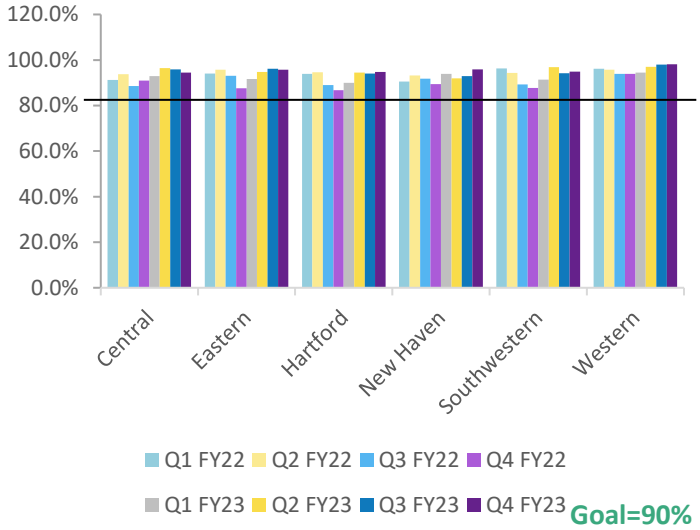
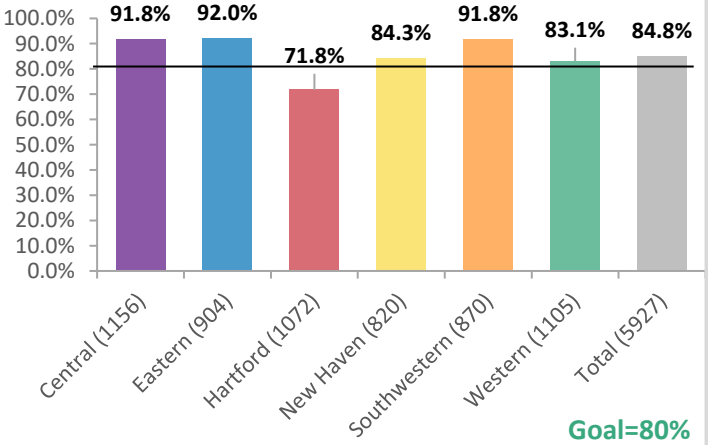
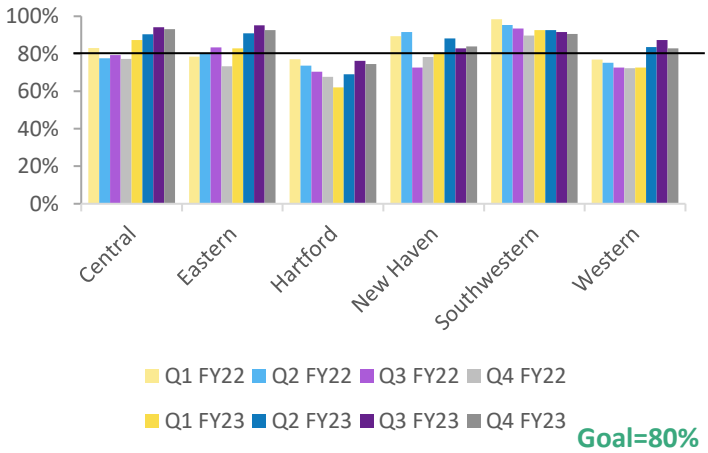


Figure 11. Total Mobile Episodes with a Response Time Under 45 Minutes



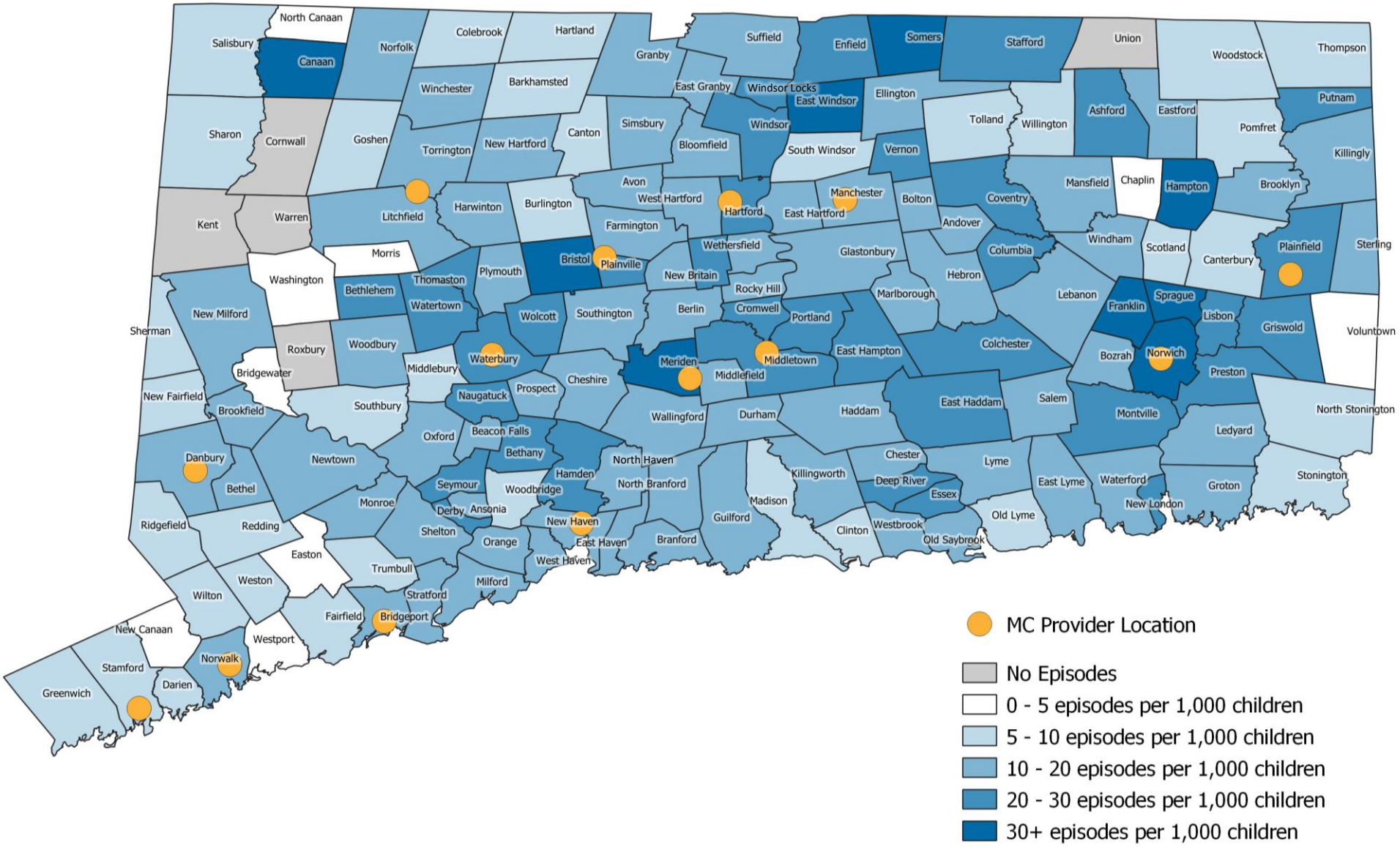
Note: Counts of mobile episodes under 45 mins. are in parentheses.

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



Section III: Mobile Crisis Volume

Figure 13. Map – FY2023 Mobile Crisis Episode Volume by Town* (Inclusive of all 24 hours post-expansion)



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

Figure 14. Total Call Volume by Call Type and Old and New Hours

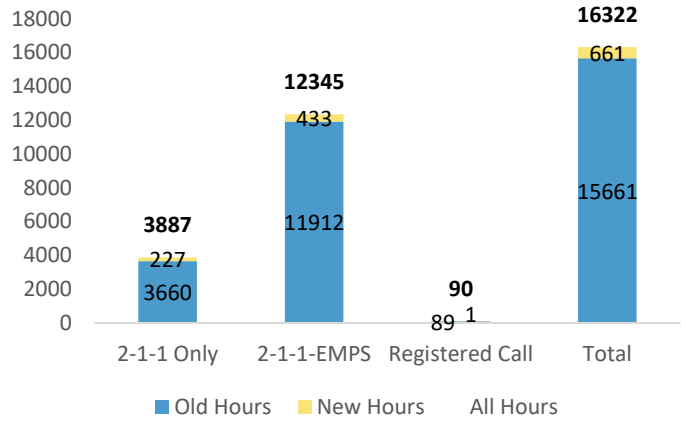
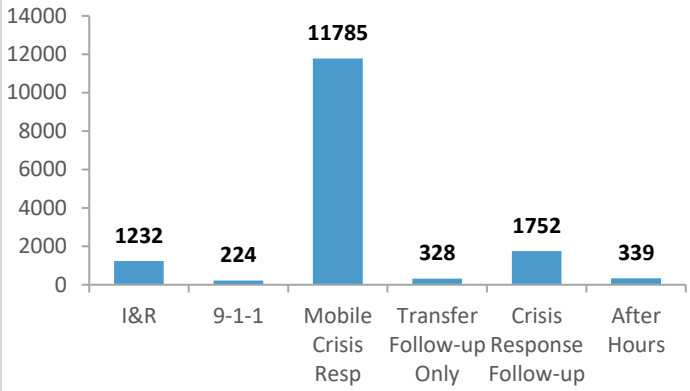


Figure 15. Statewide 2-1-1 Disposition Frequency*



*1 calls missing disposition information

Figure 16. Call and Episode Volume Over Time
(Inclusive of all 24 hours post-expansion)

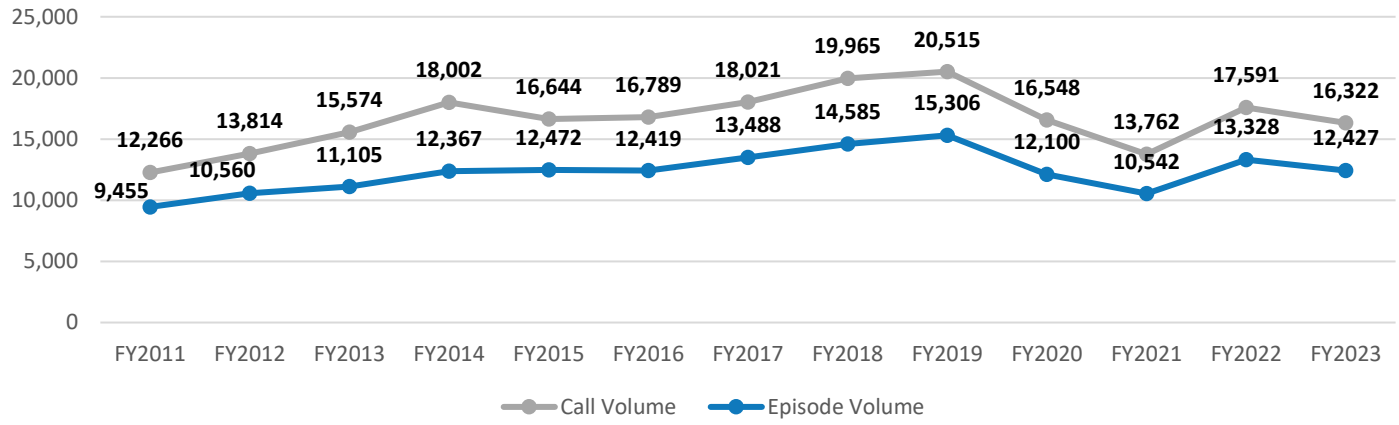
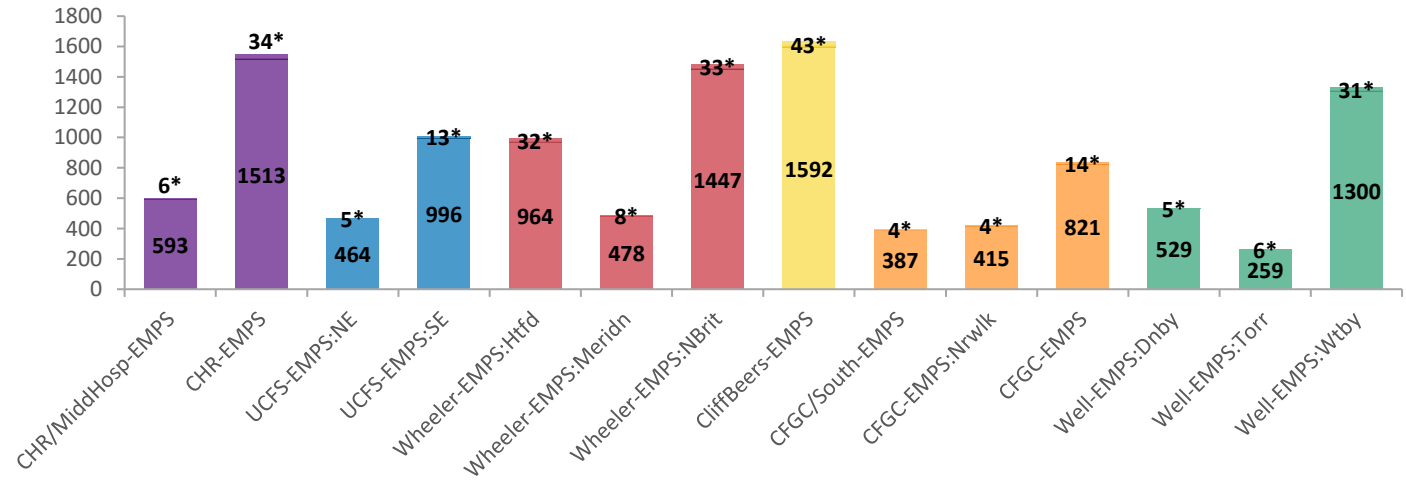


Figure 17. Mobile Crisis Response Episodes by Provider

(N = 11,996)



*After Hours Calls that resulted in an episode - only includes After Hours episodes prior to 24/7 expansion in January 2023.

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

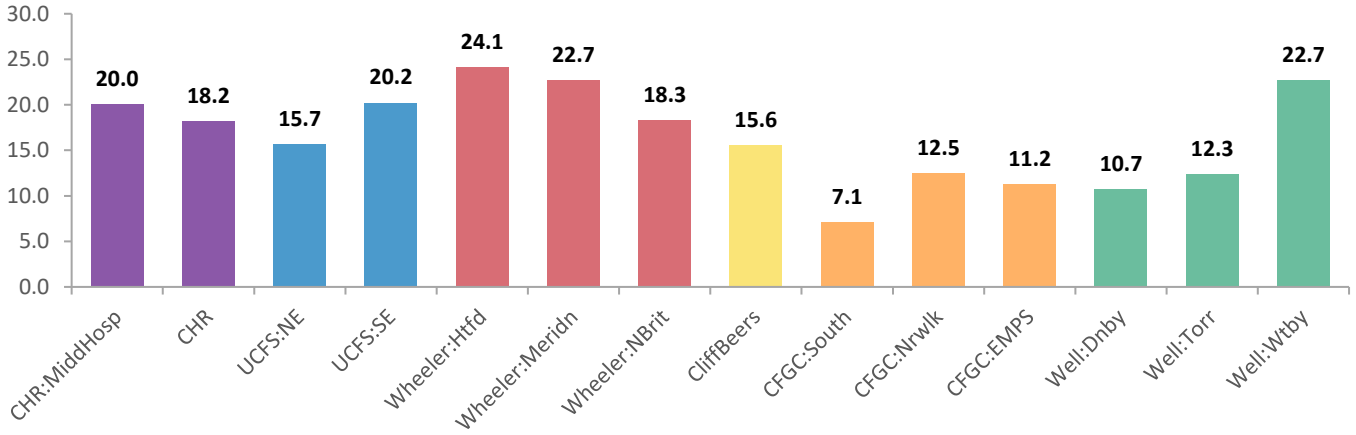


Figure 19. Episode Intervention Crisis Response Types by Service Area

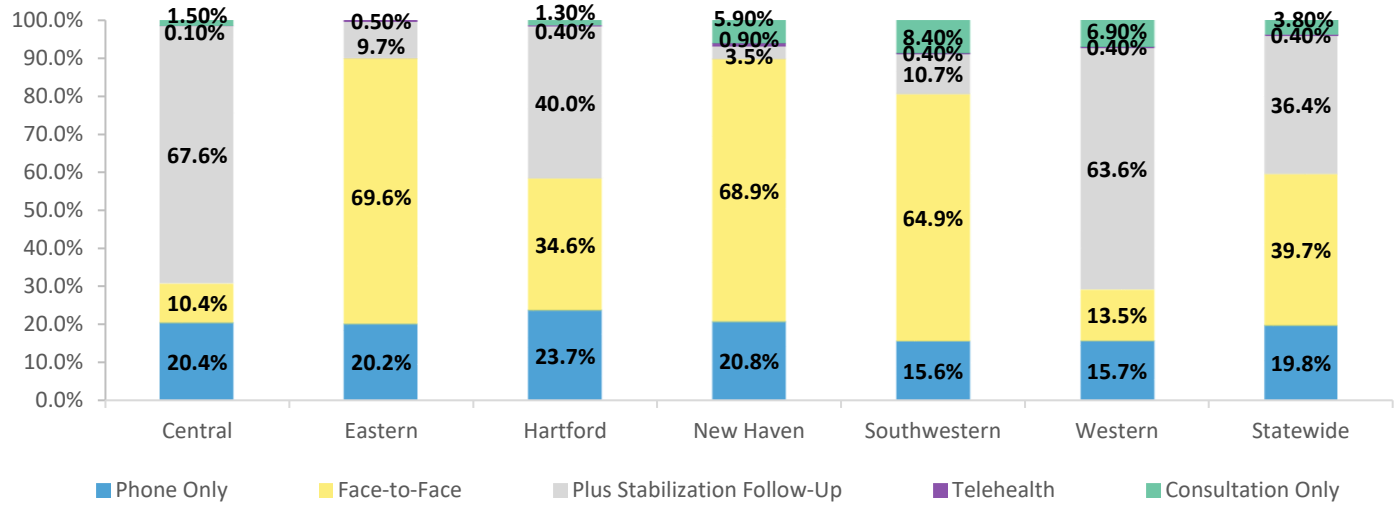
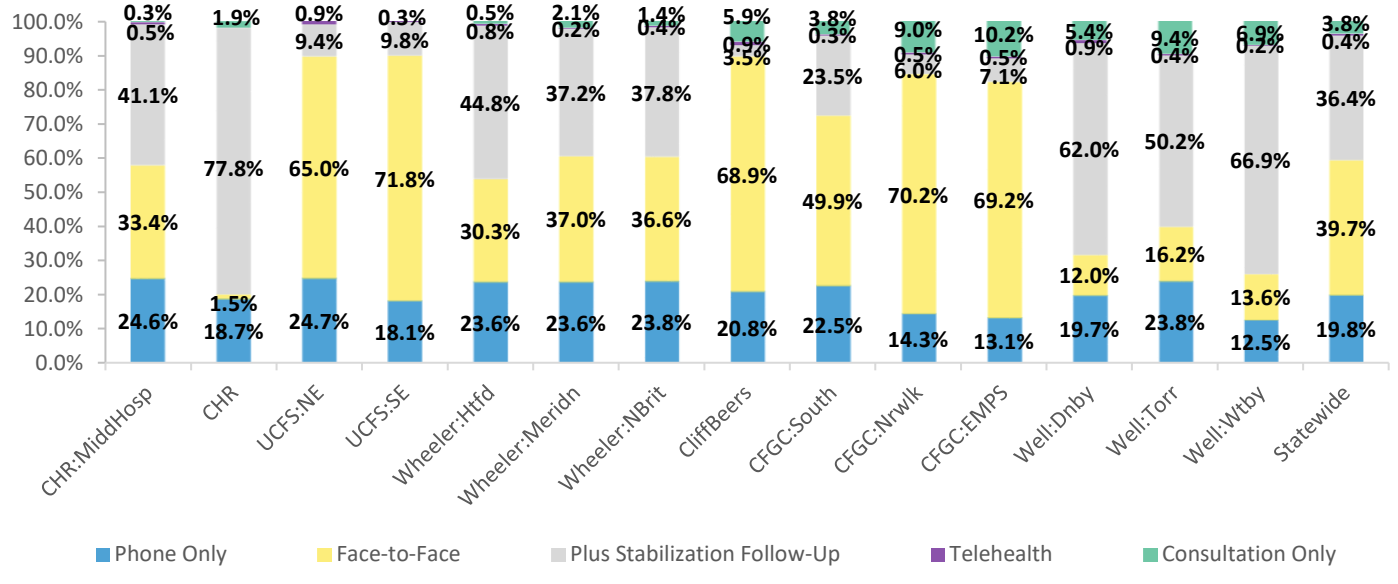
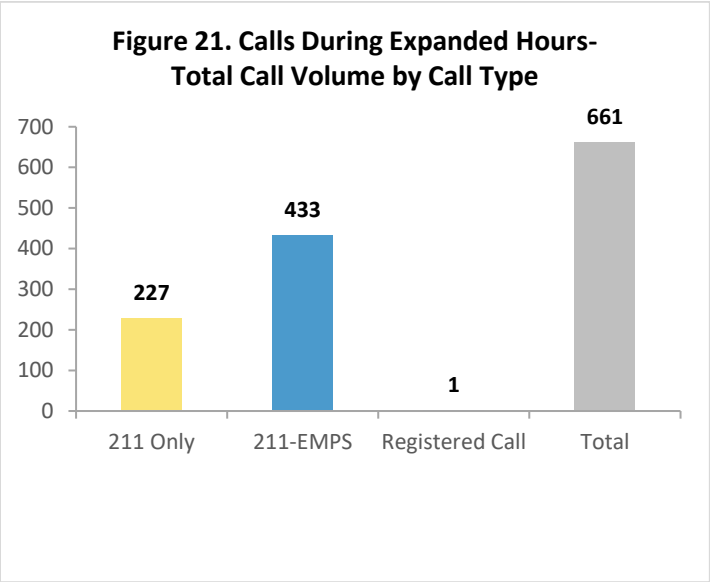


Figure 20. Episode Intervention Crisis Response Type by Provider





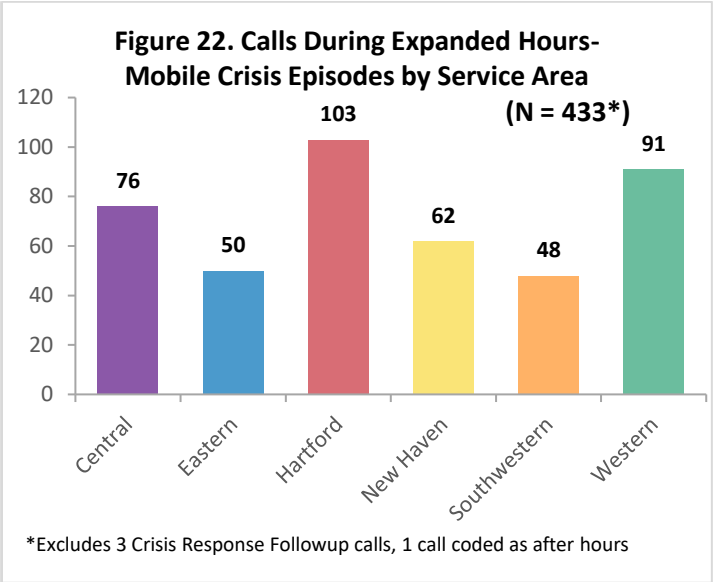


Table 1. Calls During Expanded Hours - Call Time by Day of Week

Time	Sun 10PM - Mon 6AM	Mon 10PM - Tue 6AM	Tue 10PM - Wed 6AM	Wed 10PM - Thu 6AM	Thur 10PM - Fri 6AM	Fri 10PM - Sat 1PM	Sat 10PM - Sun 1PM	Total
10:00-10:59 PM	15	13	15	15	20	16	12	**106**
11:00-11:59 PM	7	5	6	6	9	7	5	**45**
12:00-12:59 AM	8	6	5	8	4	10	2	**43**
1:00-1:59 AM	7	6	1	3	3	2	2	**24**
2:00-2:59 AM	3	1	2	0	2	1	3	**12**
3:00-3:59 AM	2	0	0	1	2	1	3	**9**
4:00-4:59 AM	1	1	2	0	1	0	1	**6**
5:00-5:59 AM	2	3	1	2	1	1	1	**11**
6:00-6:59 AM	N/A – not new hours					1	1	**2**
7:00-7:59 AM						5	3	**8**
8:00-8:59 AM						11	7	**18**
9:00-9:59 AM						9	11	**20**
10:00-10:59 AM						19	15	**34**
11:00-11:59 AM						16	25	**41**
12:00-12:59 PM						25	25	**50**
Total	**45**	**35**	**32**	**35**	**42**	**124**	**116**	**429**

Section IV: Demographics[8]

Figure 23. Sex of Children Served Statewide*

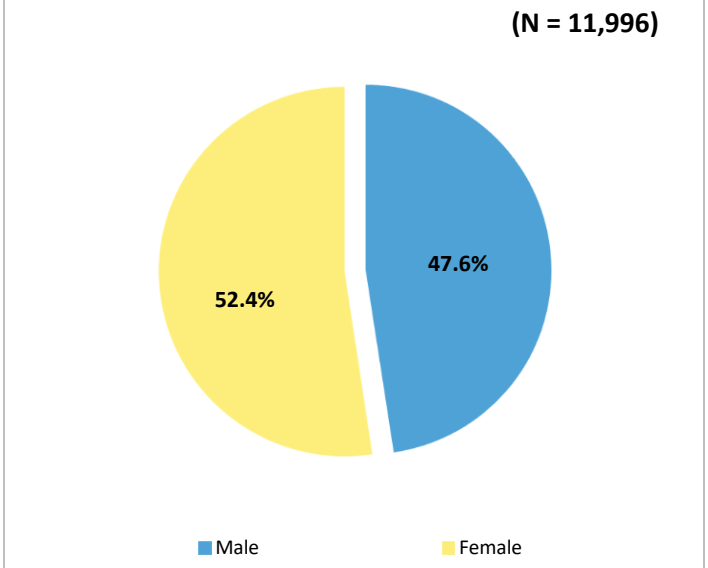


Figure 24. Age Groups of Children Served Statewide

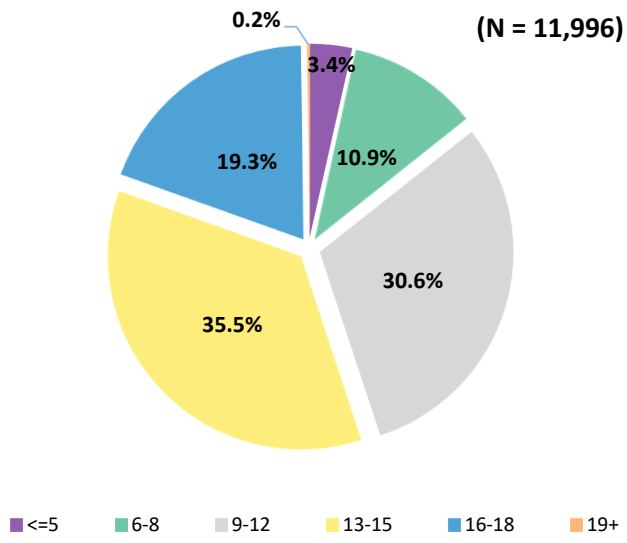


Figure 25. Ethnic Background of Children Served Statewide^

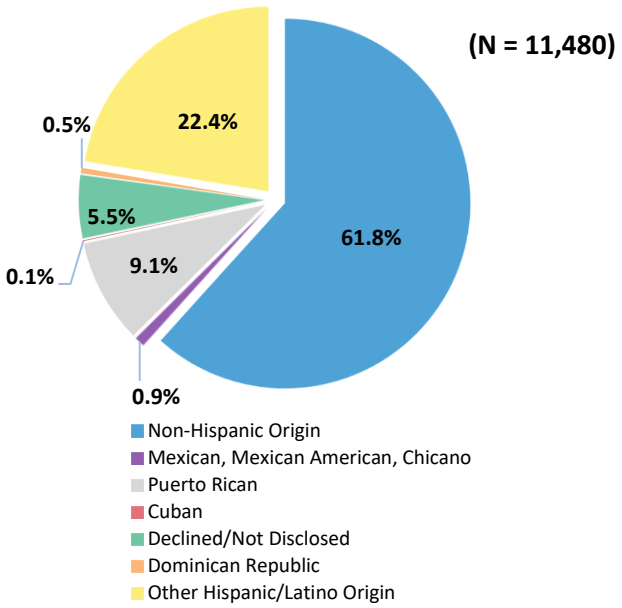
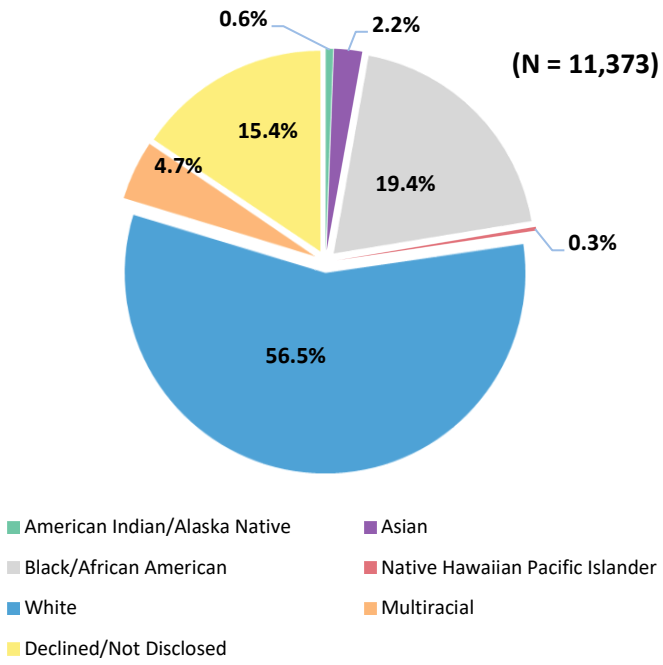


Figure 26. Race of Children Served Statewide



*Per question regarding sex assigned at birth.

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

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

Figure 27. Client's Type of Health Insurance at Intake Statewide

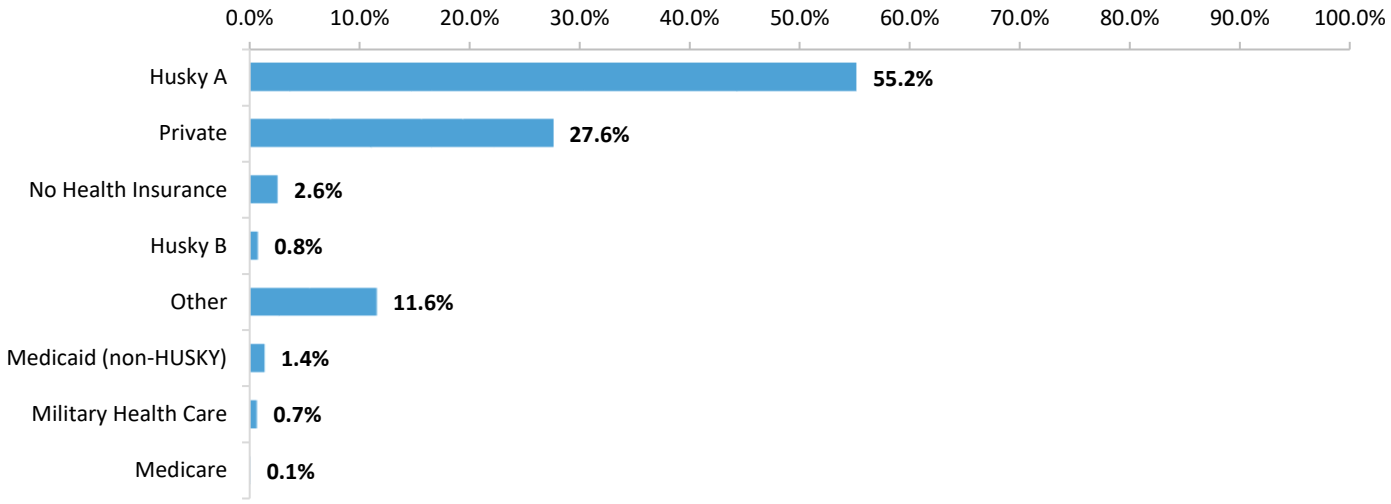
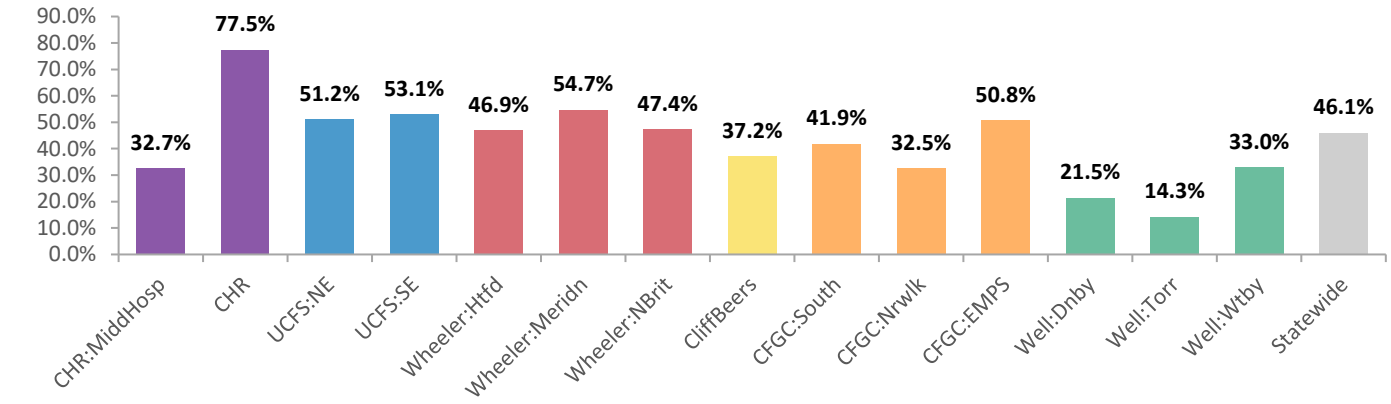
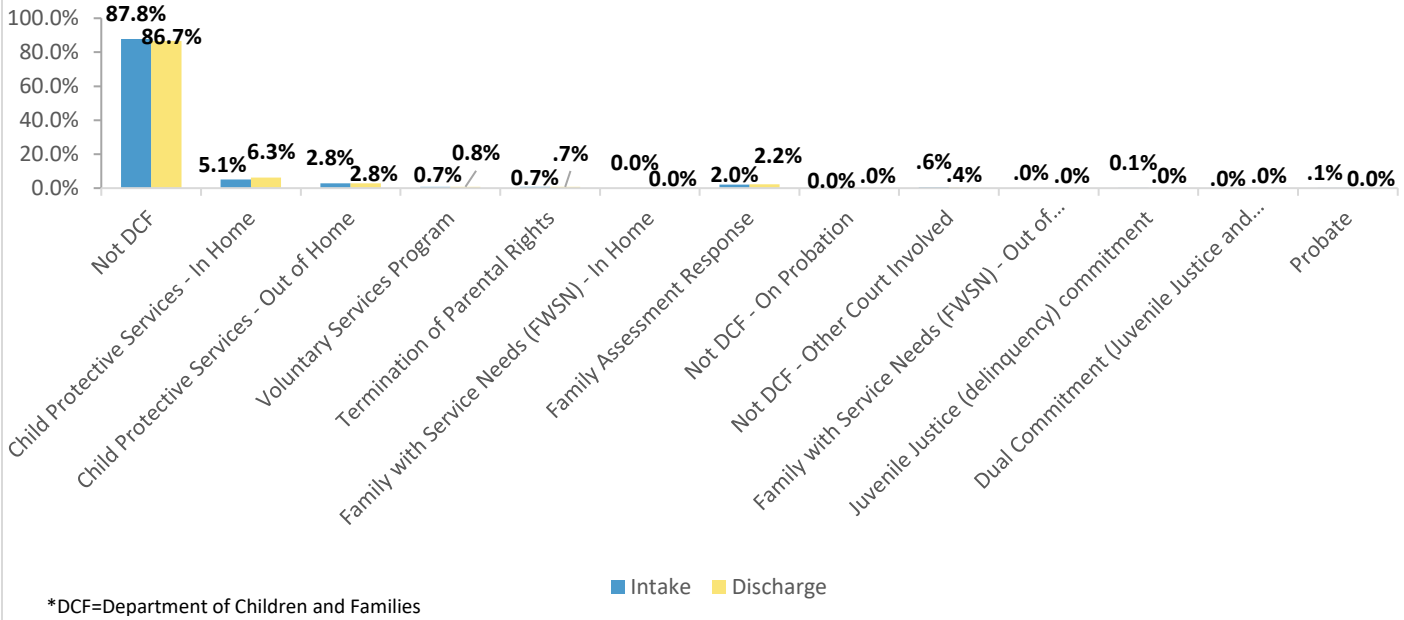


Figure 28. Families that Answered "Yes" TANF* Eligible



*TANF=Temporary Assistance for Needy Families

Figure 29. Client DCF* Status at Intake and Discharge Statewide



*DCF=Department of Children and Families

Figure 30. Calls During Expanded Hours - Race and Ethnicity of Children Served Statewide (N = 403)

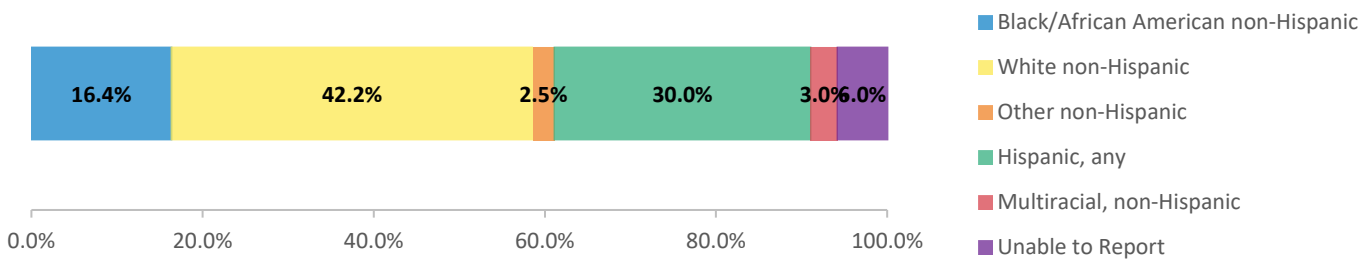


Figure 31. Calls During Expanded Hours - Sex of Children Served Statewide (N = 430)

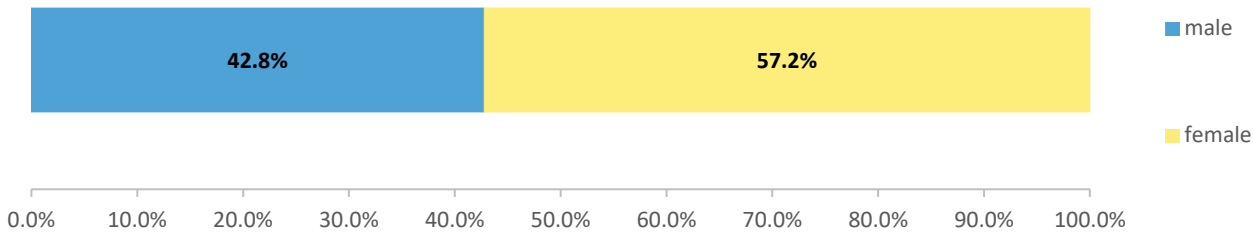
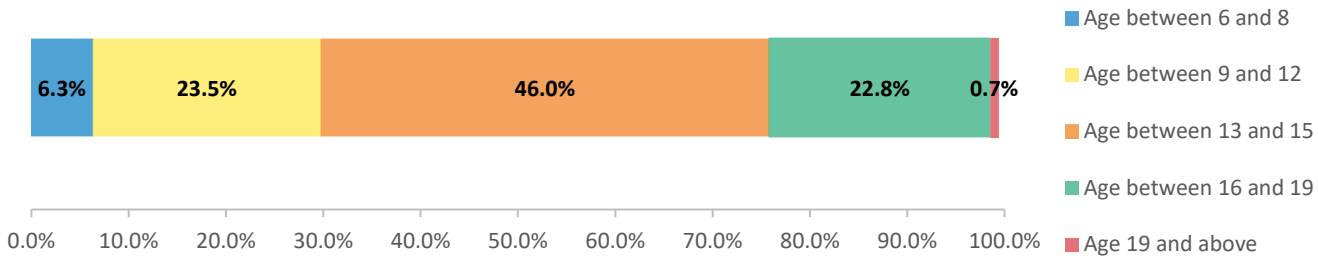


FIgure 32. Calls During Expanded Hours - Age of Children Served Statewide (N = 430)



Section V: Clinical Functioning

Figure 33. Top Six Client Primary Presenting Problems by Service Area

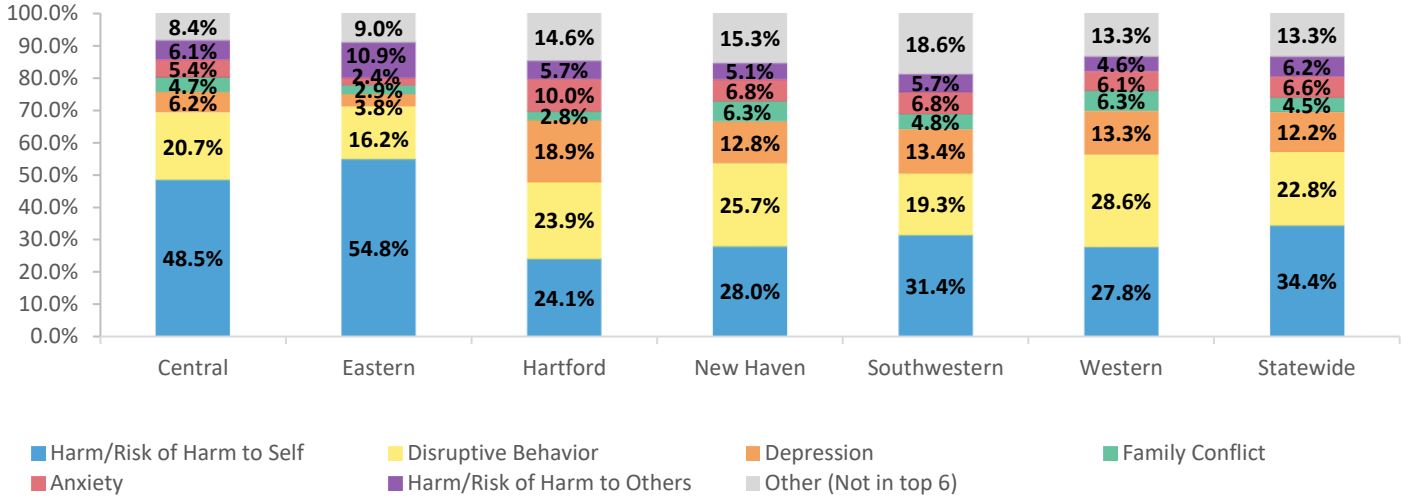
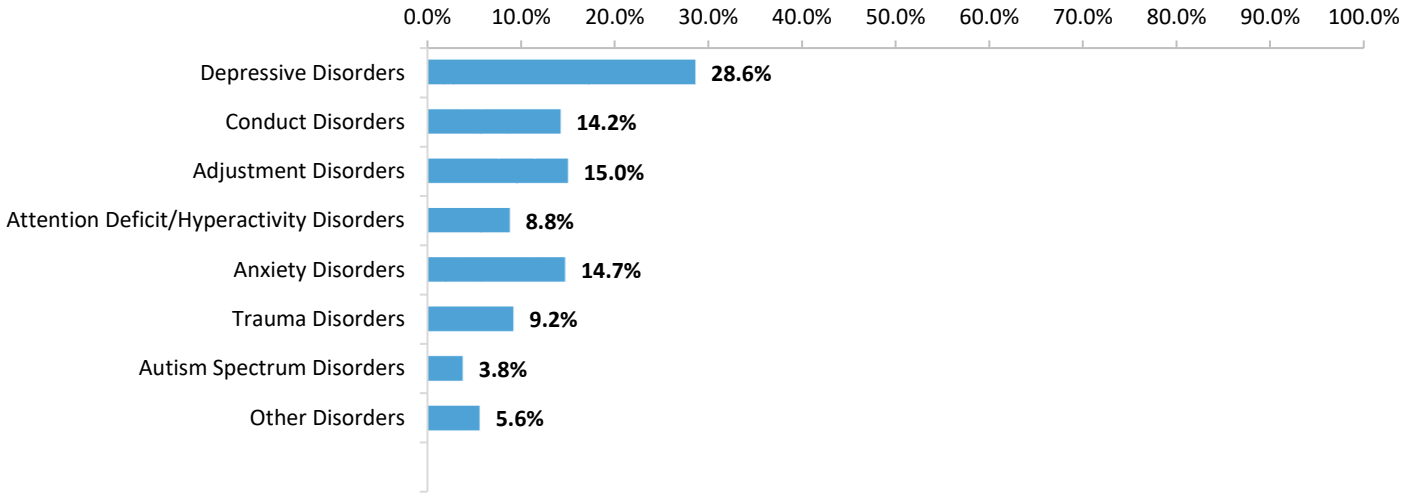


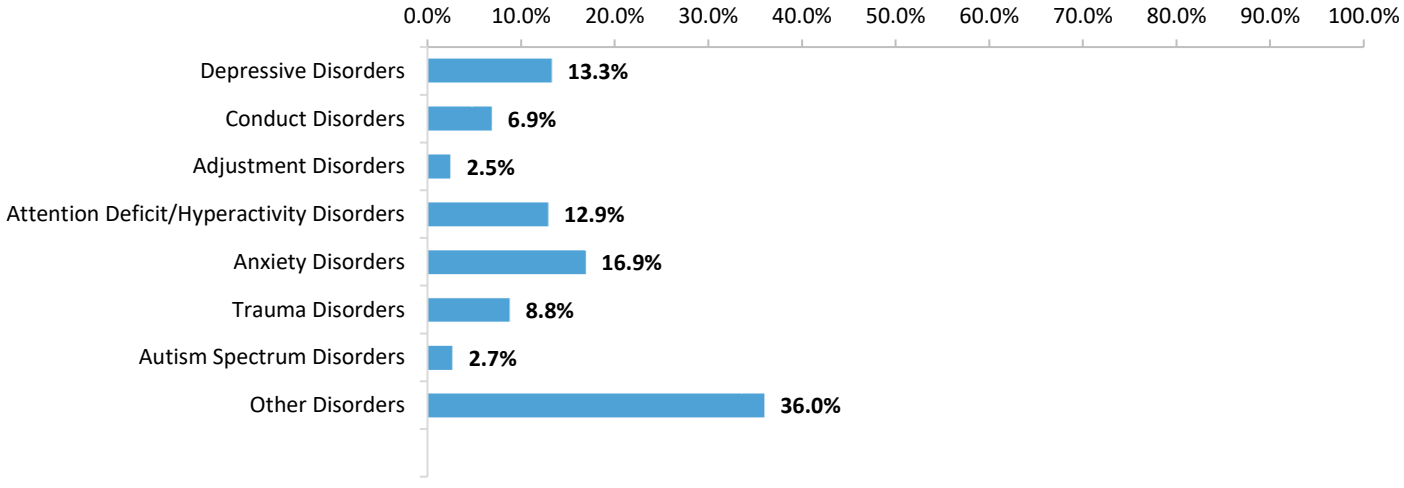
Figure 34. Distribution of Primary Diagnosis Categories* at Intake Statewide



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

Note: Excludes missing data

Figure 35. Distribution of Client Secondary Diagnosis Categories* at Intake Statewide



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

Note: Excludes missing data

Figure 36. Top 6 Primary Diagnostic Categories at Intake by Service Area

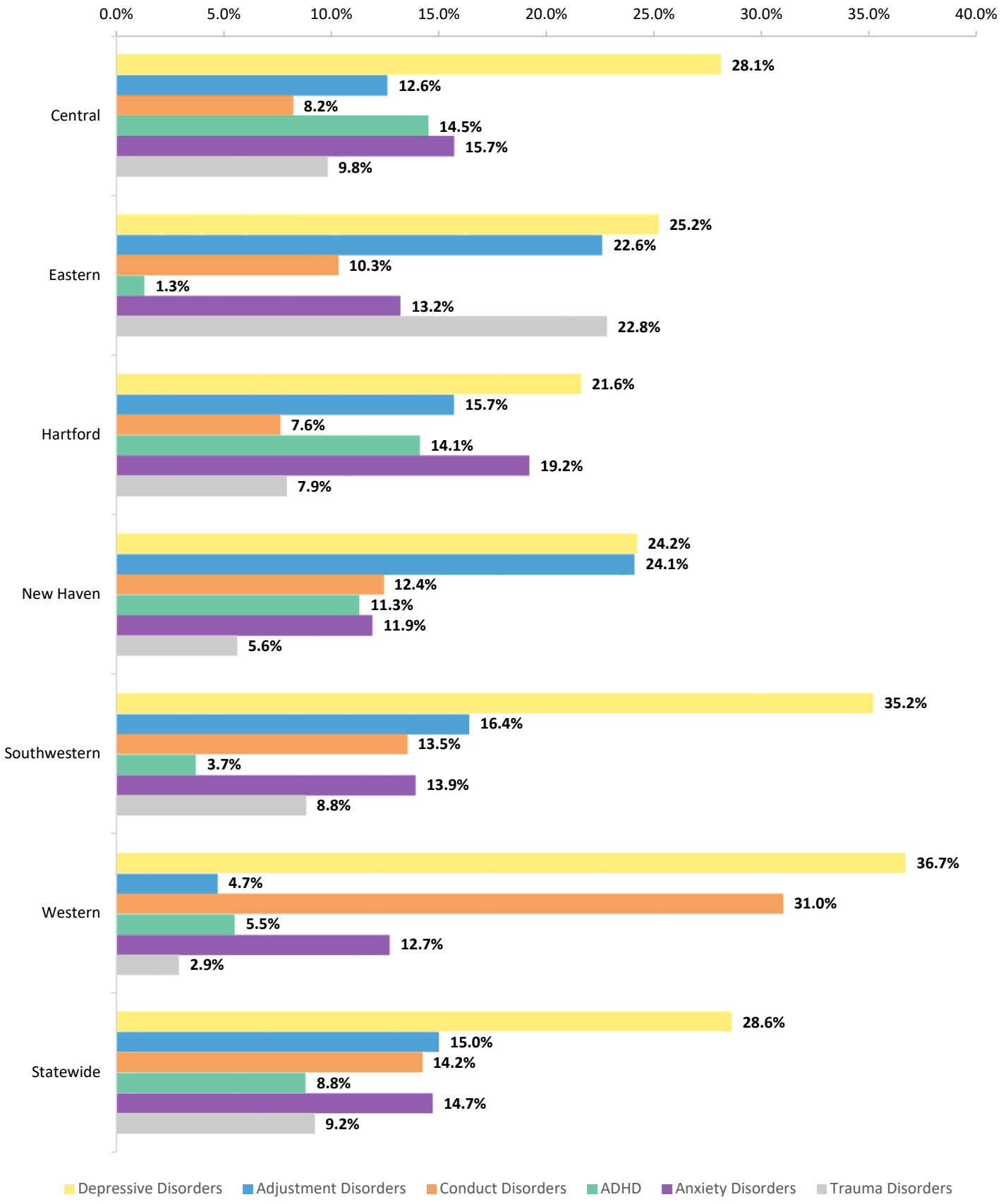


Figure 37. Top 6 Client Secondary Diagnostic Categories at Intake by Service Area

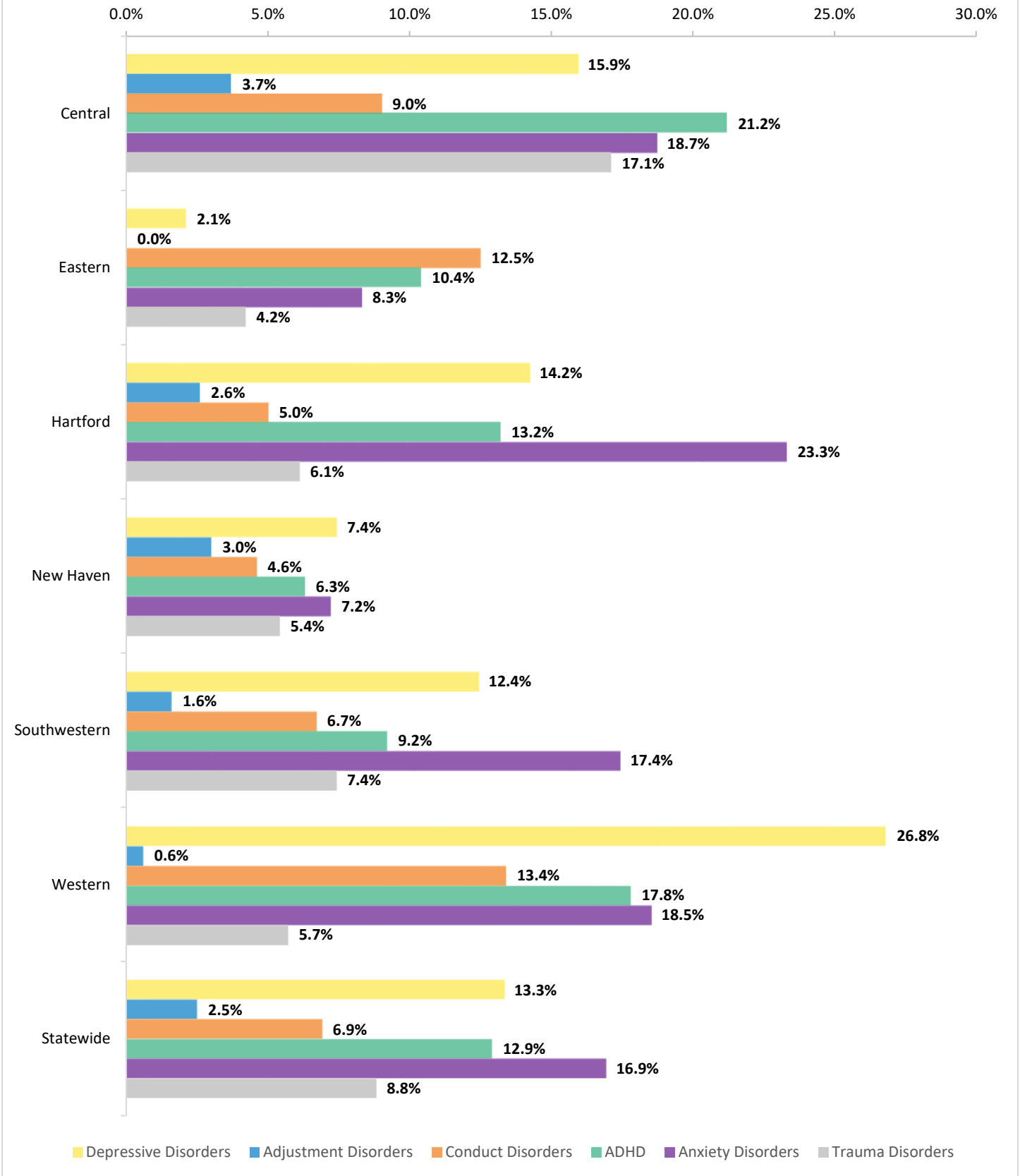
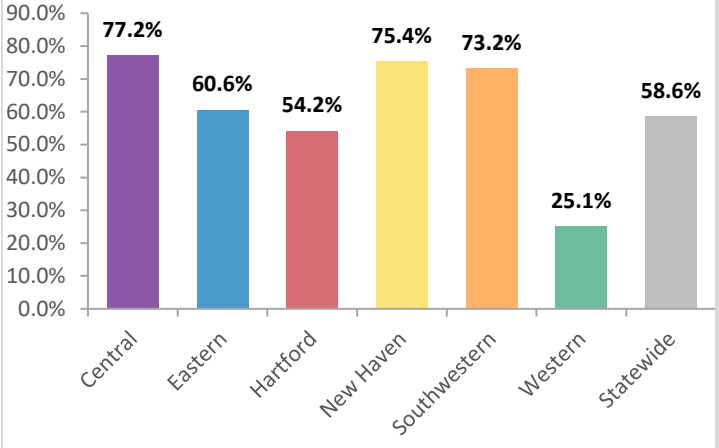


Figure 38. Children Meeting SED* Criteria by Service Area



*Serious Emotional Disturbance

Figure 39. Children with Trauma Exposure Reported at Intake by Service Area

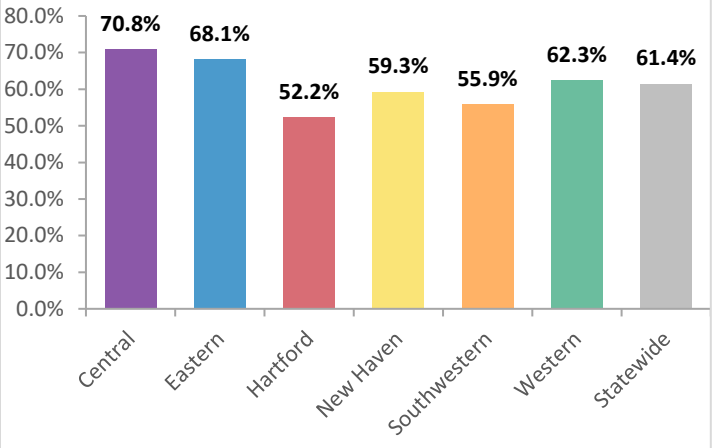


Figure 40. Type of Trauma Reported at Intake by Service Area

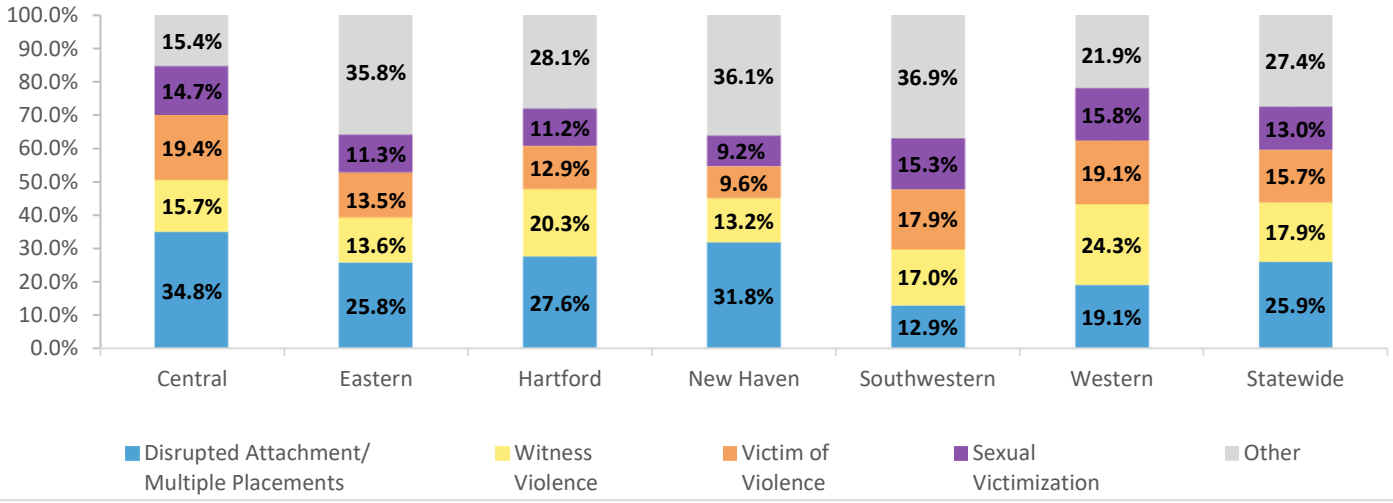


Figure 41. Clients Evaluated in an Emergency Dept. One or More Times in the Six Months Prior and During an Episode of Care

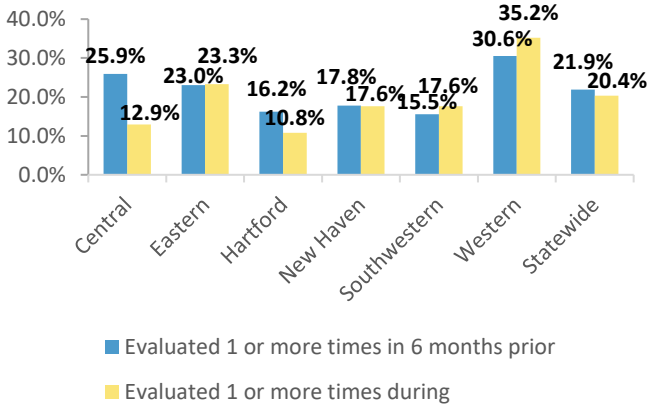


Figure 42. Clients Admitted to a Hospital (Inpatient) for Psychiatric or Behavioral Health Reasons One or More Times in His/Her Lifetime, in Six Months Prior and During the Episode of Care

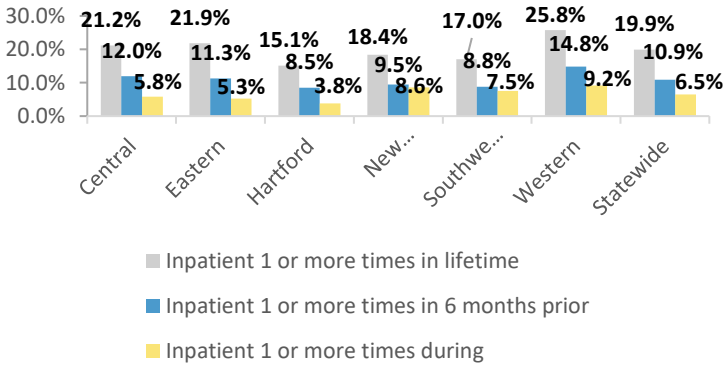


Figure 43. Clients Placed in an Out of Home Setting One or More Times in His/Her Lifetime and in the Six Months Prior to the Episode of Care

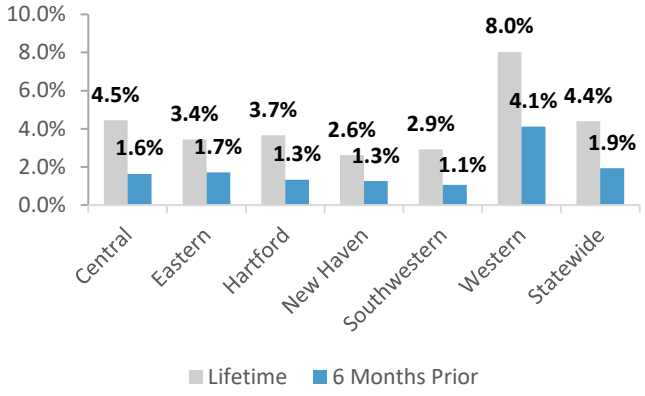


Figure 44. Clients Reported Problems with Alcohol and/or Drugs in His/Her Lifetime, in Six Months Prior to and During the Episode of Care

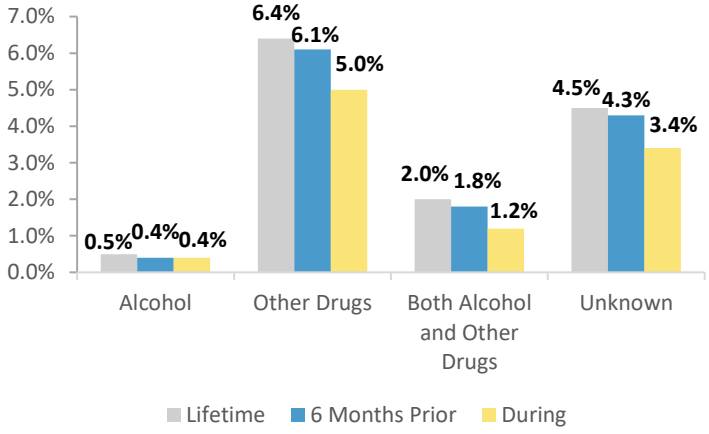


Figure 45. Type of Parent/Guardian Service Need Statewide

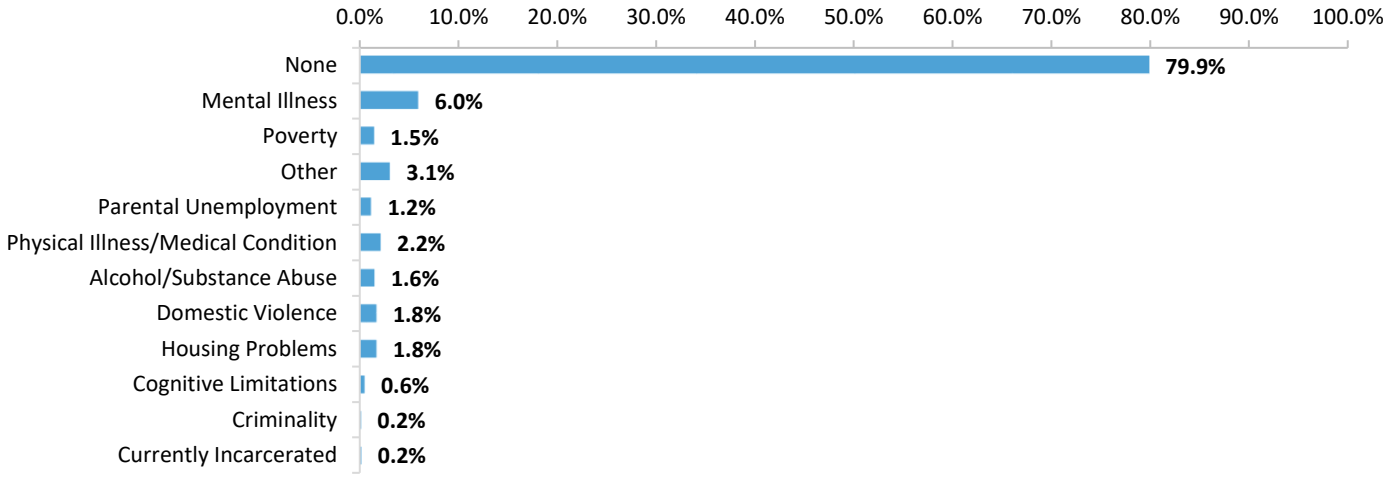


Figure 46. How Capable of Dealing with the Child's Problem Does the Parent/Guardian Feel at Intake and Discharge Statewide

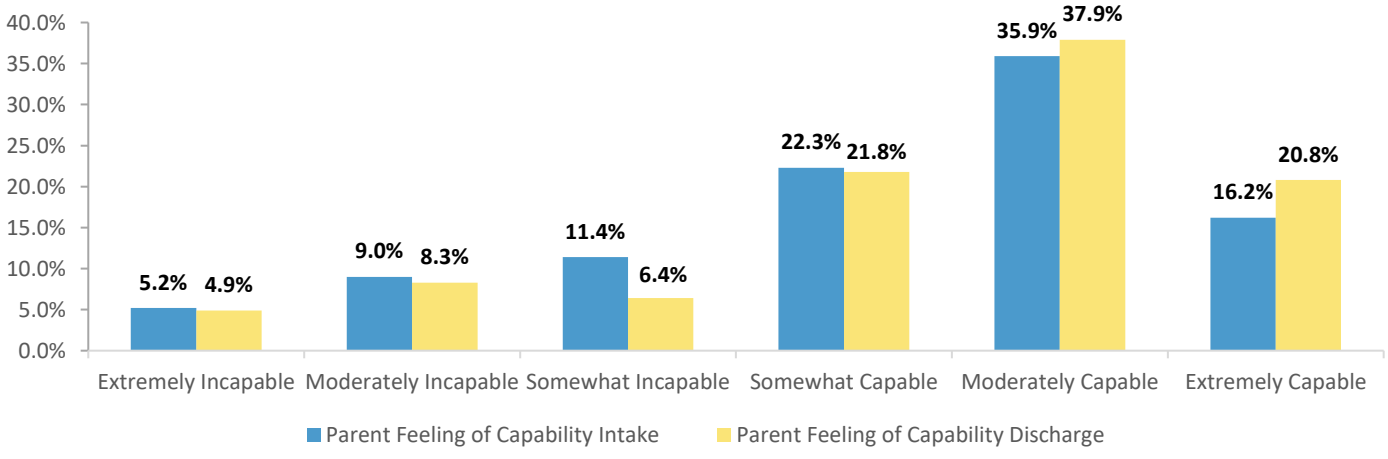


Figure 47. Statewide Parent/Guardian Rating of Client's Attendance at School During the Episode of Care (compared to pre-admission)

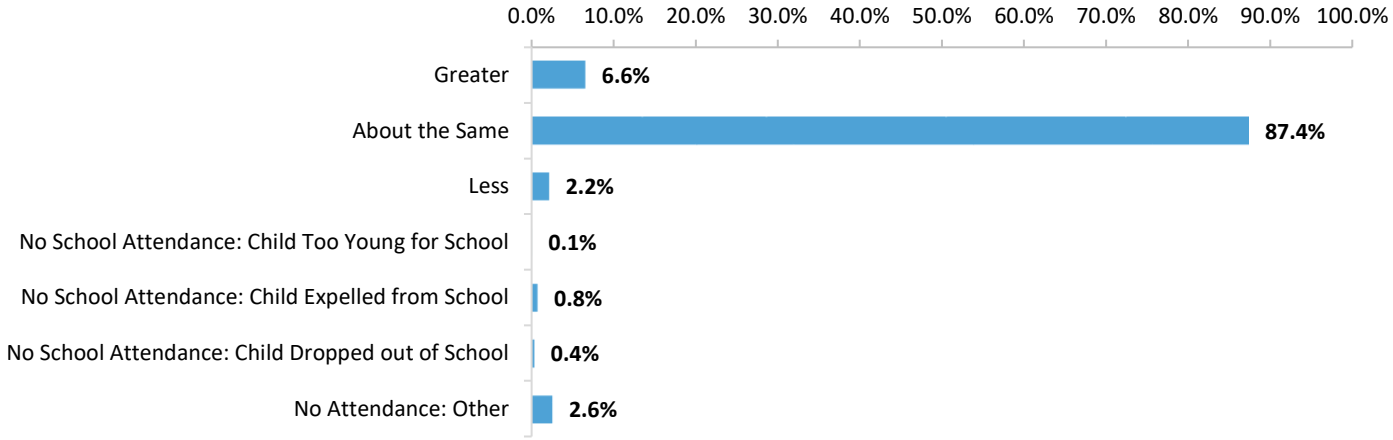


Figure 48. Clients Suspended or Expelled from School in the Six Months Prior to and During the Episode of Care

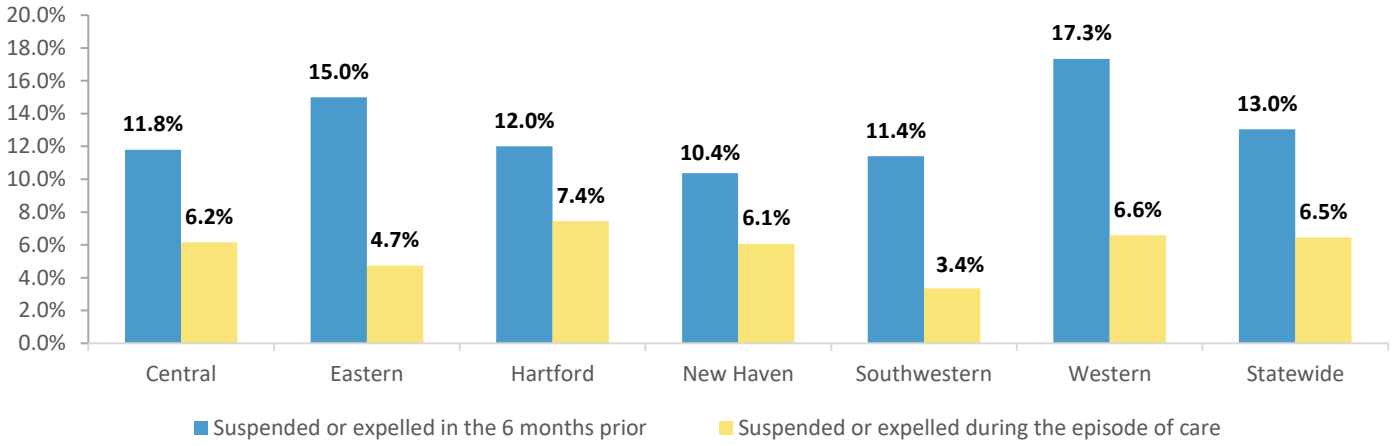


Figure 49. School Issues at Intake that have a Negative Impact on Client's Functioning at School by Service Area

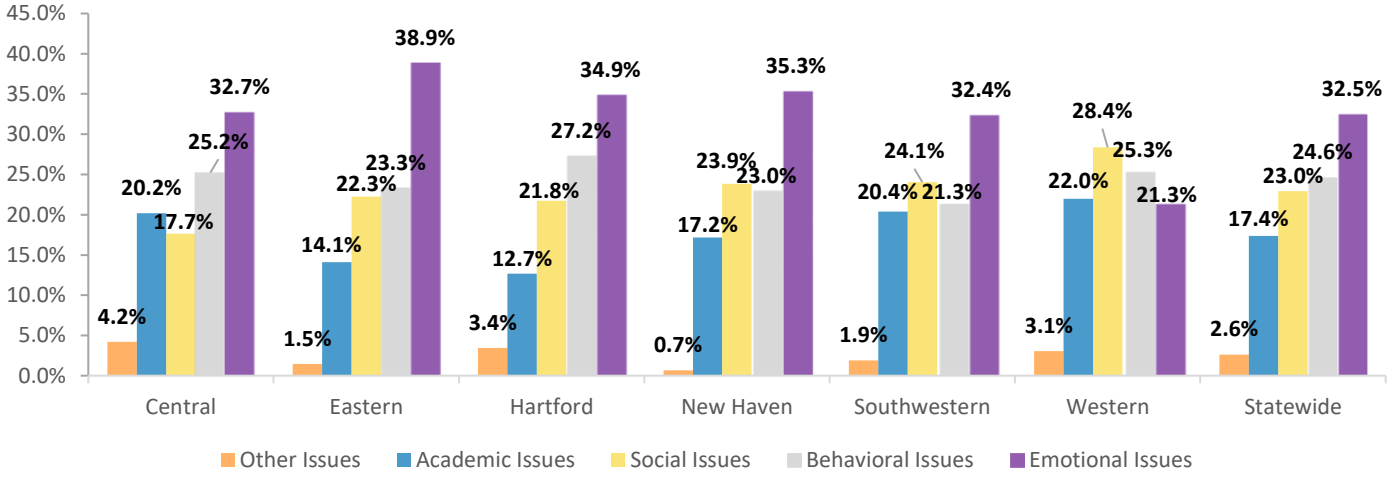
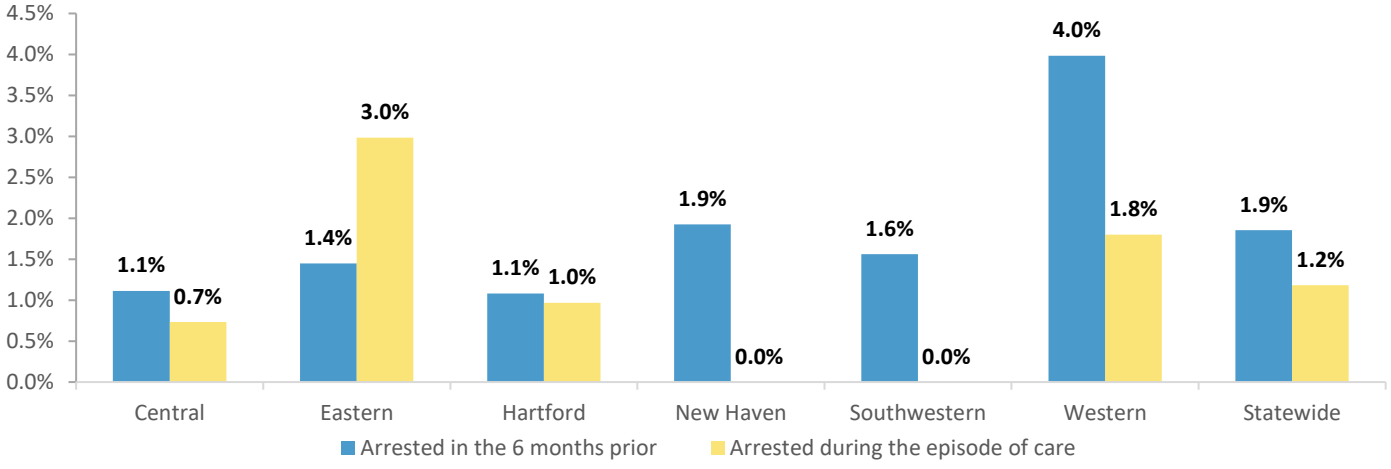
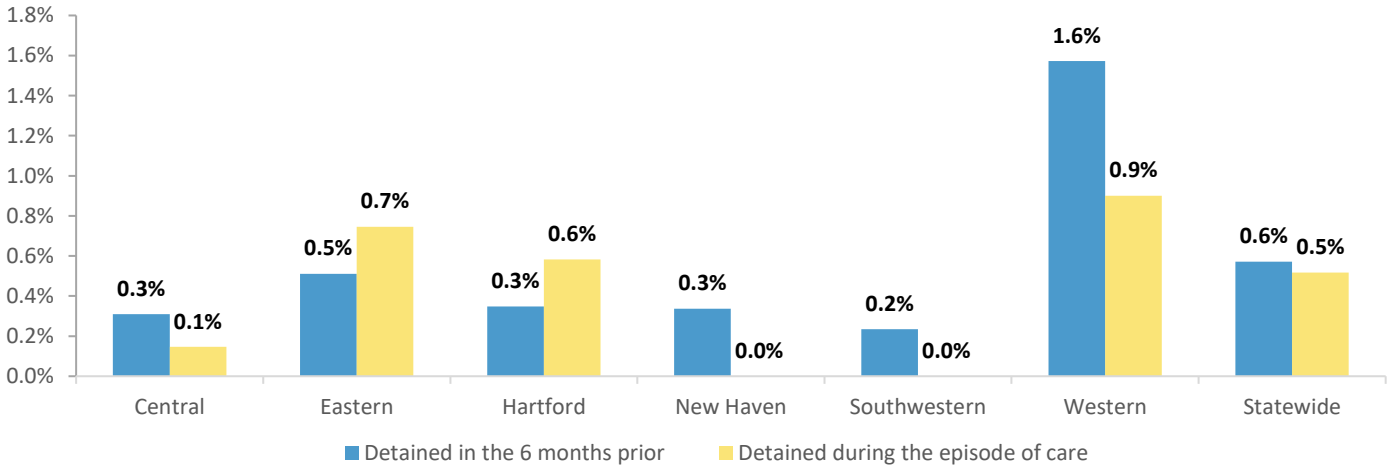


Figure 50. Clients Arrested* in the Six Months Prior to and During the Episode of Care



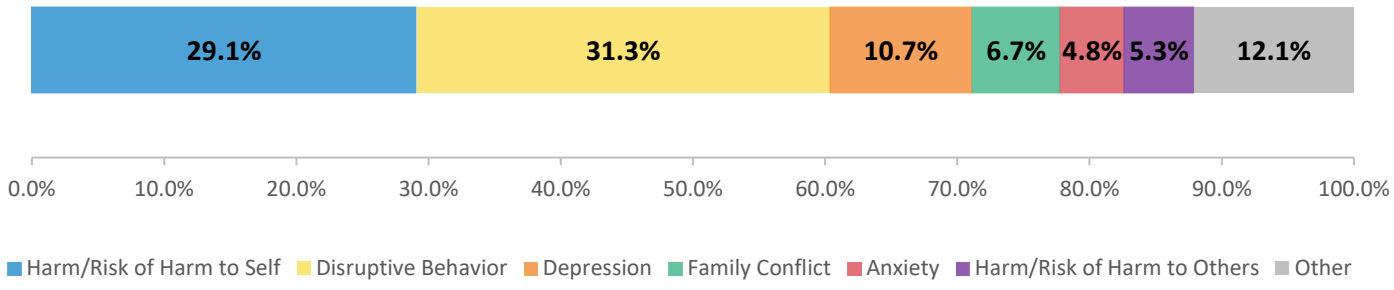
*Arrested refers to any arrest, regardless of whether it resulted in formal arraignment or adjudication.

Figure 51. Detained* in the Six Months Prior to and During the Episode of Care



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

Figure 52. Calls During Expanded Hours - Client Primary Presenting Problems



Section VI: Referral Sources

Figure 53. Referral Sources Statewide

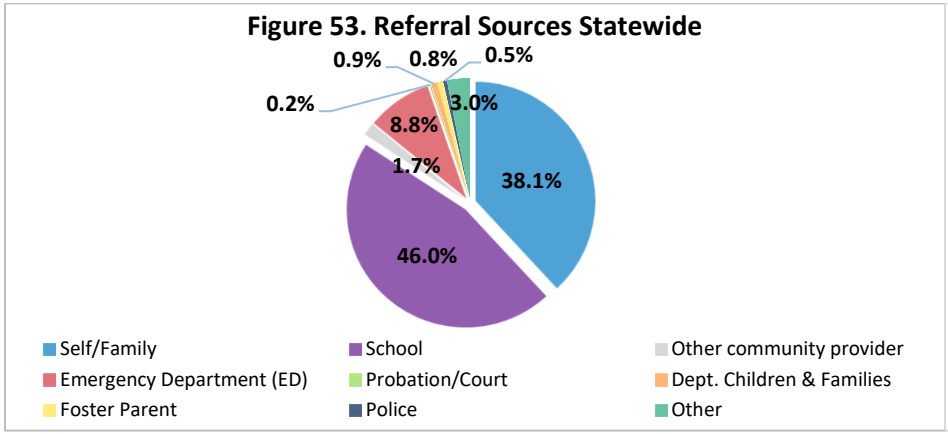


Figure 54. Top Referral Sources Over Time

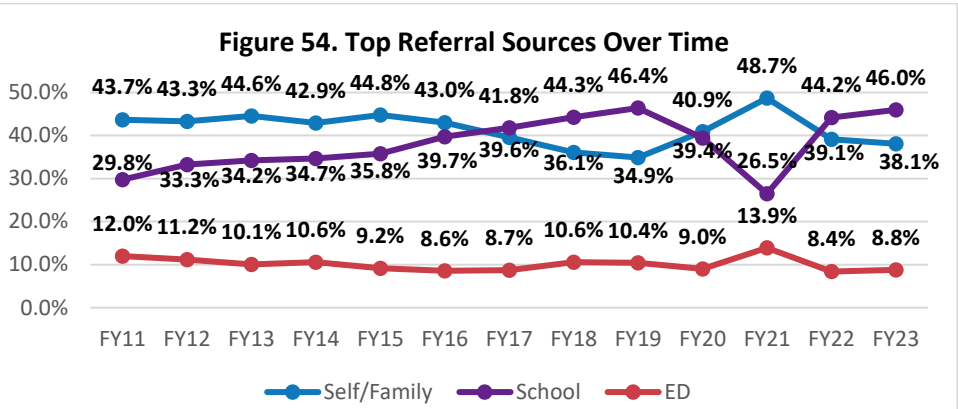


Table 2. Referral Sources

	Self/ Family	Family Adv.	School	Info-Line (2-1-1)	Other Prog. w/in Agency	Other Comm. Provider	Emer Dept. (ED)	Prob. or Court	Dept. of Child & Families (DCF)	Psych Hospital	Cong. Care Facility	Foster Parent	Police	Phys.	Comm. Nat. Supp.	Other State Agency
STATEWIDE	38.1%	0.2%	46.0%	0.0%	0.6%	1.7%	8.8%	0.2%	0.9%	1.5%	0.0%	0.8%	0.5%	0.4%	0.1%	0.0%
CENTRAL	40.0%	0.4%	43.3%	0.0%	0.4%	2.1%	9.8%	0.2%	0.5%	2.0%	0.0%	0.6%	0.4%	0.3%	0.0%	0.0%
CHR/MiddHosp-EMPS	41.1%	0.0%	45.7%	0.0%	0.5%	1.5%	7.8%	0.2%	0.2%	1.8%	0.0%	0.0%	0.7%	0.5%	0.0%	0.0%
CHR-EMPS	39.7%	0.5%	42.3%	0.0%	0.3%	2.3%	10.6%	0.2%	0.6%	2.0%	0.1%	0.8%	0.3%	0.3%	0.1%	0.1%
EASTERN	39.3%	0.2%	50.7%	0.0%	0.5%	1.4%	2.2%	0.1%	1.2%	2.3%	0.1%	0.9%	0.4%	0.5%	0.1%	0.1%
UCFS-EMPS:NE	44.3%	0.2%	42.9%	0.0%	0.4%	1.3%	3.0%	0.0%	2.6%	3.6%	0.0%	0.9%	0.4%	0.2%	0.0%	0.2%
UCFS-EMPS:SE	37.0%	0.2%	54.4%	0.0%	0.6%	1.4%	1.8%	0.1%	0.6%	1.7%	0.2%	0.9%	0.4%	0.7%	0.1%	0.0%
HARTFORD	37.0%	0.2%	44.8%	0.1%	0.8%	2.3%	9.4%	0.1%	1.0%	2.0%	0.0%	0.7%	0.9%	0.5%	0.3%	0.1%
Wheeler-EMPS:Htfd	29.4%	0.1%	46.3%	0.1%	1.1%	3.7%	13.7%	0.0%	1.0%	1.2%	0.0%	0.7%	2.2%	0.4%	0.0%	0.1%
Wheeler-EMPS:Meridn	41.2%	0.0%	47.3%	0.0%	0.2%	0.8%	5.1%	0.0%	0.6%	2.5%	0.0%	0.6%	0.4%	0.6%	0.4%	0.2%
Wheeler-EMPS:NBrit	40.7%	0.3%	43.0%	0.1%	0.7%	1.8%	8.0%	0.1%	1.1%	2.3%	0.1%	0.7%	0.2%	0.5%	0.4%	0.0%
NEW HAVEN	40.9%	0.1%	46.2%	0.0%	0.3%	1.4%	7.0%	0.3%	0.8%	1.0%	0.0%	1.1%	0.4%	0.2%	0.1%	0.0%
CliffBeers-EMPS	40.9%	0.1%	46.2%	0.0%	0.3%	1.4%	7.0%	0.3%	0.8%	1.0%	0.0%	1.1%	0.4%	0.2%	0.1%	0.0%
SOUTHWESTERN	39.7%	0.2%	52.3%	0.0%	1.3%	1.5%	1.4%	0.1%	0.9%	1.0%	0.0%	0.6%	0.4%	0.4%	0.2%	0.0%
CFGC/South-EMPS	49.4%	0.8%	41.9%	0.0%	0.5%	1.8%	1.5%	0.3%	0.5%	0.5%	0.0%	0.8%	0.3%	1.3%	0.5%	0.0%
CFGC-EMPS:Nrwlk	36.8%	0.2%	57.3%	0.0%	1.0%	1.0%	0.7%	0.0%	1.4%	0.5%	0.0%	0.2%	0.7%	0.0%	0.2%	0.0%
CFGC-EMPS	36.6%	0.0%	54.6%	0.0%	1.9%	1.6%	1.7%	0.1%	0.8%	1.6%	0.0%	0.7%	0.2%	0.1%	0.1%	0.0%
WESTERN	33.6%	0.0%	42.4%	0.0%	0.5%	1.3%	18.7%	0.5%	0.9%	0.7%	0.0%	0.8%	0.2%	0.3%	0.0%	0.0%
Well-EMPS:Dnby	44.8%	0.2%	47.2%	0.0%	0.0%	1.1%	2.6%	0.2%	1.5%	0.4%	0.0%	0.9%	0.4%	0.6%	0.0%	0.2%
Well-EMPS:Torr	41.9%	0.0%	45.3%	0.0%	0.0%	1.5%	6.0%	0.0%	1.1%	3.0%	0.0%	0.8%	0.4%	0.0%	0.0%	0.0%
Well-EMPS:Wtby	27.5%	0.0%	40.0%	0.0%	0.8%	1.4%	27.6%	0.8%	0.7%	0.4%	0.0%	0.7%	0.1%	0.2%	0.0%	0.0%

Figure 55. Emergency Department Referrals to Mobile Crisis Over Time

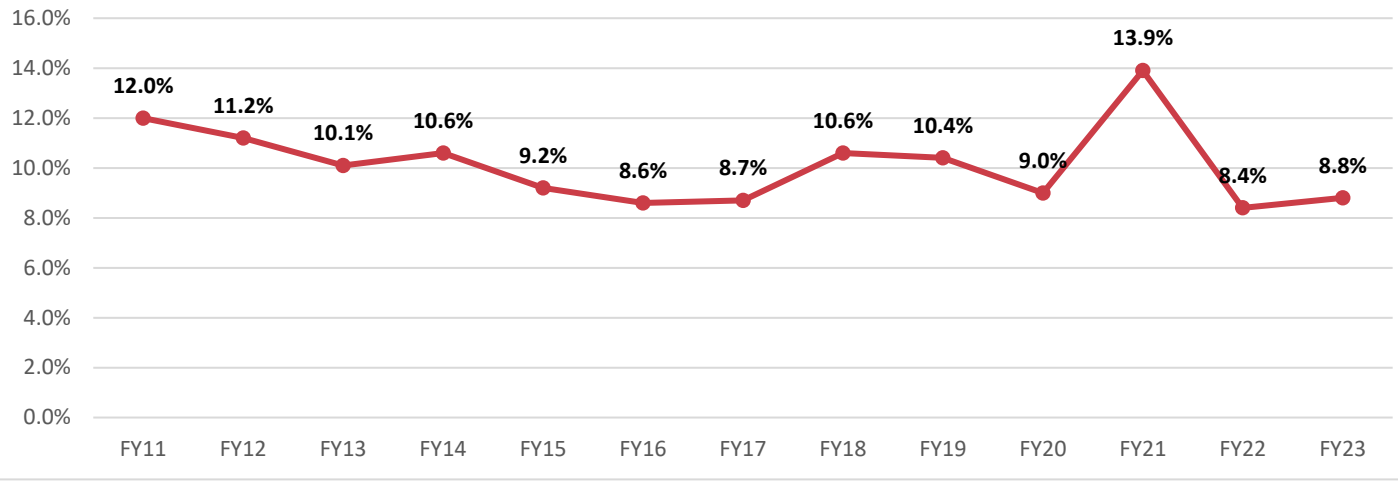
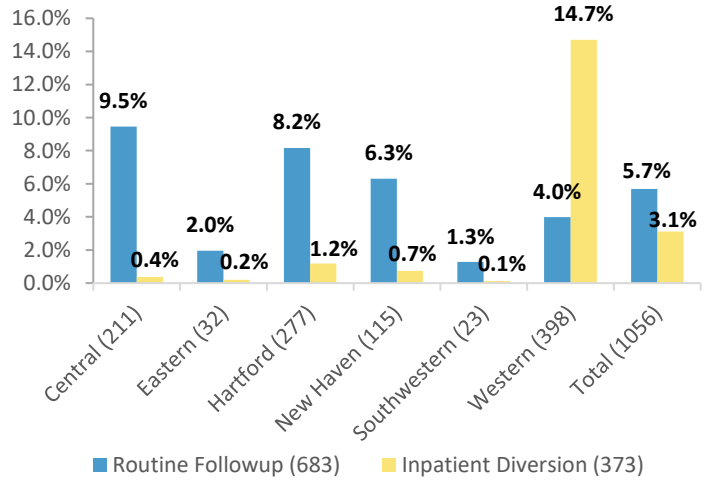
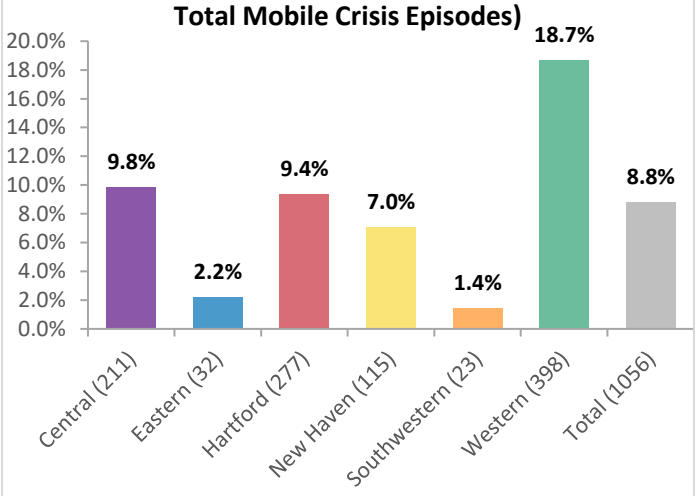


Figure 56. Type of Emergency Dept. Referral



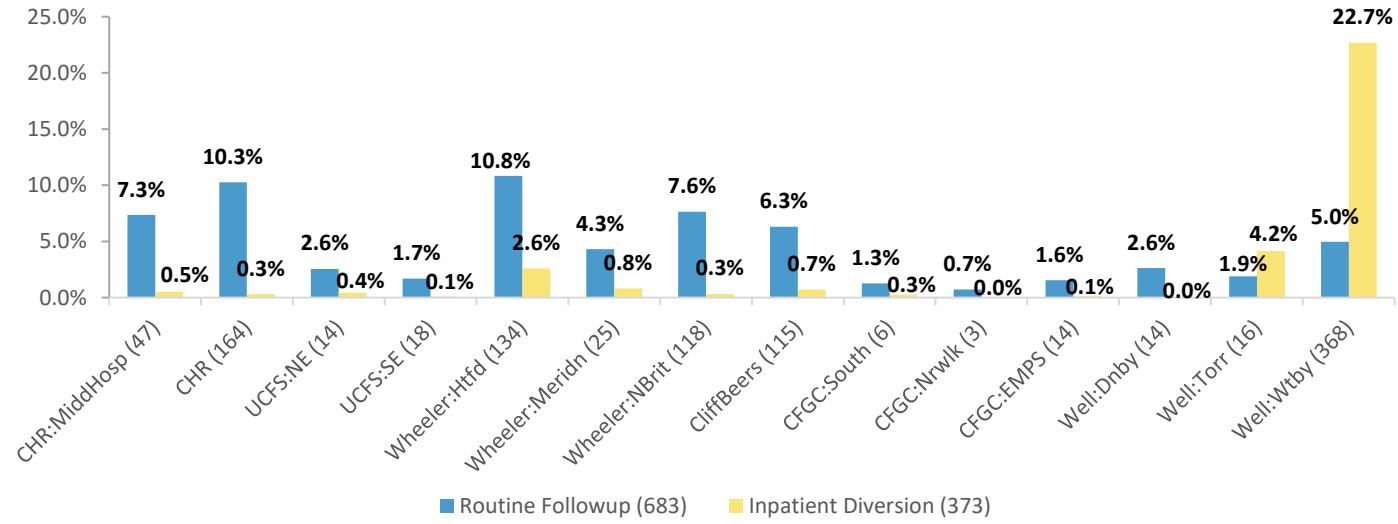
Note: Counts of ED referrals are in parentheses

Figure 57. Emergency Dept. Referral (% of Total Mobile Crisis Episodes)



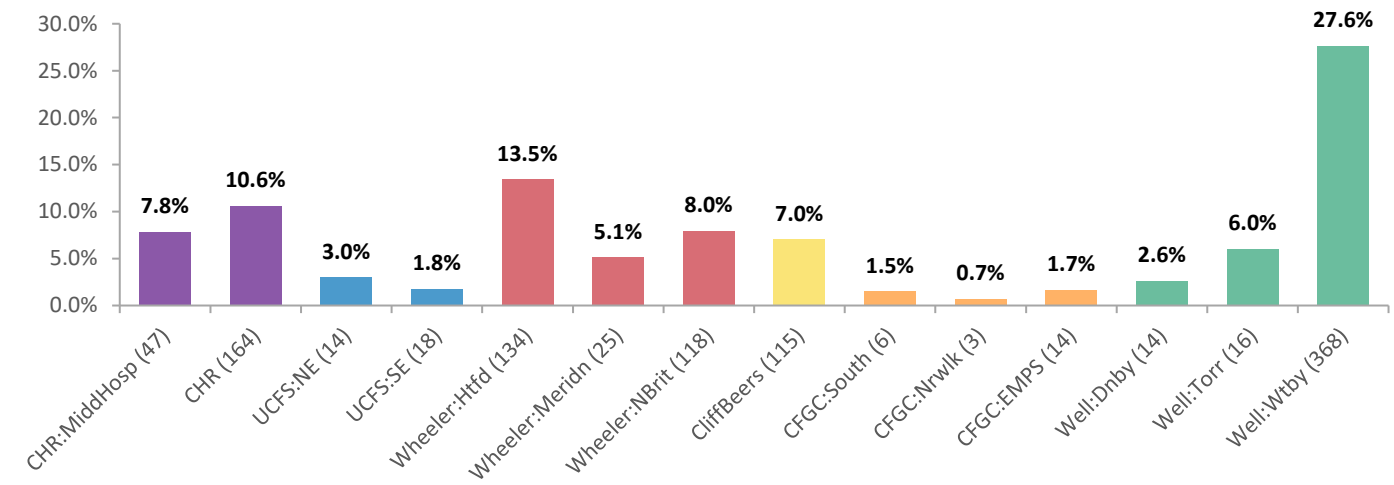
Note: Counts of ED referrals are in parentheses

Figure 58. Type of Emergency Department Referrals by Provider



Note: Counts of ED referrals are in parentheses

Figure 59. Emergency Dept. Referrals (% of Total Mobile Crisis Episodes) by Provider



Note: Counts of ED referrals are in parentheses

Figure 60. Calls During Expanded Hours - Referral Sources Statewide

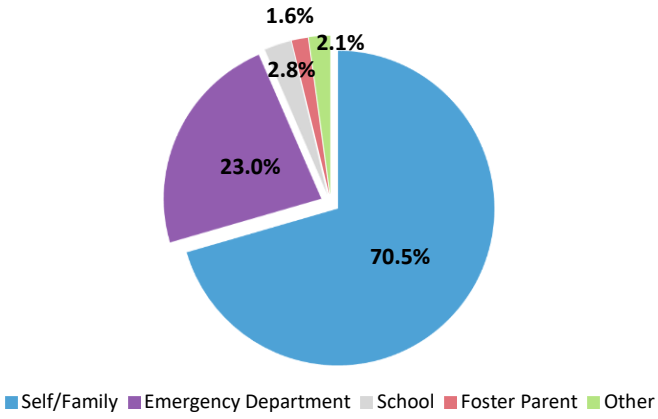
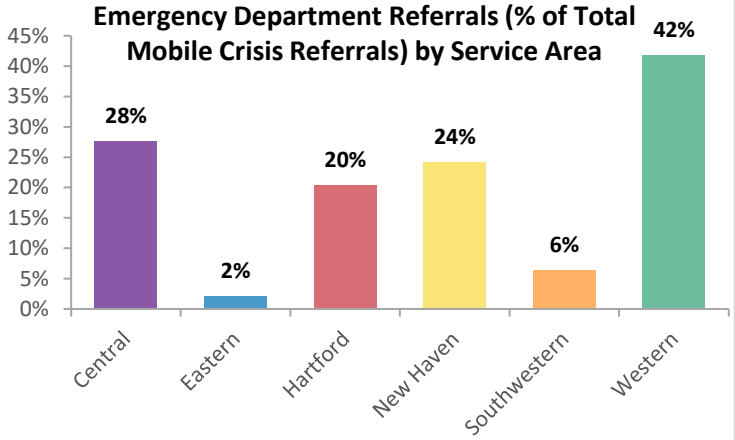


Figure 61. Calls During Expanded Hours - Emergency Department Referrals (% of Total Mobile Crisis Referrals) by Service Area



Section VII: 211 Recommendations and Mobile Crisis Response

Figure 62. 2-1-1 Recommended Initial Response

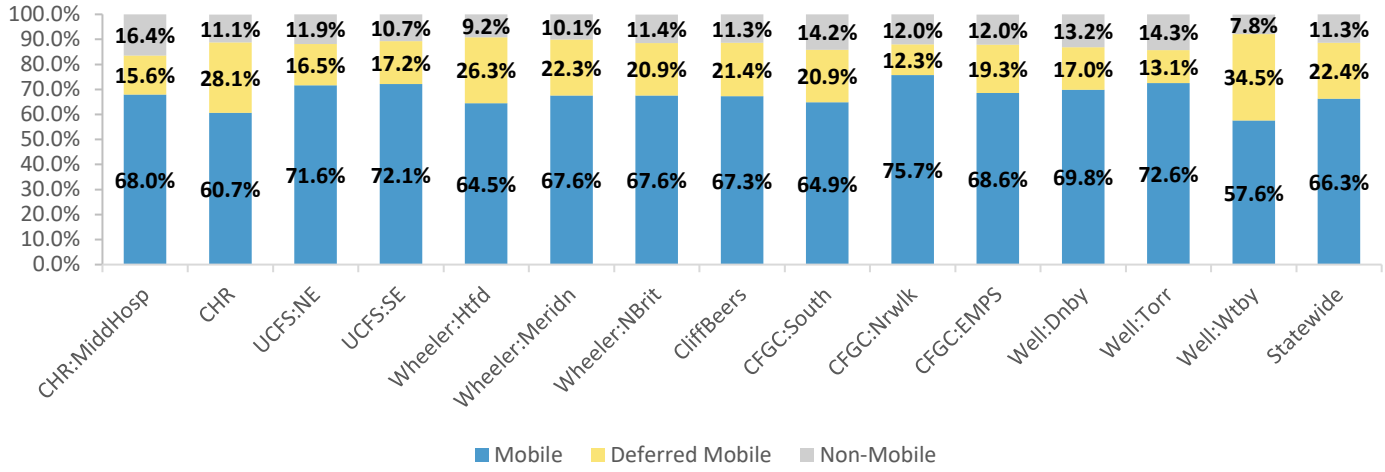


Figure 63. Actual Initial Mobile Crisis Provider Response

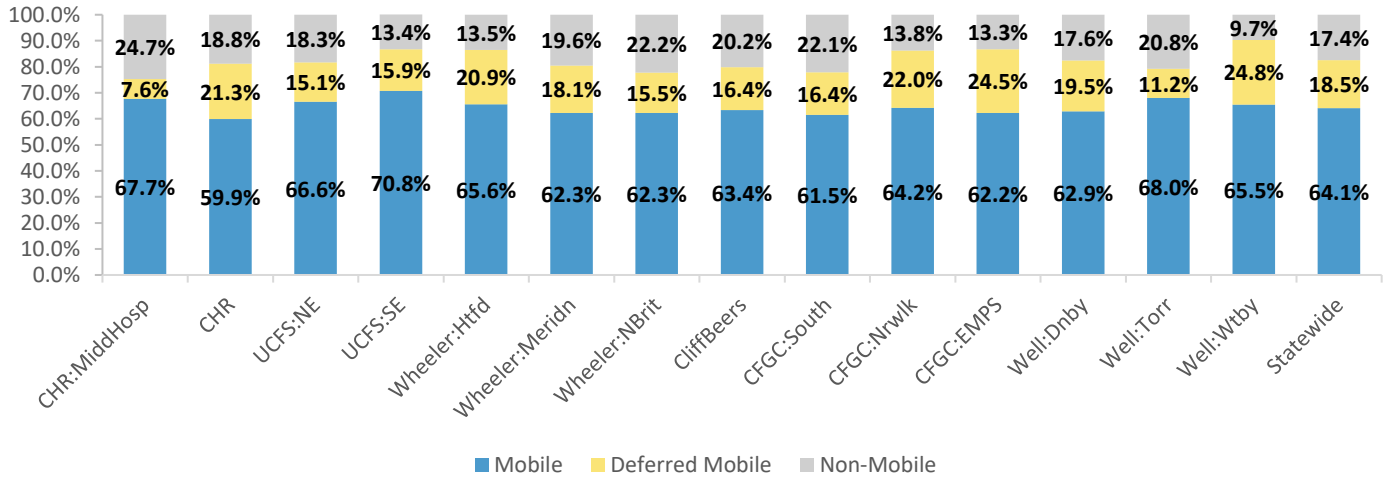
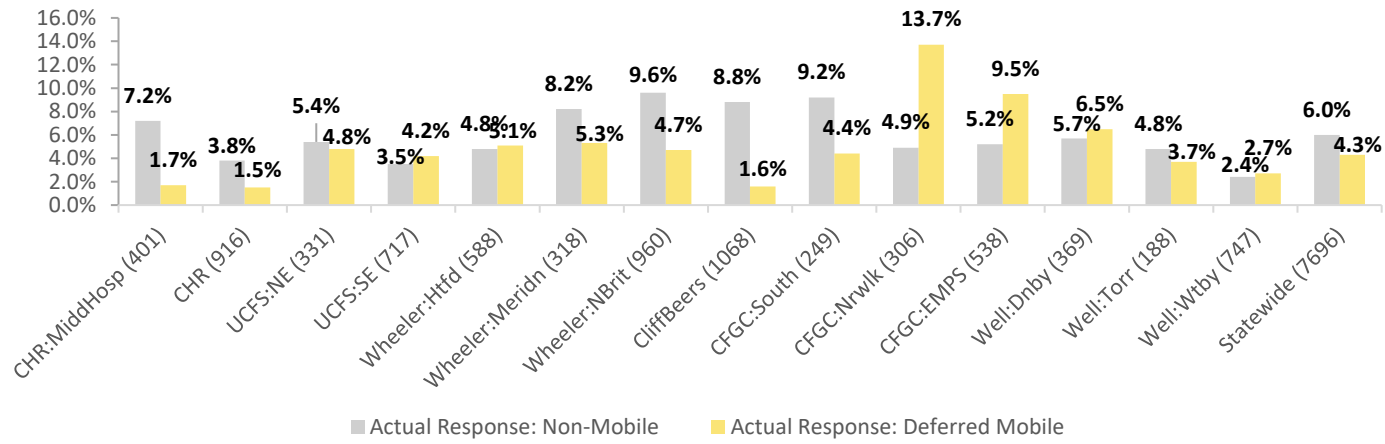
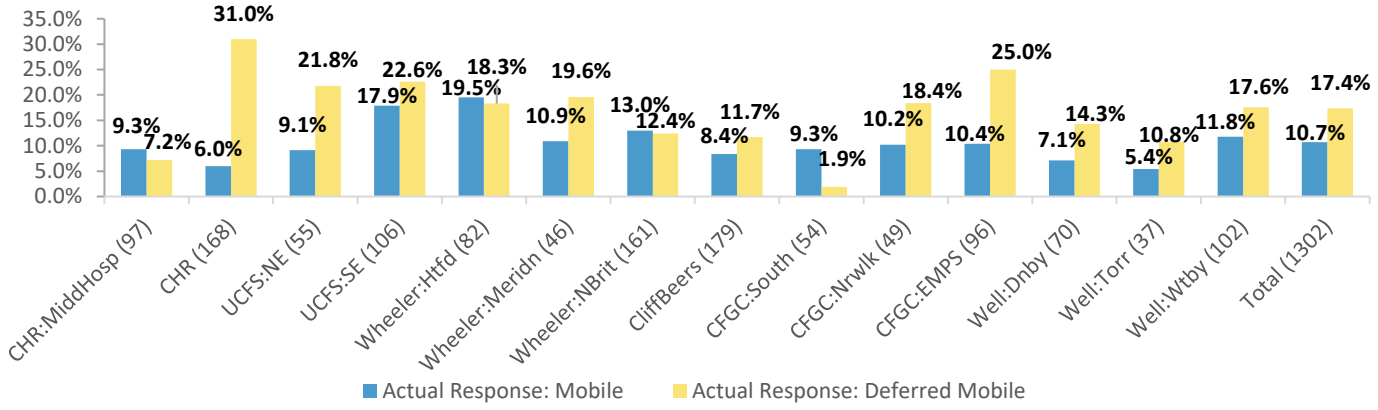


Figure 64. 2-1-1 Recommended Mobile Response Where Actual Mobile Crisis Response was Non-Mobile or Deferred Mobile



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

Figure 65. 2-1-1 Recommended Non-Mobile Response Where Actual Mobile Crisis Response was Mobile or Deferred Mobile



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

Figure 66. Statewide Mobility Rate Over Time

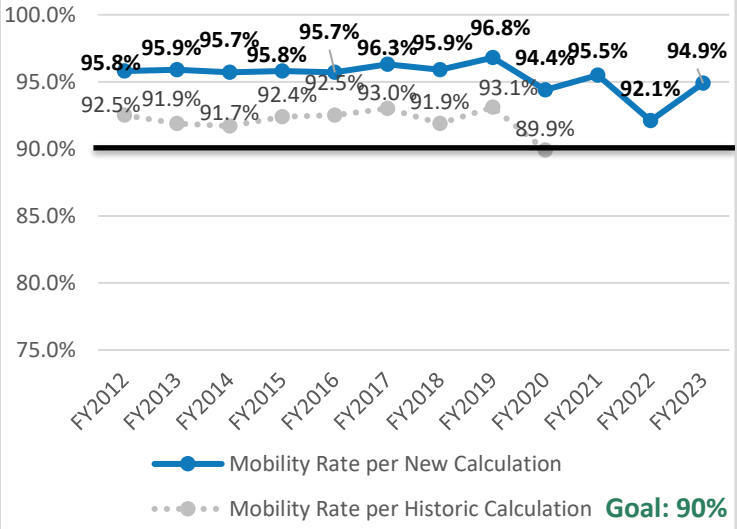
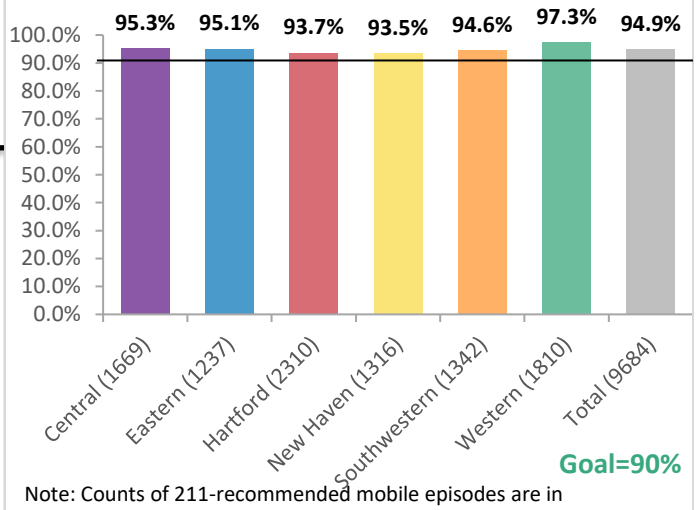
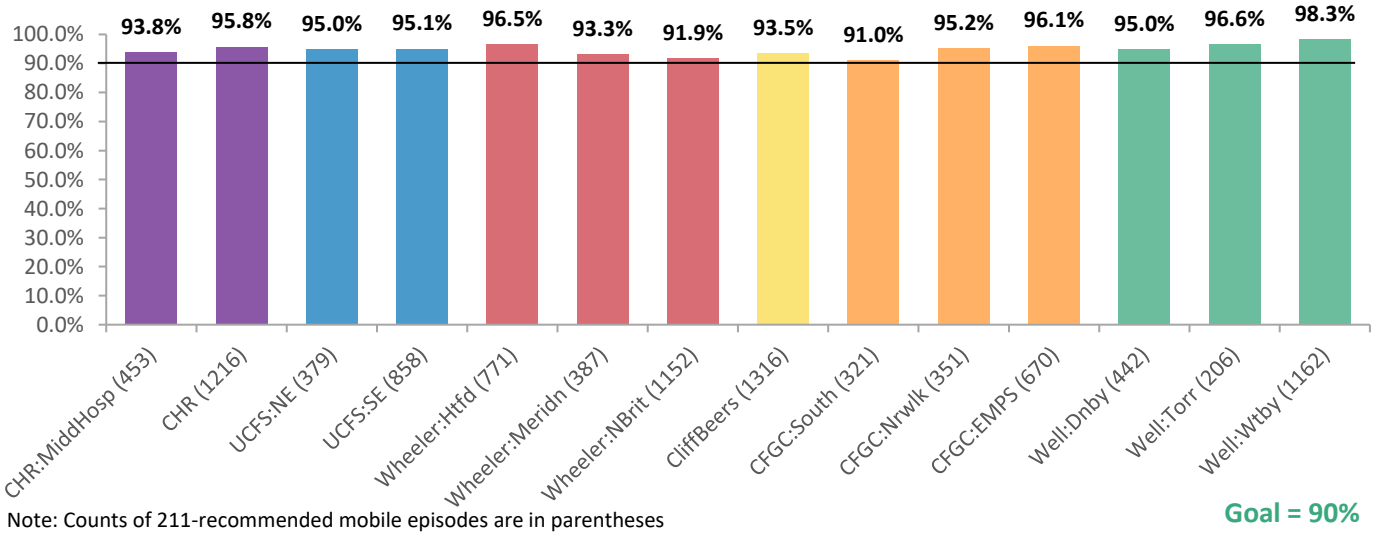


Figure 67. Mobile Response (Mobile & Deferred Mobile) By Service Area



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

Figure 68. Mobile Response (Mobile & Deferred Mobile) By Provider



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

Figure 69. Mobile Crisis First Contact Mobile Site by Service Area

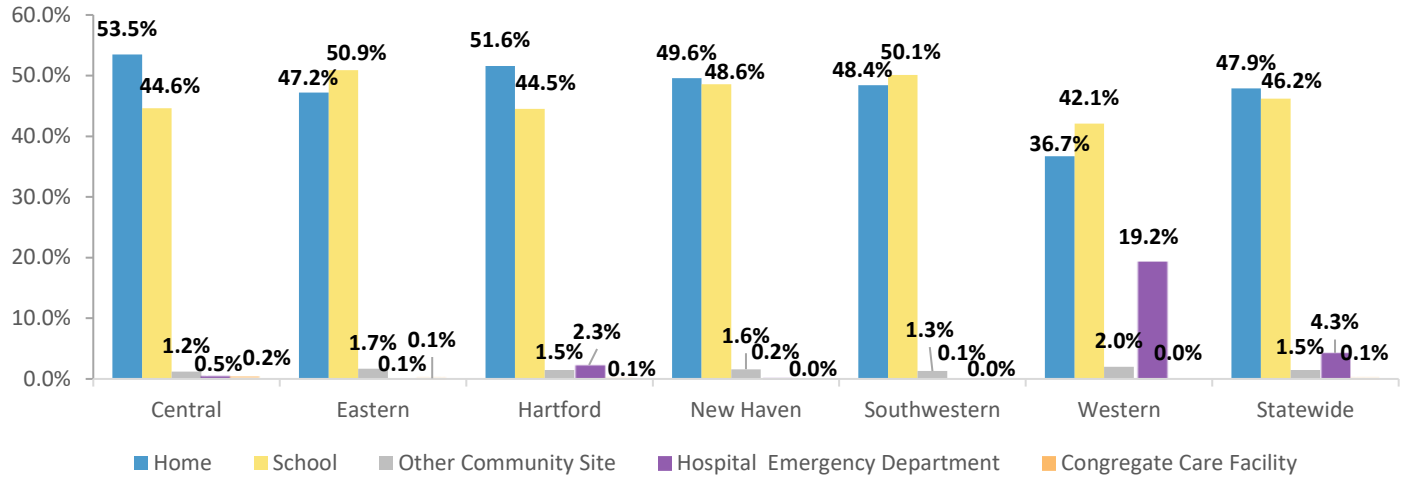
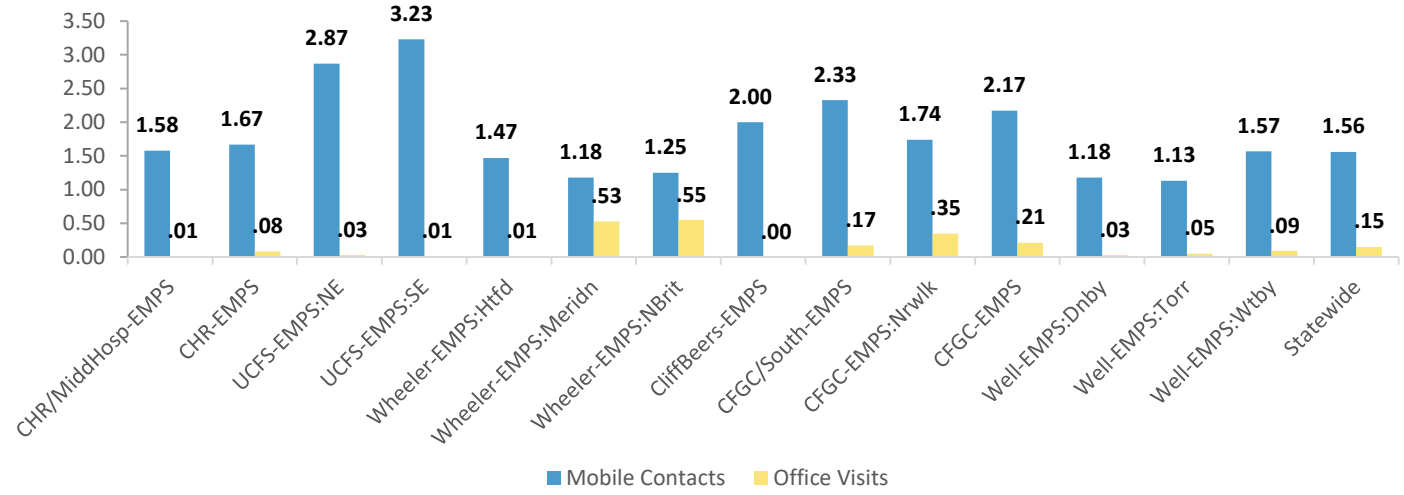
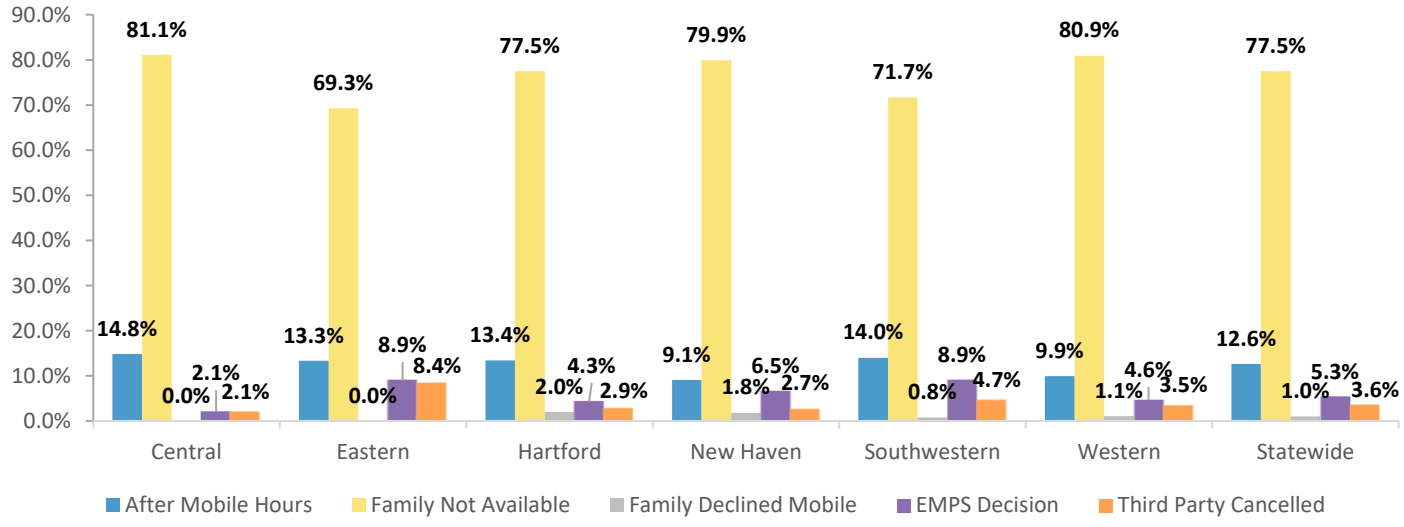


Figure 70. Mean Number of Mobile Contacts and Office Visits During an Episode of Care by Provider



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

Figure 71. Mobile Crisis Non-Mobile Reason by Service Area



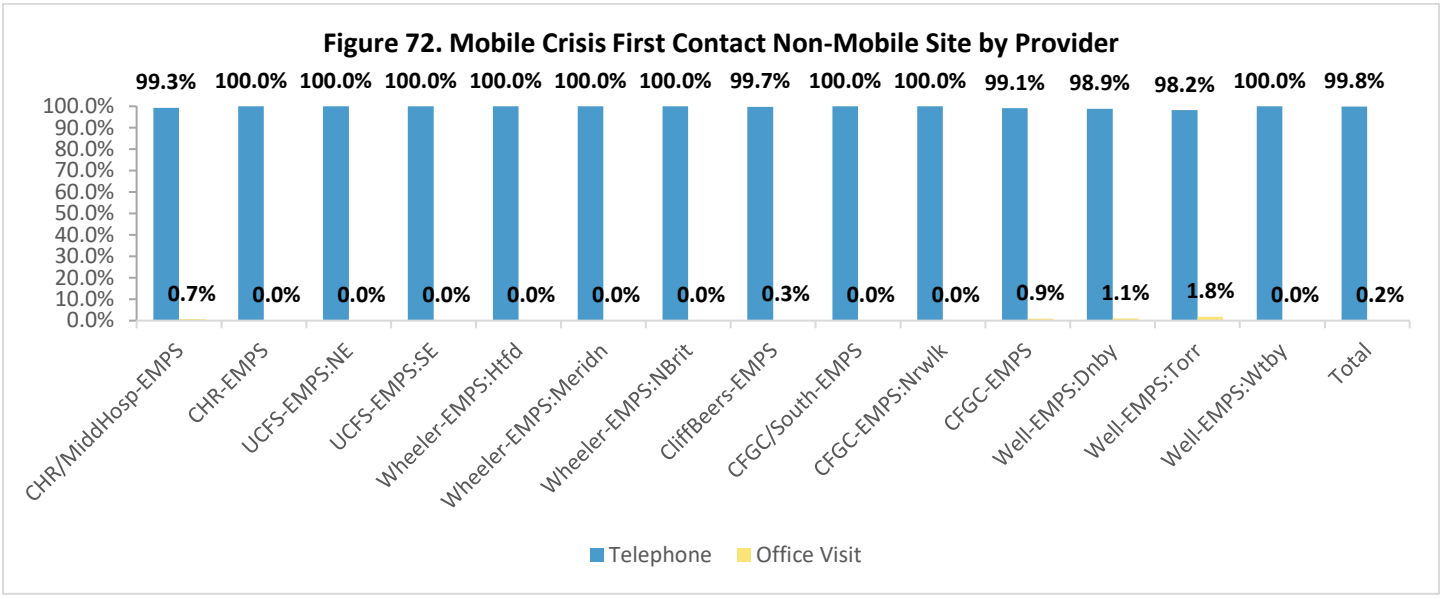
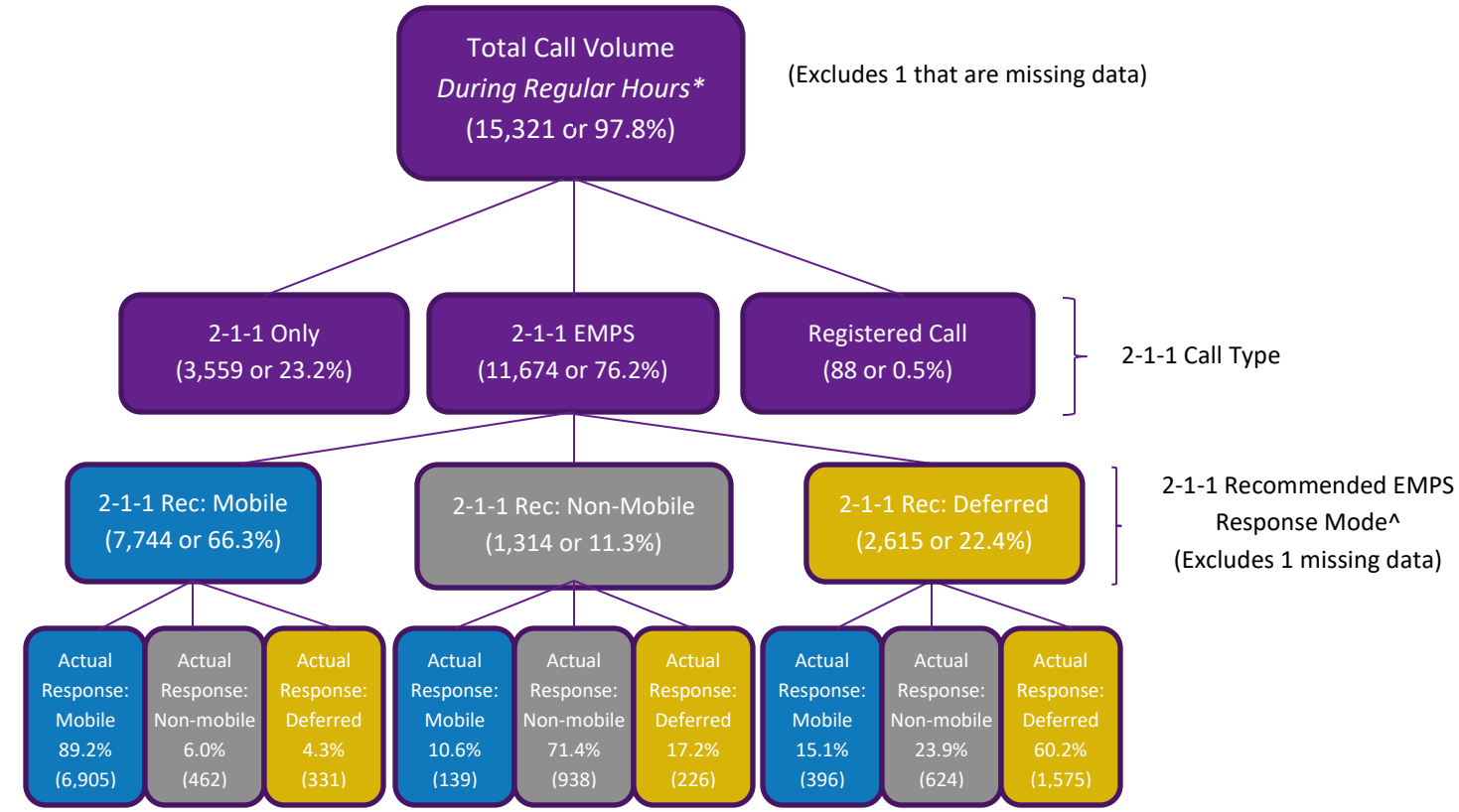


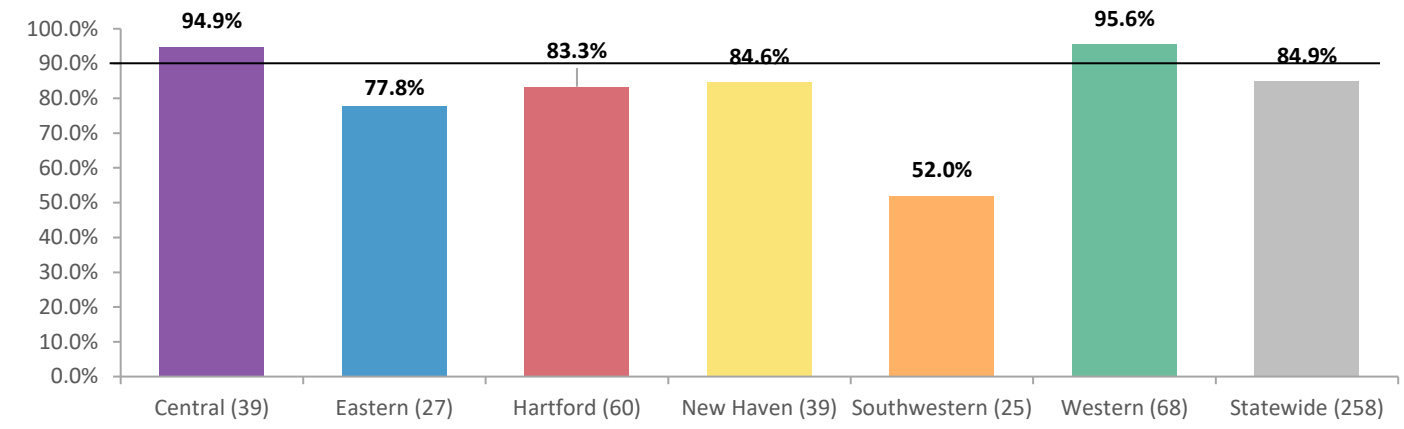
Figure 73. Breakdown of Call Volume by Call Type and Response Mode*^



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

^This figure does not include episodes initiated during the expanded hours that began in January.

Figure 74. Calls During Expanded Hours - Mobile Response by Provider



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

Goal = 90%

Figure 75. Calls During Expanded Hours - 2-1-1 Recommended Initial Response

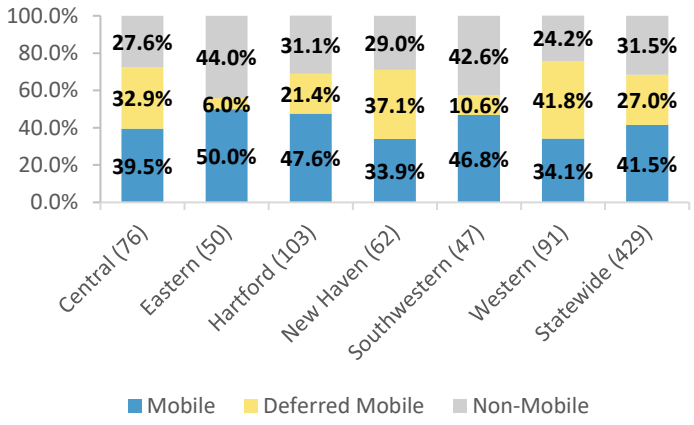


Figure 76. Calls During Expanded Hours - Actual Initial Mobile Crisis Provider Response

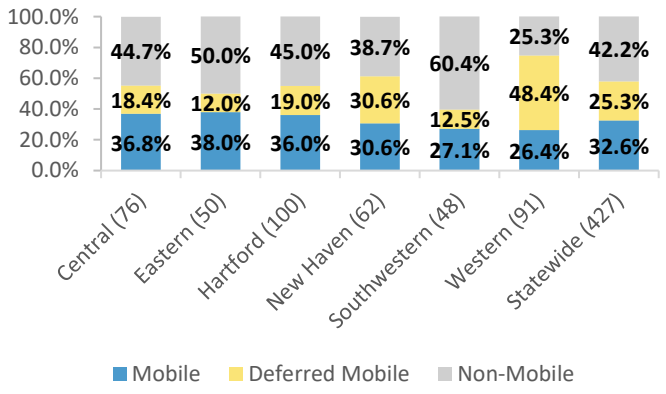


Table 3. Calls During Expanded Hours – Assessment Type by Response Mode

	Crisis Response: Phone Only	Crisis Response: Face-to-Face	Crisis Response Plus Stabilization Follow-Up	Telehealth	Face to Face: Consultation Only	
Mobile	11	66	56	1	5	**139**
Non-Mobile	180	0	0	0	0	**180**
Deferred Mobile	1	41	59	1	6	**108**
	192	**107**	**115**	**2**	**11**	**427**

Section VIII: Response Time

Figure 77. Statewide 45 Minute Response Rate Over Time

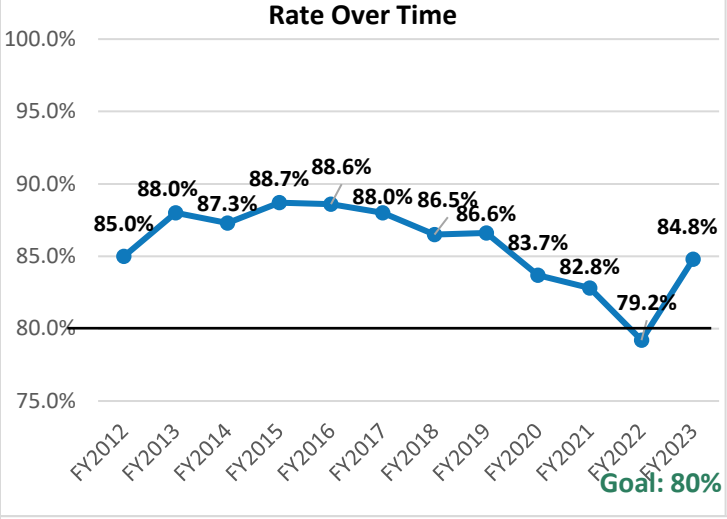
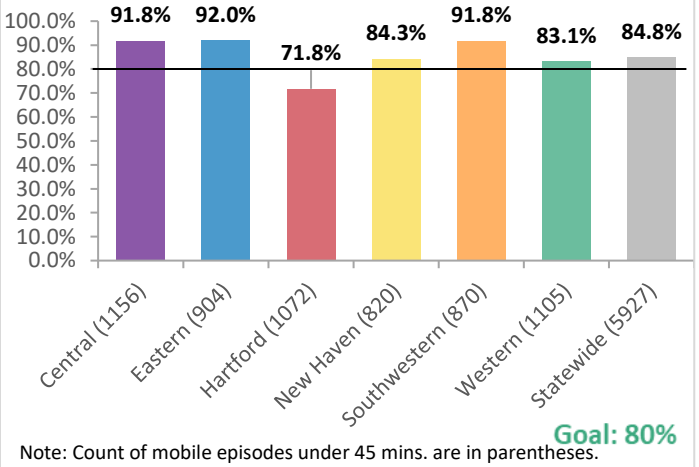
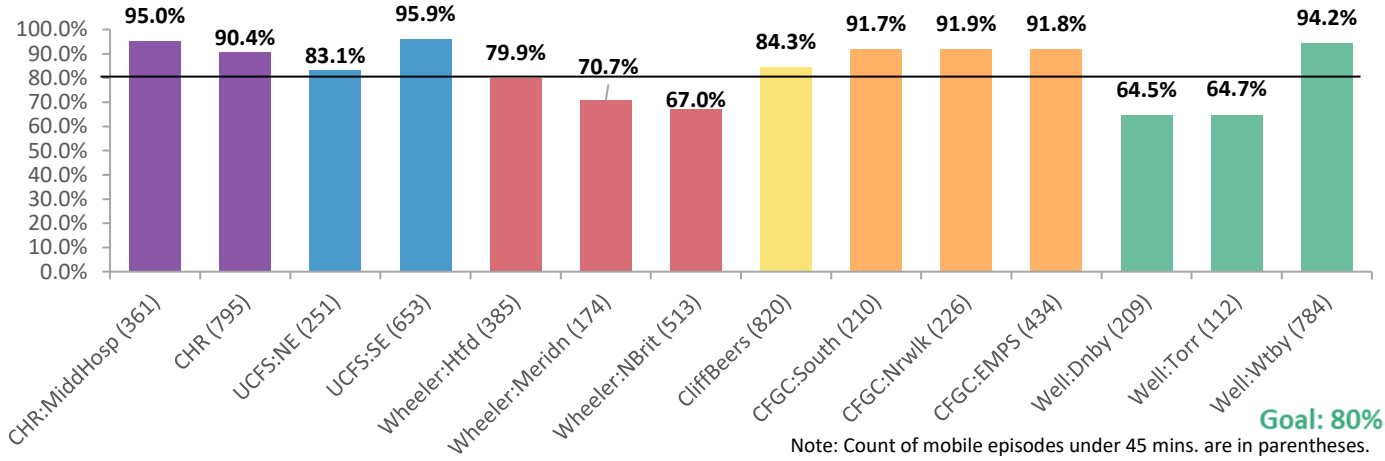


Figure 78. Total Mobile Episodes with a Reponse Time Under 45 Minutes



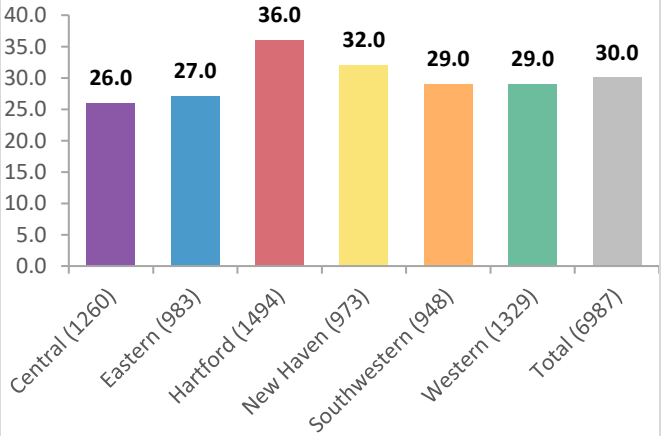
Note: Count of mobile episodes under 45 mins. are in parentheses.

Figure 79. Total Mobile Episodes with a Response Time Under 45 Minutes by Provider



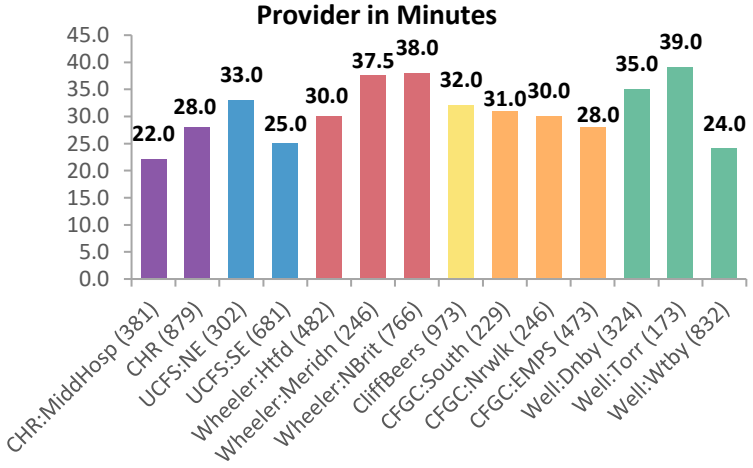
Note: Count of mobile episodes under 45 mins. are in parentheses.

Figure 80. Median Mobile Response Time by Service Area in Minutes



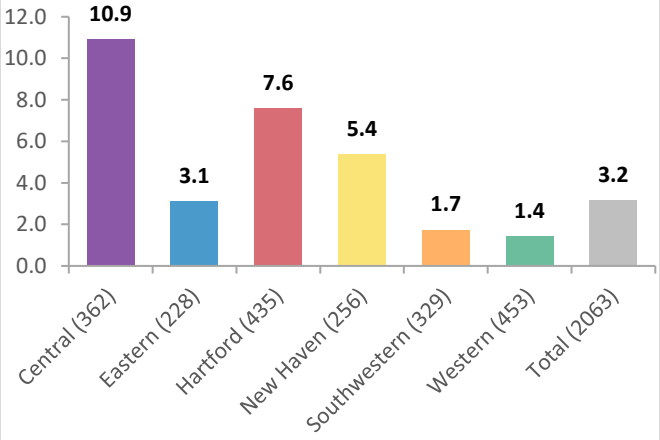
Note: Count of mobile episodes are in parentheses.

Figure 81. Median Mobile Response Time by Provider in Minutes



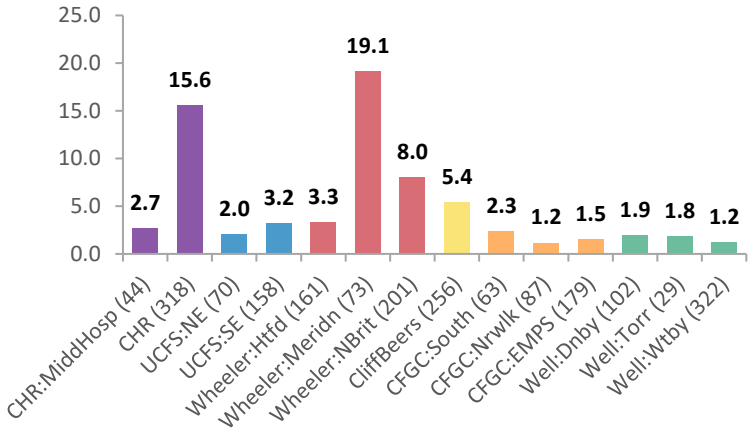
Note: Count of mobile episodes are in parentheses.

Figure 82. Median Deferred Mobile Response Time by Provider in Hours



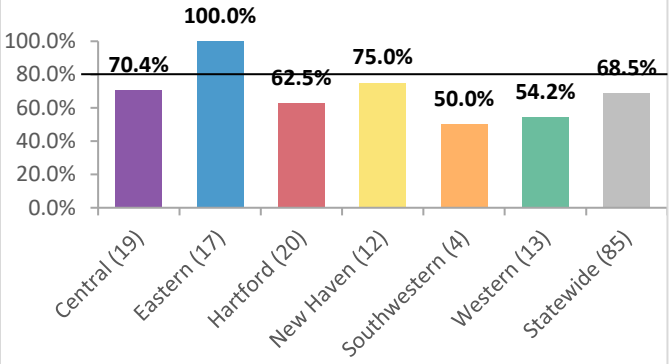
Note: Count of mobile episodes are in parentheses.

Figure 83. Median Deferred Mobile Response Time by Provider in Hours



Note: Count of mobile episodes are in parentheses.

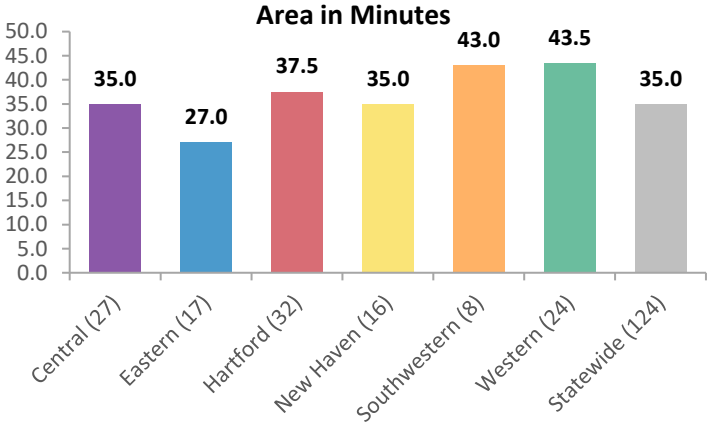
Figure 84. Calls During Expanded Hours - Total Mobile Episodes with a Reponse Time Under 45 Minutes



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

Goal = 80%

Figure 85. Calls During Expanded Hours - Median Mobile Response Time by Service Area in Minutes



Note: Count of mobile episodes are in parentheses.

Section IX: Length of Stay and Discharge Information

Table 4. Length of Stay for Discharged Episodes of Care in Days

		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
		Discharged Episodes for Current Reporting Period									*n of Discharged Episodes for FY2022*					
		Mean			Median			Percent			n used Mean/Median			n used for Percent		
		LOS: Phone	LOS: FTF	LOS: Stab.	LOS: Phone	LOS: FTF	LOS: Stab.	Phone > 1	FTF > 5	Stab. > 45	LOS: Phone	LOS: FTF	LOS: Stab.	LOS: Phone	LOS: FTF	LOS: Stab.
1	**STATEWIDE**	**1.6**	**13.9**	**18.5**	**0.0**	**5.0**	**15.0**	**20.6%**	**45.3%**	**3.3%**	**2480**	**4674**	**4329**	**510**	**2118**	**145**
2	**Central**	**2.5**	**5.6**	**17.9**	**0.0**	**3.0**	**14.0**	**36.5%**	**29.5%**	**4.5%**	**449**	**217**	**1435**	**164**	**64**	**64**
3	**CHR/MiddHosp-EMPS**	**5.6**	**5.8**	**14.5**	**3.0**	**3.0**	**12.0**	**65.0%**	**30.9%**	**0.4%**	**157**	**204**	**249**	**102**	**63**	**1**
4	**CHR-EMPS**	**0.8**	**2.4**	**18.6**	**0.0**	**0.0**	**15.0**	**21.2%**	**7.7%**	**5.3%**	**292**	**13**	**1186**	**62**	**1**	**63**
5	**Eastern**	**0.6**	**4.0**	**26.1**	**0.0**	**4.0**	**25.0**	**10.3%**	**11.4%**	**4.4%**	**330**	**1043**	**136**	**34**	**119**	**6**
6	**UCFS-EMPS:NE**	**0.7**	**3.8**	**24.1**	**0.0**	**4.0**	**21.0**	**10.2%**	**8.7%**	**4.9%**	**128**	**310**	**41**	**13**	**27**	**2**
7	**UCFS-EMPS:SE**	**0.5**	**4.0**	**27.0**	**0.0**	**4.0**	**27.0**	**10.4%**	**12.6%**	**4.2%**	**202**	**733**	**95**	**21**	**92**	**4**
8	**Hartford**	**2.2**	**8.4**	**19.2**	**0.0**	**4.0**	**16.0**	**29.0%**	**43.0%**	**2.1%**	**732**	**977**	**1160**	**212**	**420**	**24**
9	**Wheeler-EMPS:Htfd**	**2.0**	**10.5**	**25.2**	**0.0**	**5.0**	**25.0**	**25.5%**	**46.1%**	**2.3%**	**247**	**295**	**438**	**63**	**136**	**10**
10	**Wheeler-EMPS:Meridn**	**4.1**	**8.3**	**15.4**	**1.0**	**5.0**	**12.0**	**41.7%**	**47.6%**	**1.7%**	**115**	**166**	**175**	**48**	**79**	**3**
11	**Wheeler-EMPS:NBrit**	**1.8**	**7.2**	**15.7**	**0.0**	**4.0**	**13.0**	**27.3%**	**39.7%**	**2.0%**	**370**	**516**	**547**	**101**	**205**	**11**
12	**New Haven**	**0.5**	**27.5**	**26.2**	**0.0**	**17.0**	**25.0**	**3.2%**	**77.0%**	**10.9%**	**344**	**1097**	**55**	**11**	**845**	**6**
13	**CliffBeers-EMPS**	**0.5**	**27.5**	**26.2**	**0.0**	**17.0**	**25.0**	**3.2%**	**77.0%**	**10.9%**	**344**	**1097**	**55**	**11**	**845**	**6**
14	**Southwestern**	**0.7**	**19.5**	**35.6**	**0.0**	**12.0**	**35.0**	**6.0%**	**63.1%**	**19.0%**	**283**	**1042**	**163**	**17**	**657**	**31**
15	**CFGC/South-EMPS**	**0.1**	**2.0**	**28.9**	**0.0**	**0.0**	**34.0**	**2.1%**	**5.6%**	**0.0%**	**97**	**198**	**88**	**2**	**11**	**0**
16	**CFGC-EMPS:Nrwlk**	**0.9**	**20.7**	**47.5**	**0.0**	**15.0**	**42.0**	**6.2%**	**73.6%**	**47.8%**	**65**	**288**	**23**	**4**	**212**	**11**
17	**CFGC-EMPS**	**1.1**	**25.0**	**41.6**	**0.0**	**20.5**	**38.5**	**9.1%**	**78.1%**	**38.5%**	**121**	**556**	**52**	**11**	**434**	**20**
18	**Western**	**1.8**	**2.5**	**15.4**	**0.0**	**2.0**	**14.0**	**21.1%**	**4.4%**	**1.0%**	**342**	**298**	**1380**	**72**	**13**	**14**
19	**Well-EMPS:Dnby**	**1.9**	**2.5**	**15.2**	**0.0**	**2.0**	**13.0**	**20.4%**	**1.6%**	**0.6%**	**108**	**64**	**333**	**22**	**1**	**2**
20	**Well-EMPS:Torr**	**2.1**	**2.4**	**15.1**	**0.0**	**1.0**	**14.0**	**22.6%**	**9.3%**	**0.7%**	**62**	**43**	**138**	**14**	**4**	**1**
21	**Well-EMPS:Wtby**	**1.7**	**2.5**	**15.5**	**0.0**	**2.0**	**14.0**	**20.9%**	**4.2%**	**1.2%**	**172**	**191**	**909**	**36**	**8**	**11**

* Discharged episodes, as of June 30, 2022, with end dates from July 1, 2021 to June 30, 2022.

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

Definitions:

LOS: Phone	Length of Stay in Days for Phone Only
LOS: FTF	Length of Stay in Days for Face To Face Only
LOS: Stab.	Length of Stay in Days for Stabilization Plus Follow-up Only
Phone > 1	Percent of episodes that are phone only that are greater than 1 day
FTF > 5	Percent of episodes that are face to face that are greater than 5 days
Stab. > 45	Percent of episodes that are stabilization plus follow-up that are greater than 45 days

Table 5. Length of Stay for Open Episodes of Care in Days

		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
		Episodes Still in Care*									***N of Episodes Still in Care****					
		Mean			Median			Percent			n used Mean/Median			n used for Percent		
		LOS: Phone	LOS: FTF	LOS: Stab.	LOS: Phone	LOS: FTF	LOS: Stab.	Phone > 1	FTF > 5	Stab. > 45	LOS: Phone	LOS: FTF	LOS: Stab.	Phone > 1	FTF > 5	Stab. > 45
1	**STATEWIDE**	**123.5**	**105.8**	**84.1**	**109.0**	**67.0**	**34.0**	**100.0%**	**100.0%**	**50.3%**	**81**	**193**	**153**	**81**	**193**	**77**
2	**Central**	**100.0**	**98.2**	**109.8**	**86.0**	**64.0**	**36.0**	**100.0%**	**100.0%**	**52.7%**	**21**	**10**	**55**	**21**	**10**	**29**
3	**CHR/MiddHosp-EMPS**	**2.0**	**0.0**	**1.0**	**2.0**	**0.0**	**1.0**	**100.0%**	**N/A**	**0.0%**	**1**	**0**	**1**	**1**	**0**	**0**
4	**CHR-EMPS**	**105.0**	**98.2**	**111.8**	**87.5**	**64.0**	**37.0**	**100.0%**	**100.0%**	**53.7%**	**20**	**10**	**54**	**20**	**10**	**29**
5	**Eastern**	**0.0**	**4.0**	**18.4**	**0.0**	**4.0**	**16.0**	**N/A**	**100.0%**	**10.0%**	**0**	**2**	**10**	**0**	**2**	**1**
6	**UCFS-EMPS:NE**	**0.0**	**0.0**	**11.0**	**0.0**	**0.0**	**6.5**	**N/A**	**N/A**	**0.0%**	**0**	**0**	**4**	**0**	**0**	**0**
7	**UCFS-EMPS:SE**	**0.0**	**4.0**	**23.3**	**0.0**	**4.0**	**22.0**	**N/A**	**100.0%**	**16.7%**	**0**	**2**	**6**	**0**	**2**	**1**
8	**Hartford**	**168.4**	**133.2**	**116.7**	**170.0**	**119.0**	**99.5**	**100.0%**	**100.0%**	**69.6%**	**19**	**77**	**46**	**19**	**77**	**32**
9	**Wheeler-EMPS:Htfd**	**293.0**	**58.5**	**21.2**	**293.0**	**26.5**	**18.0**	**100.0%**	**100.0%**	**8.3%**	**2**	**16**	**12**	**2**	**16**	**1**
10	**Wheeler-EMPS:Meridn**	**138.7**	**156.1**	**172.8**	**140.5**	**139.5**	**177.0**	**100.0%**	**100.0%**	**100.0%**	**6**	**18**	**12**	**6**	**18**	**12**
11	**Wheeler-EMPS:NBrit**	**161.9**	**151.4**	**138.1**	**156.0**	**135.0**	**151.0**	**100.0%**	**100.0%**	**86.4%**	**11**	**43**	**22**	**11**	**43**	**19**
12	**New Haven**	**140.0**	**105.0**	**44.3**	**126.0**	**58.5**	**48.0**	**100.0%**	**100.0%**	**83.3%**	**21**	**60**	**6**	**21**	**60**	**5**
13	**CliffBeers-EMPS**	**140.0**	**105.0**	**44.3**	**126.0**	**58.5**	**48.0**	**100.0%**	**100.0%**	**83.3%**	**21**	**60**	**6**	**21**	**60**	**5**
14	**Southwestern**	**75.7**	**64.6**	**33.0**	**47.0**	**39.0**	**30.0**	**100.0%**	**100.0%**	**35.7%**	**3**	**43**	**14**	**3**	**43**	**5**
15	**CFGC/South-EMPS**	**45.5**	**6.0**	**16.2**	**45.5**	**6.0**	**15.0**	**100.0%**	**100.0%**	**0.0%**	**2**	**2**	**5**	**2**	**2**	**0**
16	**CFGC-EMPS:Nrwlk**	**136.0**	**51.8**	**70.5**	**136.0**	**54.0**	**70.5**	**100.0%**	**100.0%**	**100.0%**	**1**	**12**	**2**	**1**	**12**	**2**
17	**CFGC-EMPS**	**0.0**	**74.0**	**34.3**	**0.0**	**36.0**	**31.0**	**N/A**	**100.0%**	**42.9%**	**0**	**29**	**7**	**0**	**29**	**3**
18	**Western**	**90.6**	**92.0**	**24.8**	**89.0**	**92.0**	**12.5**	**100.0%**	**100.0%**	**22.7%**	**17**	**1**	**22**	**17**	**1**	**5**
19	**Well-EMPS:Dnby**	**85.4**	**0.0**	**27.5**	**71.0**	**0.0**	**27.5**	**100.0%**	**N/A**	**50.0%**	**7**	**0**	**2**	**7**	**0**	**1**
20	**Well-EMPS:Torr**	**90.3**	**0.0**	**1.0**	**101.0**	**0.0**	**1.0**	**100.0%**	**N/A**	**0.0%**	**4**	**0**	**1**	**4**	**0**	**0**
21	**Well-EMPS:Wtby**	**96.8**	**92.0**	**25.7**	**100.0**	**92.0**	**11.0**	**100.0%**	**100.0%**	**21.1%**	**6**	**1**	**19**	**6**	**1**	**4**

* Data includes episodes still in care, as of June 30, 2023, with referral dates from July 1, 2022 to June 30, 2023.

Definitions:

LOS: Phone	Length of Stay in Days for Phone Only
LOS: FTF	Length of Stay in Days for Face To Face Only
LOS: Stab.	Length of Stay in Days for Stabilization Plus Follow-up Only
Phone > 1	Percent of episodes that are phone only that are greater than 1 day
FTF > 5	Percent of episodes that are face to face that are greater than 5 days
Stab. > 45	Percent of episodes that are stabilization plus follow-up that are greater than 45 days

Figure 86. Top Six Reasons for Client Discharge Statewide

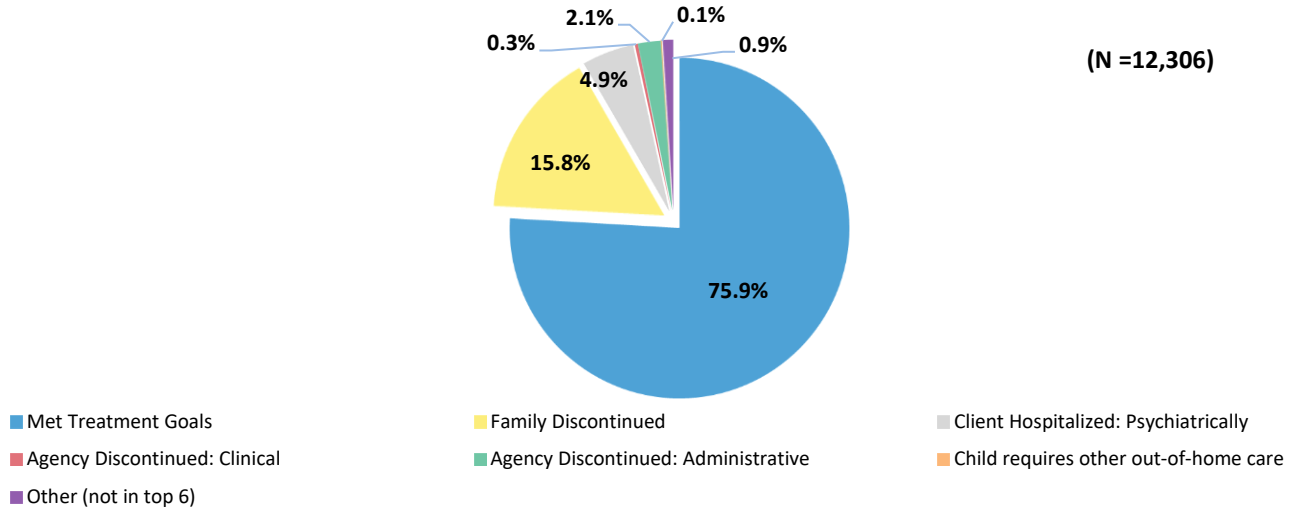


Figure 87. Top Six Places Clients Live at Discharge Statewide

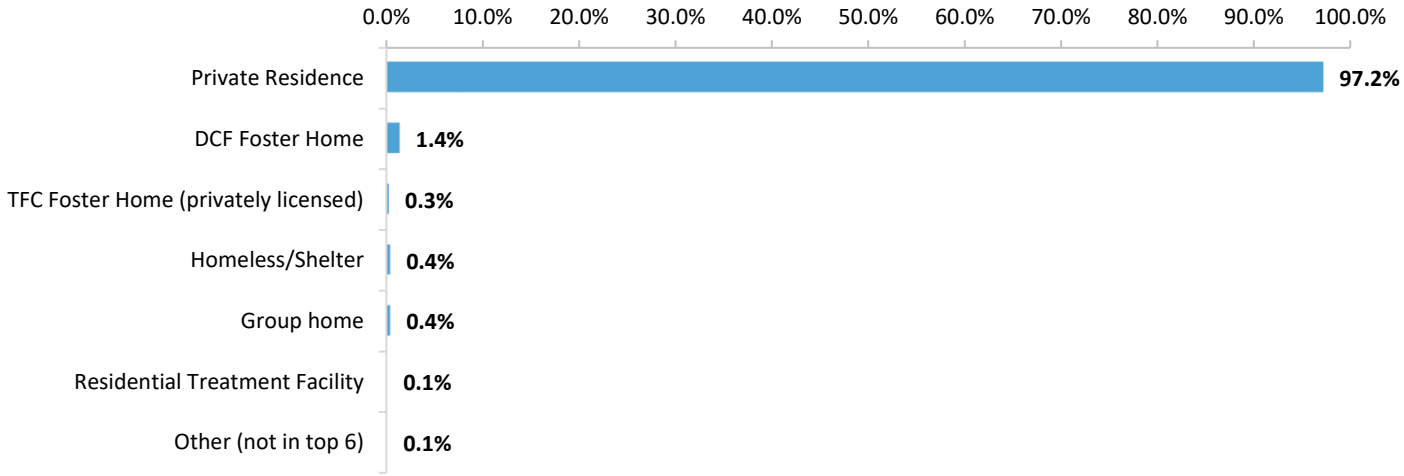
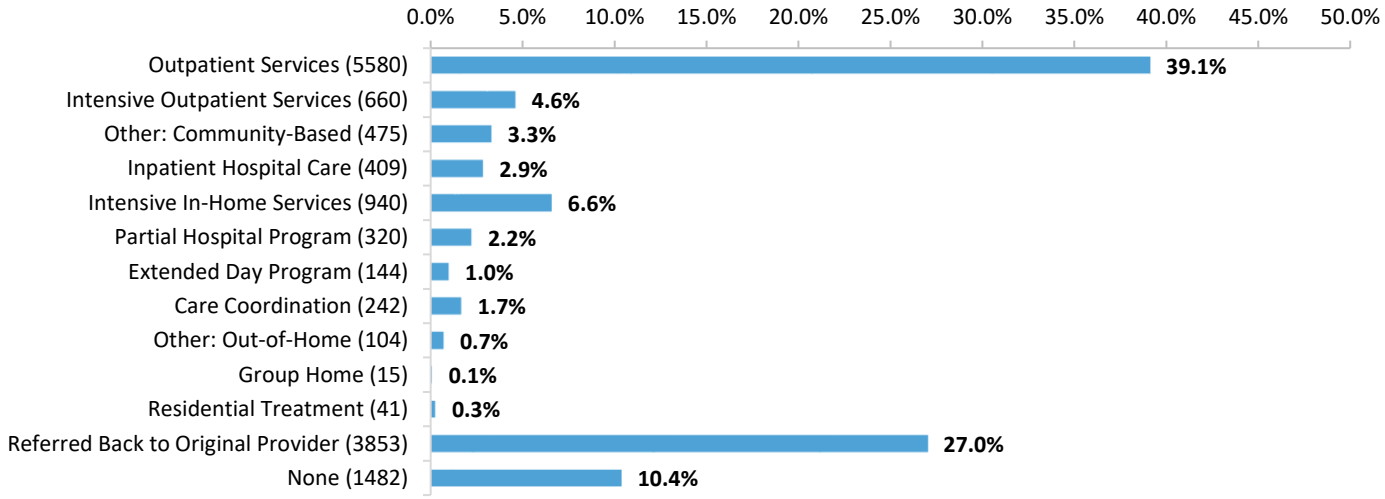


Figure 88. Type of Services Client Referred* to at Discharge Statewide



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

Table 6. Ohio Scales Scores by Service Area

Service Area	*n (paired† intake & discharge)*	*Mean (paired† intake)*	*Mean (paired† discharge)*	*Mean Difference (paired† cases)*	*t-score*	*Sig.*	*† .05-.10 * P < .05 **P < .01*
STATEWIDE							
Parent Functioning Score	421	42.00	43.85	1.85	4.62	<.001	**
Worker Functioning Score	3178	44.85	47.21	2.36	20.87	<.001	**
Parent Problem Score	424	29.51	27.66	-1.85	-3.95	<.001	**
Worker Problem Score	3177	28.26	25.22	-3.04	-24.77	<.001	**
Central							
Parent Functioning Score	44	39.66	47.02	7.36	4.74	<.001	**
Worker Functioning Score	1271	43.55	47.63	4.08	25.66	<.001	**
Parent Problem Score	44	32.77	26.82	-5.96	-3.56	<.001	**
Worker Problem Score	1271	28.08	23.46	-4.62	-28.60	<.001	**
Eastern							
Parent Functioning Score	32	48.53	51.91	3.38	1.90	0.067	†
Worker Functioning Score	90	41.77	44.84	3.08	3.34	0.001	**
Parent Problem Score	34	25.97	20.59	-5.38	-2.29	0.029	*
Worker Problem Score	90	34.83	29.46	-5.38	-4.79	<.001	**
Hartford							
Parent Functioning Score	232	39.90	40.75	0.85	2.29	0.023	*
Worker Functioning Score	965	46.90	47.64	0.73	4.33	<.001	**
Parent Problem Score	232	30.90	30.35	-0.55	-1.50	0.134	
Worker Problem Score	965	25.98	25.07	-0.91	-5.26	<.001	**
New Haven							
Parent Functioning Score	10	48.20	48.20	0.00	0.00	N/A	
Worker Functioning Score	34	46.24	47.32	1.09	1.89	0.067	†
Parent Problem Score	10	25.55	25.55	0.00	0.00	N/A	
Worker Problem Score	34	25.62	25.15	-0.47	-1.21	0.233	
Southwestern							
Parent Functioning Score	69	46.93	47.06	0.13	0.12	0.909	
Worker Functioning Score	132	45.70	46.64	0.95	1.69	0.094	†
Parent Problem Score	69	27.29	24.96	-2.33	-1.32	0.191	
Worker Problem Score	132	26.82	24.16	-2.66	-3.50	<.001	**
Western							
Parent Functioning Score	34	41.41	45.59	4.18	1.94	0.061	†
Worker Functioning Score	686	44.52	46.22	1.70	5.68	<.001	**
Parent Problem Score	34	25.09	23.59	-1.50	-0.75	0.457	
Worker Problem Score	685	31.34	28.34	-3.00	-8.89	<.001	**

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

Section X: Client & Referral Source Satisfaction

Table 7. Client and Referrer Satisfaction for 211 and Mobile Crisis*

211 Items	Q1 FY2023 Clients (n=81)	Q2 FY2023 Clients (n=73)	Q3 FY2023 Clients (n=85)	Q4 FY2023 Clients (n=73)	Q1 FY2023 Referrers (n=63)	Q2 FY2023 Referrers (n=66)	Q3 FY2023 Referrers (n=91)	Q4 FY2023 Referrers (n=63)
The 211 staff answered my call in a timely manner	4.48	4.89	4.84	4.91	4.53	4.94	4.97	4.95
The 211 staff was courteous	4.95	4.97	4.93	5.00	4.69	5.00	5.00	5.00
The 211 staff was knowledgeable	4.82	4.92	4.96	4.89	4.61	4.97	5.00	5.00
My phone call was quickly transferred to the Mobile Crisis provider	4.36	4.78	4.87	4.89	3.87	4.86	4.97	4.90
Sub-Total Mean: 211	**4.66**	**4.89**	**4.90**	**4.92**	**4.43**	**4.94**	**4.98**	**4.96**
Mobile Crisis Items								
Mobile Crisis responded to the crisis in a timely manner	4.42	4.83	4.81	4.82	3.85	4.74	4.61	4.95
The Mobile Crisis staff was respectful	4.89	5.00	4.81	4.83	4.58	4.88	4.97	4.97
The Mobile Crisis staff was knowledgeable	4.79	4.95	4.70	4.83	4.58	4.88	4.98	4.97
The Mobile Crisis staff spoke to me in a way that I understood	4.89	4.97	4.80	4.88	X	X	X	X
Mobile Crisis helped my child/family get the services needed or made contact with my current service provider (if you had one at the time you called Mobile Crisis)	4.45	4.51	4.44	4.45	X	X	X	X
The services or resources my child and/or family received were right for us	4.26	4.29	4.30	4.29	X	X	X	X
The child/family I referred to Mobile Crisis was connected with appropriate services or resources upon discharge from Mobile Crisis	X	X	X	X	3.61	4.49	4.71	4.69
Overall, I am very satisfied with the way that Mobile Crisis responded to the crisis	4.50	4.62	4.47	4.60	4.40	4.85	4.84	4.53
Sub-Total Mean: Mobile Crisis	**4.60**	**4.74**	**4.62**	**4.67**	**4.21**	**4.77**	**4.82**	**4.82**
Overall Mean Score	**4.62**	**4.79**	**4.72**	**4.76**	**4.39**	**4.89**	**4.92**	**4.91**

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

Client Comments:

- Everyone at mobile crisis was very helpful and thankful for getting an interpreter for her call.
- Caller was very impressed with 211 and the clinician who responded. Caller reports that she felt very cared for and wouldn't hesitate to use 211 Youth Mobile Crisis again.
- Caller reports that she feels all the demographic questions during the intake process are unnecessary. Caller states that there are too many questions to answer before being transferred to a clinician.
- Caller reports the wait on the EMPS line was longer than usual, but caller felt informed as the line updated her on call representative status. Caller reports there is no judgement with clinicians.
- Caller expressed her gratitude for the service.
- Clinician was very genuinely compassionate.

Referrer Comments:

- Caller reports the service is good, but it takes too long to speak to someone from 211.
- Caller reports that she is aware of a few occasions on deferred cases in which MCI did not follow up with the family and would like to know how to track those cases.
- Caller stated too long of a wait for children to get an individual therapist although caller states this feedback is unrelated to the services MCI provides.
- Very appreciative of the services. Caller reports that MCI was instrumental in supporting/ comforting children on a difficult family visit.
- Caller reports that in the past she has had to wait a very long time to get through to 211/MCI but the process was much quicker/expedient this time.

Figure 89. Parent/Guardian Satisfaction with the Mental Health Services their Child Received by Service Area

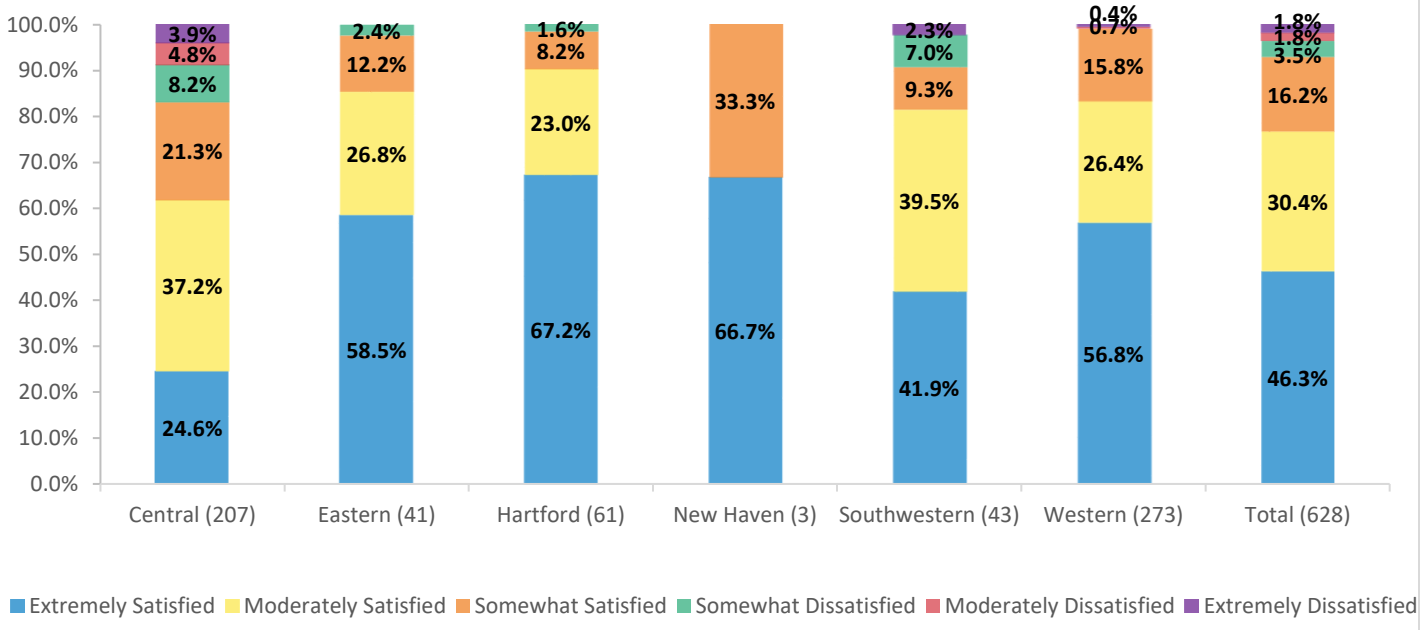
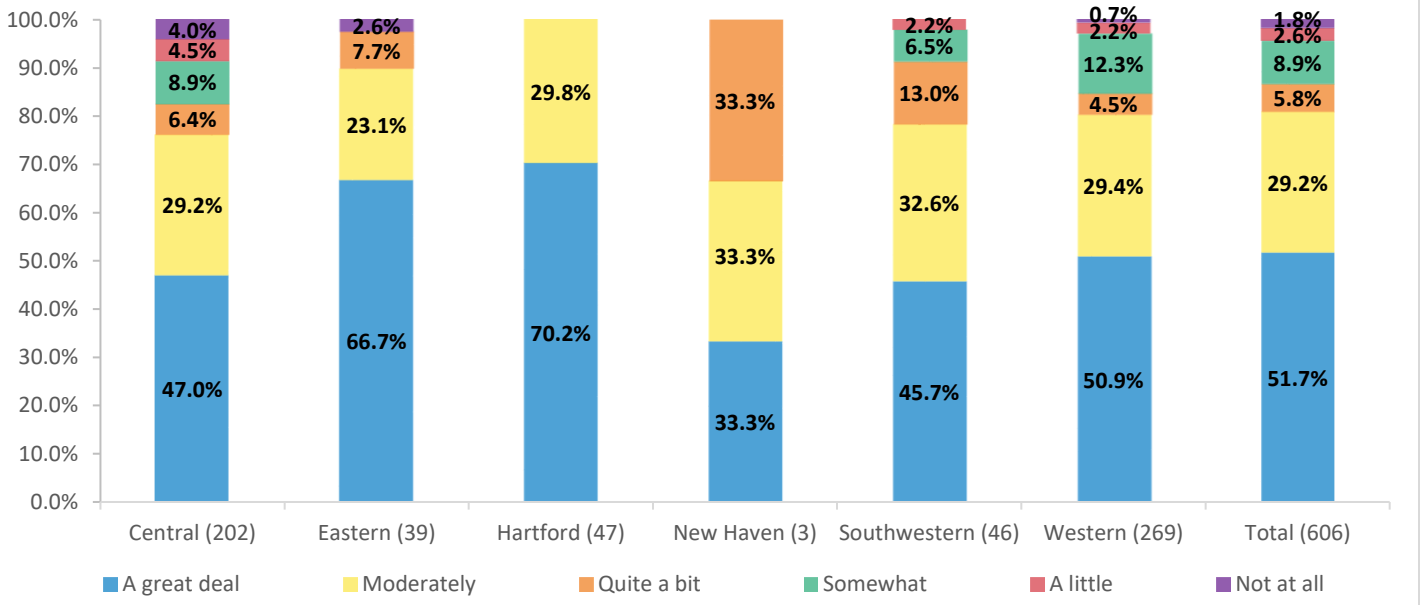


Figure 90. Parent/Guardian Rating of the Extent to Which the Child's Treatment Plan Included their Ideas about their Child's Treatment Needs by Service Area



Section XI: Training Attendance

Table 8. Trainings Completed for All Active Staff*

	DBHRN	Crisis API	DDS	CCSRS	Trauma	Violence	CRC	Emerg. Certificate	QPR	A-SBIRT	ASD	PSB	SR	All 13 Trainings Completed	All 13 Completed for Full-Time Staff Only
Statewide (209)*	29%	44%	30%	28%	42%	32%	36%	36%	16%	22%	38%	29%	35%	4%	6%
CHR:MiddHosp (14)*	36%	57%	29%	79%	50%	43%	43%	50%	79%	29%	57%	21%	29%	7%	17%
CHR (27)*	15%	33%	19%	19%	22%	30%	33%	22%	4%	4%	26%	22%	30%	0%	0%
UCFS:NE (6)*	67%	67%	83%	83%	83%	50%	83%	83%	67%	83%	50%	50%	67%	33%	40%
UCFS:SE (22)*	36%	68%	36%	91%	55%	27%	32%	41%	23%	82%	36%	45%	50%	5%	9%
Wheeler:Htfd (23)*^	35%	52%	39%	4%	48%	26%	39%	35%	9%	4%	39%	30%	13%	0%	0%
Wheeler:Meridn (3)*	33%	33%	33%	33%	33%	33%	33%	33%	0%	0%	33%	33%	33%	0%	0%
Wheeler:NBrit (17)*	24%	24%	24%	6%	29%	24%	18%	24%	0%	6%	29%	0%	29%	0%	0%
CliffBeers (23)*	35%	43%	39%	48%	65%	52%	52%	52%	39%	43%	65%	39%	65%	17%	14%
CFGC:South (4)*	75%	75%	50%	25%	75%	25%	50%	50%	0%	25%	25%	100%	50%	0%	0%
CFGC:Nrwlk (1)*	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
CFGC:EMPS (21)*^	29%	38%	24%	10%	38%	38%	52%	33%	0%	10%	43%	38%	43%	0%	0%
Well:Dnby (11)*^	18%	27%	9%	0%	27%	18%	18%	27%	0%	0%	27%	9%	18%	0%	0%
Well:Torr (3)*	33%	67%	33%	33%	67%	33%	33%	67%	33%	33%	67%	0%	0%	0%	0%
Well:Wtby (23)*^	18%	39%	24%	0%	27%	24%	24%	27%	0%	3%	24%	15%	30%	0%	0%
Full-Time Staff Only (117)	34%	54%	39%	33%	52%	41%	53%	46%	21%	28%	50%	38%	49%	6%	

* Count of active staff for each provider or category is in parentheses. Includes all full-time, part-time and per diem staff employed by the provider as of 6/30/23.
^Includes staff without assigned location or working across multiple sites.

Training Title Abbreviations

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

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

Section XII: Ohio Scales Completion

Figure 91. Ohio Scales Collected at Intake by Provider

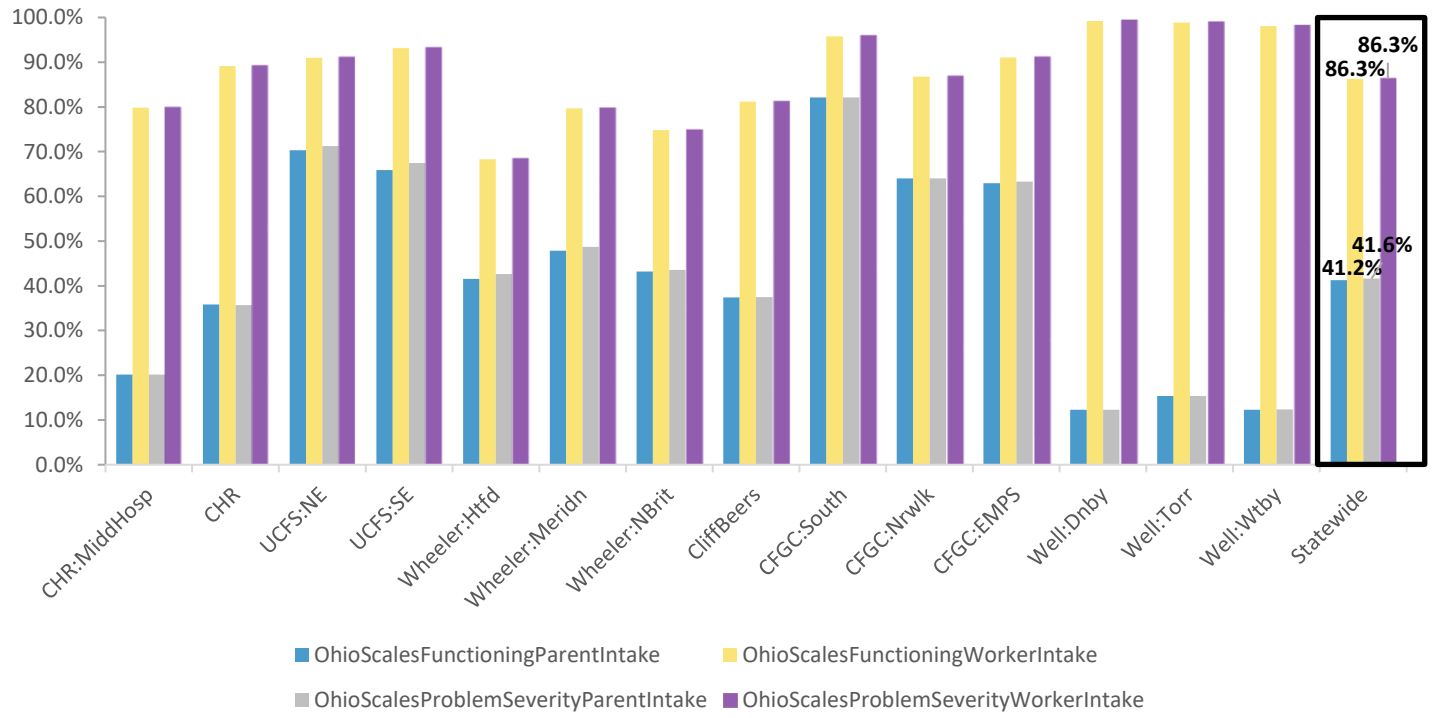
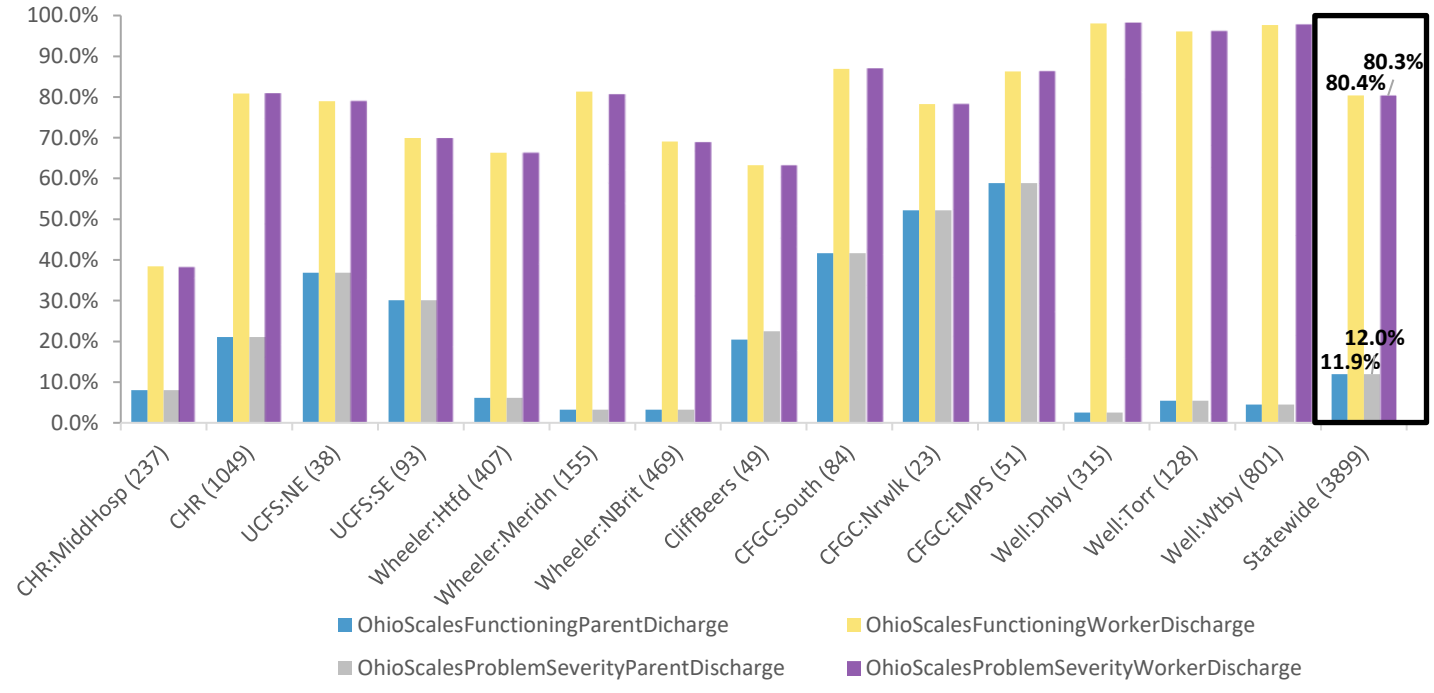


Figure 92. Ohio Scales Collected at Discharge by Provider



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

Section XIII: Provider Community Outreach

Table 9. Number of Times Providers Conducted Formal* Outreach to the Community

Provider	Q1 FY22	Q2 FY22	Q3 FY22	Q4 FY22	Total
CENTRAL	**4**	**2**	**7**	**3**	**16**
CHR/MiddHosp-EMPS	1	2	3	2	8
CHR-EMPS	3	0	4	1	8
EASTERN	**4**	**2**	**12**	**13**	**31**
UCFS-EMPS:NE	2	1	6	1	10
UCFS-EMPS:SE	2	1	6	12	21
HARTFORD	**1**	**2**	**5**	**2**	**10**
Wheeler-EMPS:Htfd	1	0	1	2	4
Wheeler-EMPS:Meridn	0	0	0	0	0
Wheeler-EMPS:NBrit	0	2	4	0	6
NEW HAVEN	**6**	**5**	**5**	**2**	**18**
CliffBeers-EMPS	6	5	5	2	18
SOUTHWESTERN	**11**	**8**	**8**	**5**	**32**
CFGC/South-EMPS	8	5	3	3	19
CFGC-EMPS:Nrwlk	0	0	0	0	0
CFGC-EMPS Bridgeport	3	3	5	2	13
WESTERN	**10**	**1**	**2**	**5**	**18**
Well-EMPS:Dnby	4	0	1	3	8
Well-EMPS:Torr	0	0	0	1	1
Well-EMPS:Wtby	6	1	1	1	9
Statewide	**34**	**20**	**41**	**30**	**125**

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

Appendices

Appendix A: Description of Calculations

Section II: Primary Mobile Crisis Performance Indicators and Monthly Trends

- Figures 1 and 2 tabulate the total number of calls by 211-Only, 211-EMPS, or Registered Calls. Figure 1 breaks down call volume according to old and new hours. "Old hours" includes calls that came in anytime between July and December of 2022, and calls that came in during traditional mobile hours (6 a.m. – 10 p.m. Monday through Friday, 1 p.m. – 10 p.m. on weekends) after the expansion in January 2023. "New hours" represents calls that occurred during the expanded hours of 10 p.m. – 6 a.m. during the week and 10 p.m. – 1 p.m. on weekends.
- Figures 3 and 4 calculate the total number of Mobile Crisis episodes, including After Hours calls for the designated service area. Mobile Crisis previously operated between 6:00 a.m. and 10:00 p.m. Monday through Friday, and 1:00 p.m. to 10:00 p.m. on weekends and holidays. Calls that were placed outside of these times were considered "After Hours calls". Due to the expansion of mobile hours in January 2023, any "after hours calls" reported would have taken place between July and December of 2022. Figure 3 also notes the number of Crisis-Response Follow-up calls that did not result in episodes but were coded with a call type "211-EMPS" – these account for the discrepancy in episode count between Figures 1 and 3.
- Figures 5 and 6 show the number of children served by Mobile Crisis per 1,000 children. This is calculated by summing the total number of episodes for the specified service area multiplied by 1,000; this result is then divided by the total number of youth in that particular service area as reported by U.S. Census data.
- Figures 7 and 8 determine the number of children served by Mobile Crisis that are TANF eligible out of the total number of children in that service area that are eligible for free or reduced lunch[9].
- Figures 9 and 10 calculate a mobility rate by dividing the number of episodes that both received a mobile or deferred mobile response from a Mobile Crisis provider *and* were recommended by 2-1-1 for a mobile or deferred mobile response by the total number of episodes that were recommended to receive a mobile or deferred mobile response by 2-1-1. This calculation excludes calls that were referred by a third party (schools, EDs, etc.) where the family declined services or was not available.
- Figures 11 and 12 isolate the total number of episodes that were coded as having a mobile response and had a response time under 45 minutes divided by the total number of episodes that were coded as having a mobile response. Response time is calculated by subtracting the episode Call Date Time (time of the call to 2-1-1) from the First Contact Date Time (time Mobile Crisis arrived on site). The calculation then subtracts 10 minutes from the response time to account for the time it generally takes to complete the intake with 2-1-1 and transfer the call to a Mobile Crisis provider.

Section III: Episode Volume

- Figure 13 is a map showing the number of Mobile Crisis Episodes relative to the child population of each town. The total number of episodes in a town is multiplied by 1,000 and then divided by the child population. 211-Only calls are not assigned a town and thus excluded from this calculation. This map shows episodes that were initiated at any time, including those during the new hours post-expansion.
- Figure 14 tabulates the total number of calls by the "Call Type" categories of 211 Only, 211-EMPS, or Registered Calls. Calls categorized as "211-EMPS" or "Registered Calls" generally result in new episodes of care, whereas calls categorized as "211 Only" may be calls that resulted in follow up responses to already open episodes, transfers to 9-1-1, provision of information and referrals, etc. Figure 14 breaks down call volume according to old and new hours. "Old hours" includes calls that came in anytime between July and December of 2022, and calls that came in during traditional mobile hours (6 a.m. – 10 p.m. Monday through Friday, 1 p.m. – 10 p.m. on weekends) after the expansion in January 2023. "New hours" represents calls that occurred during the expanded hours of 10 p.m. – 6 a.m. during the week and 10 p.m. – 1 p.m. on weekends.
- Figure 15 shows the 2-1-1 disposition of all calls received.

[9] National Center for Education Statistics, 2016-2017 via PolicyMap

- Figure 16 displays the trend in call and episode volume since FY2011. This chart displays total call and episode volume, including those during the new hours post-expansion.
- Figure 17 shows the total Mobile Crisis response episodes, including After Hours calls by provider.
- Figure 18 show the number served per 1,000 children in the population by provider and uses the same calculation as Figure 5.
- Figure 19 is a stacked bar chart that represents the percent of episodes that have a crisis response of phone only, face-to-face, plus stabilization follow-up (episodes that required follow up care by Mobile Crisis in addition to the immediate crisis stabilization), telehealth, and consultation only. Each percentage is calculated by counting the number of episodes in the respective category (e.g., phone only) divided by the total number of episodes coded for crisis response for that specified service area.
- Figure 20 calculates the same percentage as Figure 19, but is shown by provider.
- Figure 21 shows the breakdown of 211 Only, 211-EMPS, and Registered Calls that took place during the expanded hours starting in January.
- Figure 22 provides the number of episodes for each service area that were initiated during the expanded hours starting in January.
- Table 1 breaks down calls by hour and day of week during the expanded hours, showing when the highest volume of calls is during these new hours.

Section IV: Demographics

- Figure 23 shows the percentage of male and female children served per the response provided to the intake question regarding sex assigned at birth.
- Figure 24 age groups reflect episode counts, and may include duplicate counts of children who were served for multiple episodes within the year.
- Figure 25 shows the percentage of episodes with children identified as Hispanic by their ethnic background. Figure 25 and 26 report data as collected which aligns with the categories used by the U.S. Census.
- Figure 26 breaks out the percentages of episodes by the races of children served.
- Figure 27 is calculated by taking the count of each type of health insurance reported at intake, dividing by the total number of responses.
- Figure 28 is calculated by taking the count of "yes" TANF responses across episodes by each provider, and dividing by the total number of TANF responses collected across episodes by provider.
- Figure 29 is calculated by taking the count of each DCF status category reported at intake, dividing by total count of responses collected.
- Figure 30 breaks out the percentages of episodes by the race and ethnicity of children served during the expanded hours starting in January.
- Figure 31 shows the percentage of male and female children served during the expanded hours per the response provided to the intake question regarding sex assigned at birth
- Figure 32 shows the percentage of children served by age for episodes initiated during the expanded hours. Age groups reflect episode counts, and may include duplicate counts of children who were served for multiple episodes within the year.

Section V: Diagnosis and Clinical Functioning

- Figure 33 shows the percentages for the top six primary presenting problems by service area. The top 6 presenting problems are Harm/Risk of Harm to Self, Disruptive Behavior, Depression, Family Conflict, Anxiety, and Harm/Risk of Harm to Others. Remaining presenting problems reported are combined into the category “other”. The count of each presenting problem is divided by the total reported.
- Figure 34 is calculated by taking the count of each primary diagnostic category reported at intake, dividing by total count collected.
- Figure 35 is calculated by taking the count of each secondary diagnostic category reported at intake, dividing by total count collected.
- Figure 36 is calculated by taking the count of each primary diagnostic category reported at intake for each provider and dividing by the total count collected for the given provider. Only the top 6 diagnostic categories are included in this chart: Depressive Disorders, Adjustment Disorders, Conduct Disorders, ADHD, Anxiety Disorders, and Trauma Disorders.
- Figure 37 reports on the secondary diagnostic category, and is calculated in the same way as figure 36.
- Figure 38 shows the percentage of children meeting SED criteria. Serious Emotional Disturbance is defined by the federal statute as applying to a child with a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM), and whose condition results in functional impairment, substantially interfering with one or more major life activities or the ability to function effectively in social, familial, and educational contexts.
- Figure 39 is calculated by taking the count of "yes" responses to trauma history at intake divided by the total count of responses. Calculations are broken down by service area.
- Figure 40 is calculated by dividing the count of each individual type of trauma by the total of yes responses to trauma history by service area. Calculations are broken down by service area.
- Figure 41 is calculated by taking the number of clients evaluated in an ED 1 or more times (during the episode and in the six months prior) divided by the total number of responses. The data is broken down by service area.
- Figure 42 is calculated by taking the number of clients admitted (inpatient) 1 or more times divided by the total responses. Inpatient history was considered during the child’s lifetime, in the six months prior to the episode, and during the episode. The data is broken down by service area.
- Figure 43 is calculated in the same way as Figure 41, but considering whether or not the client has been placed in an out of home setting.
- Figure 44 is calculated in the same way as Figure 42, but reports the child’s history of alcohol and drug use.
- Figure 45 shows the percentages of each type of parent/guardian service needs statewide, out of the total responses provided.
- Figure 46 shows the parent reported feeling of capability for dealing with the child's problems, rated from extremely capable to extremely incapable. The percentage of each response is calculated, and reported comparing intake scores to discharge scores.
- Figure 47 shows the parent/guardian rating of the child’s school attendance during the episode of care compared to pre-admission. The percentages are calculated using the count answered in each category (ranging from less attendance to greater, or indicating no school attendance), divided by the total number answered.
- Figure 48 is calculated in the same way as Figure 41, but reports whether the child has been suspended or expelled from school.
- Figure 49 shows the percentage of school issues that impact the client's functioning at school, reported at intake. This is calculated by taking the count of each type of school issue (Academic, Social, Behavioral, Emotional, Other) divided by the total responses provided. Data is broken down by service area.

- Figure 50 is calculated in the same way as Figure 40, but reports the child's history of arrest in the 6 months prior to and during the episode of care.
- Figure 51 is calculated in the same way as Figure 40, but reports the child's history of being detained in the six months prior to or during the episode of care.
- Figure 52 shows the percentages for the top six primary presenting problems for episodes initiated during the expanded hours starting in January. Figure 52 is calculated the same way as Figure 33, on only a statewide level.

Section VI: Referral Sources

- Figure 53 and Table 2 are percentage break outs of referral sources across the state. Table 2 is broken down by service area and provider, in addition to reporting statewide percentages.
- Figure 54 displays trends since FY2011 for the top 3 referral sources – self/family, school, and emergency departments.
- Figure 55 is the same as Figure 54, but only showing the trends in Emergency Department referrals.
- Figure 56 counts the number of referrals made to Mobile Crisis by the ED (categorized as routine follow-up or in-patient diversion) out of total episodes, and is broken down by service area.
- Figure 57 calculates the percent of Mobile Crisis episodes that were referred by EDs by service area. This is calculated by counting the total number of ED referrals for the specified service area divided by the total number of Mobile Crisis response episodes for that service area.
- Figures 58 and 59 use the same calculation as 56 and 57 respectively, but are broken down by provider.
- Figure 60 uses the same calculation as Figure 53, for only episodes initiated during the expanded hours that started in January.
- Figure 61 uses the same calculation as Figure 57, for only episodes initiated during the expanded hours that started in January.

Section VII: 211 Recommendations and Mobile Crisis Response

- Figure 62 calculates the percent of each response mode (i.e., mobile, non-mobile, deferred mobile) recommended by 2-1-1, broken down by provider.
- Figure 63 (in contrast to Figure 55) shows the percentage of the actual Mobile Crisis response mode (i.e., mobile, non-mobile, deferred mobile), regardless of recommended response, broken down by provider.
- Figures 64 and 65 show the percent of 2-1-1 recommended response of mobile and non-mobile episodes where the actual Mobile Crisis response was different than the recommended response. These are broken down by provider.
- Figure 66 shows the trend in statewide mobility rate since FY2011.
- Figure 67 is the same graph as Figure 9 from the Dashboard section of the report.
- Figure 68 uses the same calculation as Figure 9 but shows the mobility rate (percent mobile & deferred mobile) by provider.
- Figure 69 shows the percent of each type of mobile site location (i.e., home, school, emergency department, etc.) where the first mobile contact for the episode took place, broken down by service area.
- Figure 70 shows the mean number of mobile contacts and office visits occurring during an episode of care. This is calculated by finding the average number of all mobile contacts and all office visits occurring during an episode of care. Only episodes with a crisis response of *stabilization plus follow up* are included.
- Figure 71 provides the percent break down of the different reasons for an episode receiving a non-mobile Mobile Crisis response.

- Figure 72 shows the rate at which the first contact for a non-mobile response occurs via telephone or office visit.
- Figure 73 is a visual representation of actual Mobile Crisis responses for each of the 2-1-1 recommended response categories for the total number of calls to Mobile Crisis.
- Figure 74 uses the same calculation as Figure 66, for only episodes initiated during the expanded hours that started in January.
- Figures 75 and 76 use the same calculations as Figures 62 and 63 respectively, for only episodes initiated during the expanded hours that started in January.
- Table 3 provides a breakdown of Crisis Assessment Type (phone only, face-to-face, etc.) by response mode (mobile, non-mobile, deferred mobile) for episodes initiated during the expanded hours that started in January.

Section VIII: Response Time

- Figure 77 shows the trend in statewide response rate under 45 minutes since FY2011.
- Figure 78 is the same graph as shown in Figure 11 from the Dashboard section of the report.
- Figure 79 uses the same calculation as Figure 11 but shows the percent of mobile episodes with response time under 45 minutes by provider.
- Figure 80 reports the median response time for mobile responses by service area. The median is calculated by selecting the middle response time when listing all response times from shortest to longest.
- Figure 81 uses the same calculation as Figure 80 but is broken down by provider. a
- Figure 82 uses the same calculation as Figures 80 but includes only deferred mobile responses and is reported in hours by services area.
- Figure 83 uses the same calculation as Figure 82, but is broken down by provider.
- Figures 84 and 85 use the same calculations as Figures 78 and 80 respectively, for only episodes initiated during the expanded hours that started in January.

Section IX: Length of Stay and Discharge Information

- Table 4 shows the mean and median lengths of stay for episodes with Phone Only, Face to Face, and Plus Stabilization Follow-up responses, broken down by service area and by provider for discharged episodes for the current reporting period. Additionally, the table reports the percentages of episodes within each response type that are open beyond the identified threshold for each type of response (for Phone Only, the percentage reflects the proportion of discharged episodes with a Phone Only response that were open for more than one day; for Face to Face, the percentage reflects episodes open for more than five days, and for Stabilization Plus Follow-up, the percentage reflects episodes open for more than 45 days). N/A indicates that there were no episodes fitting the criteria to include in the calculation. This table also shows the total number of episodes used to calculate the mean, median and percentages.
- Table 5 shows the same information as Table 4 but for open episodes still in care.
- Figure 86 shows the top six reasons for client discharge statewide. This percentage is calculated based upon the number of discharged episodes with the "Reason for Discharge" response completed.
- Figure 87 represents the statewide percentages of the top six places where clients live at discharge. Only episodes with an end date are included.
- Figure 88 shows percentages for the types of services clients were referred to at discharge. Only episodes with an end date are included.

- Table 6 shows the number and mean scores of the Ohio Scales collected at intake and discharge. Ohio Scales are a reliable and valid assessment tool used to track progress of children and youth receiving mental health intervention services. Ohio Scales measure both the youth's problem severity (rated across 44 items related to common problems for youth), as well as his/her ability to function (rated across 20 items related to typical daily activity).[10] Ohio Scales are completed separately by the parent, the clinician, and the youth.
  In the table the term "paired" refers to pairing an intake and discharge score; i.e., only episodes with both intake and discharge scales collected were included. The table also only includes episodes with a mobile or deferred mobile response and a crisis response type of Face-to-Face or Plus Stabilization Follow-up. The Mean Intake and Mean Discharge refer to the average scores at intake and discharge for the given region, and the Mean Difference refers to the difference between the two averages. Statistical significance associated with a given scale indicates a likelihood that the difference from intake to discharge is not due to chance.

Section X: Client and Referral Source Satisfaction

- Table 7 shows the mean outcomes of the client and referral source satisfaction survey collected for 2-1-1 and Mobile Crisis. All items are measured on a scale of 1 (strongly disagree) to 5 (strongly agree). A sample of comments are also included. These survey responses are collected by 2-1-1 each quarter across approximately 60 client families and another 60 referring parties.
- Figure 89 shows the statewide percent of parent/guardian satisfaction with the mental health services their child received, calculated by taking the count for each category divided by the total responses to the survey broken down by service area.
- Figure 90 shows the statewide percent of parent/guardian rating of the extent to which the child's treatment plan included their ideas, calculated by taking the count for each category divided by the total responses to the survey.

Section XI: Training Attendance

- Table 8 shows the trainings completed by staff employed by the agency as of June 30, 2023

Section XII: Data Quality Monitoring

- Figure 91 calculates the percent of Ohio Scales collected by each provider *at intake* by dividing actual over expected. Only episodes that have a mobile or deferred mobile response with a crisis response type of Face-to-Face or *stabilization plus follow up* are expected to have Ohio Scales collected. Therefore, this criteria is applied to both the actual (numerator) and the expected (denominator) in calculating the percentage collected.
- Figure 92 is the same as Figure 78, but only includes Ohio Scales collected *at discharge.*

Section XIII: Provider Community Outreach

- Table 9 is a count of formal outreach activities performed in the community by each provider during each quarter. The definition of "formal outreach" is included below the table.

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

Appendix B: List of Diagnostic Codes[11] Combined

Adjustment Disorders:

F43.22 - Adjustment disorders; With anxiety
F43.21 - Adjustment disorders; With depressed mood
F43.24 - Adjustment disorders; With disturbance of conduct
F43.23 - Adjustment disorders; With mixed anxiety and depressed mood
F43.25 - Adjustment disorders; With mixed disturbance of emotions and conduct
F43.20 - Adjustment disorders; Unspecified
F43.20 - Adjustment disorder, unspecified
F43.21 - Adjustment disorder with depressed mood
F43.22 - Adjustment disorder with anxiety
F43.23 - Adjustment disorder with mixed anxiety and depressed mood
F43.24 - Adjustment disorder with disturbance of conduct
F43.25 - Adjustment disorder with mixed disturbance of emotions and conduct
F43.29 - Adjustment disorder with other symptoms
F43.2 - Adjustment disorders
F51.02 - Adjustment insomnia
Z60.0 - Problems of adjustment to life-cycle transitions
F43.8 - Other reactions to severe stress
F43 - Reaction to severe stress, and adjustment disorders
F43.9 - Reaction to severe stress, unspecified

Anxiety Disorders:

F06.4 - Anxiety disorder due to another medical condition
F41.1 - Generalized anxiety disorder
F45.21 - Illness anxiety disorder
F41.8 - Other specified anxiety disorder
F93.0 - Separation anxiety disorder
F40.10 - Social anxiety disorder (social phobia)
F41.9 - Unspecified anxiety disorder
F40 - Phobic anxiety disorders
F41 - Other anxiety disorders
F41.9 - Anxiety disorder, unspecified
F93.0 - Separation anxiety disorder of childhood
F40.8 - Other phobic anxiety disorders
F40.9 - Phobic anxiety disorder, unspecified
F41.3 - Other mixed anxiety disorders
F41.8 - Other specified anxiety disorders
F40.00 - Agoraphobia
F19.980 - Other (or unknown) substance-induced anxiety disorder; Without use disorder
F41.0 - Panic disorder
F94.0 - Selective mutism
F40.218 - Specific phobia; Animal
F40.298 - Specific phobia; Other
F41.0 - Panic disorder [episodic paroxysmal anxiety]
F06.4 - Anxiety disorder due to known physiological condition

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

F19.980 - Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
F40.00 - Agoraphobia, unspecified
F40.01 - Agoraphobia with panic disorder
F40.1 - Social phobias
F40.10 - Social phobia, unspecified
F40.11 - Social phobia, generalized
F40.218 - Other animal type phobia
F40.228 - Other natural environment type phobia
F40.24 - Situational type phobia
F40.248 - Other situational type phobia
F40.29 - Other specified phobia

Attention Deficit/Hyperactivity Disorders:
F90.2 - Attention-deficit/hyperactivity disorder; Combined presentation
F90.1 - Attention-deficit/hyperactivity disorder; Predominantly hyperactive/impulsive presentation
F90.0 - Attention-deficit/hyperactivity disorder; Predominantly inattentive presentation
F90.8 - Other specified attention-deficit/hyperactivity disorder
F90.9 - Unspecified attention-deficit/hyperactivity disorder
F90 - Attention-deficit hyperactivity disorders
F90.0 - Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1 - Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2 - Attention-deficit hyperactivity disorder, combined type
F90.8 - Attention-deficit hyperactivity disorder, other type
F90.9 - Attention-deficit hyperactivity disorder, unspecified type

Autism Spectrum Disorder
F84.0 - Autism spectrum disorder
F84.0 - Autistic disorder

Bipolar & Related Disorders:
F31.9 - Bipolar I disorder, Current or most recent episode hypomanic; Unspecified
F31.73 - Bipolar I disorder, Current or most recent episode manic; In partial remission
F31.81 - Bipolar II disorder
F06.33 - Bipolar and related disorder due to another medical condition; With manic- or hypomanic-like episodes
F34.0 - Cyclothymic disorder
F31.9 - Unspecified bipolar and related disorder
F31 - Bipolar disorder
F34 - Persistent mood [affective] disorders
F06.33 - Mood disorder due to known physiological condition with manic features
F06.34 - Mood disorder due to known physiological condition with mixed features
F30.2 - Manic episode, severe with psychotic symptoms
F30.8 - Other manic episodes
F31.0 - Bipolar disorder, current episode hypomanic
F31.11 - Bipolar disorder, current episode manic without psychotic features, mild
F31.12 - Bipolar disorder, current episode manic without psychotic features, moderate
F31.2 - Bipolar disorder, current episode manic severe with psychotic features
F31.31 - Bipolar disorder, current episode depressed, mild
F31.32 - Bipolar disorder, current episode depressed, moderate
F31.5 - Bipolar disorder, current episode depressed, severe, with psychotic features

F31.62 - Bipolar disorder, current episode mixed, moderate
F31.64 - Bipolar disorder, current episode mixed, severe, with psychotic features
F31.72 - Bipolar disorder, in full remission, most recent episode hypomanic
F31.73 - Bipolar disorder, in partial remission, most recent episode manic
F31.89 - Other bipolar disorder
F31.9 - Bipolar disorder, unspecified
F34.8 - Other persistent mood [affective] disorders
F34.9 - Persistent mood [affective] disorder, unspecified
F39 - Unspecified mood [affective] disorder

Conduct Disorders/Disruptive Behavior:
F91.2 - Conduct disorder; Adolescent-onset type
F91.1 - Conduct disorder; Childhood-onset type
F91.9 - Conduct disorder; Unspecified onset
F91.8 - Other specified disruptive, impulse-control, and conduct disorder
F91.9 - Unspecified disruptive, impulse-control, and conduct disorder
F91 - Conduct disorders
F91.0 - Conduct disorder confined to family context
F91.1 - Conduct disorder, childhood-onset type
F91.2 - Conduct disorder, adolescent-onset type
F91.8 - Other conduct disorders
F63.81 - Intermittent explosive disorder
F63.2 - Kleptomania
F91.3 - Oppositional defiant disorder
F63.9 - Impulse disorder, unspecified
F91.2 - Conduct disorder, adolescent-onset type

Depressive Disorders:
F06.31 - Depressive disorder due to another medical condition; With depressive features
F06.32 - Depressive disorder due to another medical condition; With major depressive-like episode
F33.42 - Major depressive disorder, Recurrent episode; In full remission
F33.41 - Major depressive disorder, Recurrent episode; In partial remission
F33.0 - Major depressive disorder, Recurrent episode; Mild
F33.1 - Major depressive disorder, Recurrent episode; Moderate
F33.2 - Major depressive disorder, Recurrent episode; Severe
F33.3 - Major depressive disorder, Recurrent episode; With psychotic features
F33.9 - Major depressive disorder, Recurrent episode; Unspecified
F32.5 - Major depressive disorder, Single episode; In full remission
F32.4 - Major depressive disorder, Single episode; In partial remission
F32.0 - Major depressive disorder, Single episode; Mild
F32.1 - Major depressive disorder, Single episode; Moderate
F32.2 - Major depressive disorder, Single episode; Severe
F32.3 - Major depressive disorder, Single episode; With psychotic features
F32.9 - Major depressive disorder, Single episode; Unspecifed
F32.8 - Other specified depressive disorder
F34.1 - Persistent depressive disorder (dysthymia)
F32.9 - Unspecified depressive disorder
N94.3 - Premenstrual dysphoric disorder
F32.9 - Major depressive disorder, single episode, unspecified

F33.9 - Major depressive disorder, recurrent, unspecified
F32 - Major depressive disorder, single episode
F32.0 - Major depressive disorder, single episode, mild
F32.1 - Major depressive disorder, single episode, moderate
F32.2 - Major depressive disorder, single episode, severe without psychotic features
F32.3 - Major depressive disorder, single episode, severe with psychotic features
F32.4 - Major depressive disorder, single episode, in partial remission
F32.5 - Major depressive disorder, single episode, in full remission
F32.8 - Other depressive episodes
F32.81 - Premenstrual dysphoric disorder
F32.89 - Other specified depressive episodes
F33 - Major depressive disorder, recurrent
F33.0 - Major depressive disorder, recurrent, mild
F33.1 - Major depressive disorder, recurrent, moderate
F33.2 - Major depressive disorder, recurrent severe without psychotic features
F33.3 - Major depressive disorder, recurrent, severe with psychotic symptoms
F33.4 - Major depressive disorder, recurrent, in remission
F33.40 - Major depressive disorder, recurrent, in remission, unspecified
F33.41 - Major depressive disorder, recurrent, in partial remission
F33.42 - Major depressive disorder, recurrent, in full remission
F33.8 - Other recurrent depressive disorders
F34.8 - Disruptive mood dysregulation disorder
N94.3 - Premenstrual dysphoric disorder
F06.3 - Mood disorder due to known physiological condition
F06.31 - Mood disorder due to known physiological condition with depressive features
F06.32 - Mood disorder due to known physiological condition with major depressive-like episode
F34.1 - Dysthymic disorder

Eating & Feeding Disorders

F50.8 - Avoidant/restrictive food intake disorder
F50.2 - Bulimia nervosa
F50.8 - Pica; In adults
F50.00 - Anorexia nervosa, unspecified
F50.01 - Anorexia nervosa, restricting type
F50.02 - Anorexia nervosa, binge eating/purging type
F50.81 - Binge eating disorder
F50.89 - Other specified eating disorder
F50.9 - Eating disorder, unspecified
F98.3 - Pica of infancy and childhood

Obsessive Compulsive Disorder & Related Disorders

F45.22 - Body dysmorphic disorder
L98.1 - Excoriation (skin-picking) disorder
F42 - Obsessive-compulsive disorder
F63.3 - Trichotillomania (hair-pulling disorder)
F42 - Unspecified obsessive-compulsive and related disorder
F42.2 - Mixed obsessional thoughts and acts
F42.8 - Other obsessive-compulsive disorder

F42.9 - Obsessive-compulsive disorder, unspecified
F63.3 - Trichotillomania

Psychotic Disorder
F23 - Brief psychotic disorder
F28 - Other specified schizophrenia spectrum and other psychotic disorder
F25.0 - Schizoaffective disorder; Bipolar type
F20.9 - Schizophrenia
F20.81 - Schizophreniform disorder
F29 - Unspecified schizophrenia spectrum and other psychotic disorder
F21 - Schizotypal disorder
F20.9 - Schizophrenia, unspecified
F25.0 - Schizoaffective disorder, bipolar type
F25.1 - Schizoaffective disorder, depressive type
F28 - Other psychotic disorder not due to a substance or known physiological condition
F29 - Unspecified psychosis not due to a substance or known physiological condition

Trauma Disorders – PTSD and Trauma Exposure
F43.8 - Other specified trauma- and stressor-related disorder
F43.10 - Posttraumatic stress disorder
F43.9 - Unspecified trauma- and stressor-related disorder
F43.1 - Post-traumatic stress disorder (PTSD)
F43.10 - Post-traumatic stress disorder, unspecified
F43.11 - Post-traumatic stress disorder, acute
F43.12 - Post-traumatic stress disorder, chronic
Z91.49 - Other personal history of psychological trauma, not elsewhere classified
F43.0 - Acute stress disorder
F43.0 - Acute stress reaction
F43 - Reaction to severe stress, and adjustment disorders
F43.8 - Other reactions to severe stress
F43.9 - Reaction to severe stress, unspecified
F94.2 - Disinhibited attachment disorder of childhood
T74.22XA - Child sexual abuse, Confirmed; Initial encounter
T76.22XA - Child sexual abuse, Suspected; Initial encounter
F94.2 - Disinhibited social engagement disorder
Z69.010 - Encounter for mental health services for victim of child sexual abuse by parent
Z69.11 - Encounter for mental health services for victim of spouse or partner neglect
F94.1 - Reactive attachment disorder
F94.1 - Reactive attachment disorder of childhood
Z63.4 - Disappearance and death of family member
Z69.010 - Encounter for mental health services for victim of parental child abuse
Z69.020 - Encounter for mental health services for victim of non-parental child abuse
Z91.49 - Other personal history of psychological trauma, not elsewhere classified
T74.12 - Child physical abuse, confirmed
T74.22 - Child sexual abuse, confirmed

Substance Use
F10.10 - Alcohol use disorder; Mild
F12.20 - Cannabis use disorder; Severe

F19.10 - Other (or unknown) substance use disorder; Mild
F10.20 - Alcohol dependence, uncomplicated
F12.10 - Cannabis abuse, uncomplicated
F12.180 - Cannabis abuse with cannabis-induced anxiety disorder
F12.20 - Cannabis dependence, uncomplicated
F12.21 - Cannabis dependence, in remission
F12.90 - Cannabis use, unspecified, uncomplicated
F12.99 - Cannabis use, unspecified with unspecified cannabis-induced disorder

Other Diagnosis
F80.89 - Social (pragmatic) communication disorder
F45.1 - Somatic symptom disorder
F80.9 - Unspecified communication disorder
Z60.9 - Unspecified problem related to social environment
F72 - Severe intellectual disabilities
F64.0 - Transsexualism
F80.0 - Phonological disorder
F80.82 - Social pragmatic communication disorder
F89 - Unspecified disorder of psychological development
F95.2 - Tourettes disorder
F95.9 - Tic disorder, unspecified
F98.9 - Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
R32 - Unspecified urinary incontinence
Z55.9 - Problems related to education and literacy, unspecified
Z62.891 - Sibling rivalry
F48.1 - Depersonalization/derealization disorder
F98.1 - Encopresis
F98.0 - Enuresis
F64.1 - Gender dysphoria in adolescents and adults
F64.2 - Gender dysphoria in children
Z59.1 - Inadequate housing
F70 - Intellectual disability (intellectual developmental disorder); Mild
F71 - Intellectual disability (intellectual developmental disorder); Moderate
F80.2 - Language disorder
Z59.6 - Low income
F02.81 - Major neurocognitive disorder due to traumatic brain injury (code first 907.0 late effect of intracranial injury without skull fracture [S06.2X9S diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela]); With behavioral disturbance
Z76.5 - Malingering
F51.5 - Nightmare disorder
F44.89 - Other specified dissociative disorder
F88 - Other specified neurodevelopmental disorder
F45.8 - Other specified somatic symptom and related disorder
Z62.820 - Parent-child relational problem
Z91.5 - Personal history of self-harm
F99 - Unspecified mental disorder
F89 - Unspecified neurodevelopmental disorder
F48.1 - Depersonalization-derealization syndrome
F64 - Gender identity disorders

F70 - Mild intellectual disabilities
F71 - Moderate intellectual disabilities
F79 - Unspecified intellectual disabilities
F80 - Specific developmental disorders of speech and language
F84 - Pervasive developmental disorders
F98.0 - Enuresis not due to a substance or known physiological condition
F98.1 - Encopresis not due to a substance or known physiological condition
F02.80 - Dementia in other diseases classified elsewhere without behavioral disturbance
F06.8 - Other specified mental disorders due to known physiological condition
F19.99 - Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
F44.4 - Conversion disorder with motor symptom or deficit
F44.5 - Conversion disorder with seizures or convulsions
F44.8 - Other dissociative and conversion disorders
F45.8 - Other somatoform disorders
F48.9 - Nonpsychotic mental disorder, unspecified
F64.1 - Dual role transvestism
F64.2 - Gender identity disorder of childhood
F64.8 - Other gender identity disorders
F64.9 - Gender identity disorder, unspecified
F80.2 - Mixed receptive-expressive language disorder
F80.8 - Other developmental disorders of speech and language
F80.9 - Developmental disorder of speech and language, unspecified
F81.2 - Mathematics disorder
F81.9 - Developmental disorder of scholastic skills, unspecified
F82 - Specific developmental disorder of motor function
F88 - Other disorders of psychological development
F95.1 - Chronic motor or vocal tic disorder
F98.8 - Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99 - Mental disorder, not otherwise specified
G47.20 - Circadian rhythm sleep disorder, unspecified type
G47.8 - Other sleep disorders
R15.9 - Full incontinence of feces
Z60.9 - Problem related to social environment, unspecified
Z62.820 - Parent-biological child conflict
Z63.5 - Disruption of family by separation and divorce
Z63.8 - Other specified problems related to primary support group
Z65.1 - Imprisonment and other incarceration
Z65.8 - Other specified problems related to psychosocial circumstances
Z71.9 - Counseling, unspecified
Z91.89 - Other specified personal risk factors, not elsewhere classified

Appendix C: Tables

Table 10. Percent Type of Health Insurance at Intake (relates to Figure 25)

	HUSKY A	Private	No Health Insurance	Other	HUSKY B	Medicaid (non-HUSKY)	Military Health Care	Medicare
STATEWIDE	55.2%	27.6%	2.6%	11.6%	0.8%	1.4%	0.7%	0.1%
CENTRAL	49.5%	40.1%	1.0%	3.0%	0.3%	6.0%	0.1%	0.0%
CHR/MiddHosp-EMPS	28.4%	48.5%	1.4%	0.9%	0.9%	19.6%	0.2%	0.0%
CHR-EMPS	57.1%	37.1%	0.8%	3.7%	0.1%	1.2%	0.0%	0.0%
EASTERN	63.4%	27.2%	1.9%	2.1%	0.7%	0.1%	4.6%	0.0%
UCFS-EMPS:NE	65.3%	27.7%	2.0%	2.6%	0.9%	0.0%	1.5%	0.0%
UCFS-EMPS:SE	62.7%	26.9%	1.9%	1.9%	0.6%	0.1%	6.0%	0.0%
HARTFORD	70.9%	23.5%	1.6%	2.3%	1.2%	0.1%	0.4%	0.0%
Wheeler-EMPS:Htfd	79.3%	15.6%	2.6%	1.3%	0.9%	0.0%	0.1%	0.1%
Wheeler-EMPS:Meridn	74.0%	21.8%	1.2%	1.8%	0.9%	0.3%	0.0%	0.0%
Wheeler-EMPS:NBrit	64.5%	29.1%	1.0%	3.1%	1.5%	0.2%	0.7%	0.0%
NEW HAVEN	62.7%	31.8%	1.5%	2.8%	0.8%	0.1%	0.3%	0.0%
CliffBeers-EMPS	62.7%	31.8%	1.5%	2.8%	0.8%	0.1%	0.3%	0.0%
SOUTHWESTERN	54.0%	34.7%	5.3%	3.9%	0.8%	1.1%	0.2%	0.1%
CFGC/South-EMPS	46.8%	39.9%	5.5%	4.4%	1.0%	2.0%	0.3%	0.0%
CFGC-EMPS:Nrwlk	43.0%	47.6%	4.6%	2.7%	1.5%	0.3%	0.0%	0.3%
CFGC-EMPS	62.8%	25.8%	5.5%	4.3%	0.3%	1.1%	0.2%	0.0%
WESTERN	31.1%	12.8%	4.5%	50.1%	1.0%	0.3%	0.0%	0.3%
Well-EMPS:Dnby	24.1%	21.9%	3.0%	49.5%	1.0%	0.2%	0.0%	0.2%
Well-EMPS:Torr	16.2%	10.3%	3.8%	67.6%	1.1%	0.5%	0.0%	0.5%
Well-EMPS:Wtby	36.2%	9.8%	5.2%	47.3%	0.9%	0.3%	0.0%	0.3%

Table 11. Type of Trauma Reported at Intake (relates to Figure 35)

	Witness Violence	Victim Violence	Sexual Victimization	Disrupted Attachment / Multiple Placements	Recent Arrest of Caregiver (last 30 days)*	Other
STATEWIDE	17.9%	15.7%	13.0%	25.9%	0.4%	27.1%
CENTRAL	20.3%	12.9%	11.2%	27.6%	0.1%	27.9%
CHR/MiddHosp-EMPS	11.0%	9.6%	16.2%	25.0%	0.0%	38.2%
CHR-EMPS	21.2%	13.2%	10.7%	27.9%	0.1%	26.9%
EASTERN	13.6%	13.5%	11.3%	25.8%	0.5%	35.3%
UCFS-EMPS:NE	12.1%	13.1%	9.9%	25.6%	1.0%	38.3%
UCFS-EMPS:SE	14.2%	13.7%	11.9%	25.9%	0.3%	34.0%
HARTFORD	24.3%	19.1%	15.8%	19.1%	0.2%	21.6%
Wheeler-EMPS:Htfd	22.6%	18.0%	17.6%	18.4%	0.0%	23.4%
Wheeler-EMPS:Meridn	25.3%	18.9%	14.7%	20.0%	0.5%	20.5%
Wheeler-EMPS:NBrit	25.3%	19.9%	14.7%	19.2%	0.3%	20.6%
NEW HAVEN	13.2%	9.6%	9.2%	31.8%	0.8%	35.3%
CliffBeers-EMPS	13.2%	9.6%	9.2%	31.8%	0.8%	35.3%
SOUTHWESTERN	17.0%	17.9%	15.3%	12.9%	0.1%	36.8%
CFGC/South-EMPS	16.0%	20.5%	14.1%	15.4%	0.0%	34.0%
CFGC-EMPS:Nrwlk	13.0%	18.6%	15.8%	9.6%	0.0%	42.9%
CFGC-EMPS	19.1%	16.7%	15.5%	13.3%	0.2%	35.3%
WESTERN	15.7%	19.4%	14.7%	34.8%	0.6%	14.7%
Well-EMPS:Dnby	11.9%	17.6%	10.7%	38.8%	0.0%	20.9%
Well-EMPS:Torr	18.9%	20.9%	18.9%	27.7%	0.0%	13.5%
Well-EMPS:Wtby	16.6%	19.9%	15.6%	34.5%	1.0%	12.5%

*Included in "Other" category in Figure 35.

Table 12. Reasons for Client Discharge (relates to Figure 73)

	Met Treatment Goals	Family Discontinued	Client Hospitalized: Psychiatrically	Agency Discontinued: Administrative	Agency Discontinued: Clinical	Child Requires Other Out of Home Care	Family Moved	Child Ran Away	Client Incarcerated	Client Hospitalized: Medically	No Payment Source	Age (too old)	Child Is Deceased
STATEWIDE	83.4%	9.4%	5.2%	1.1%	0.2%	0.1%	0.4%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%
CENTRAL	89.4%	3.2%	4.5%	2.2%	0.2%	0.2%	0.4%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
CHR/MiddHosp-EMPS	84.2%	2.2%	5.8%	6.4%	0.4%	0.0%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CHR-EMPS	91.3%	3.5%	4.0%	0.5%	0.1%	0.3%	0.2%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
EASTERN	92.6%	3.8%	2.6%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
UCFS-EMPS:NE	92.8%	3.4%	2.9%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
UCFS-EMPS:SE	92.6%	4.0%	2.4%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
HARTFORD	70.9%	22.9%	3.0%	1.9%	0.5%	0.0%	0.3%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%
Wheeler-EMPS:Htfd	56.4%	36.3%	5.0%	0.4%	0.7%	0.0%	0.8%	0.1%	0.3%	0.0%	0.0%	0.0%	0.0%
Wheeler-EMPS:Meridn	78.7%	16.5%	0.9%	3.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%
Wheeler-EMPS:NBrit	78.4%	15.6%	2.3%	2.4%	0.6%	0.1%	0.1%	0.2%	0.1%	0.2%	0.0%	0.1%	0.0%
NEW HAVEN	81.5%	11.2%	5.9%	0.7%	0.1%	0.0%	0.5%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
CliffBeers-EMPS	81.5%	11.2%	5.9%	0.7%	0.1%	0.0%	0.5%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
SOUTHWESTERN	81.0%	10.0%	7.2%	0.2%	0.0%	0.3%	0.9%	0.0%	0.1%	0.0%	0.0%	0.3%	0.0%
CFGC/South-EMPS	81.9%	6.7%	9.6%	0.0%	0.0%	1.4%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
CFGC-EMPS:Nrwlk	79.0%	11.7%	8.4%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%
CFGC-EMPS	81.7%	10.7%	5.5%	0.3%	0.0%	0.0%	1.5%	0.0%	0.2%	0.0%	0.0%	0.2%	0.0%
WESTERN	90.2%	0.5%	8.8%	0.2%	0.1%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%
Well-EMPS:Dnby	95.2%	0.5%	4.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Well-EMPS:Torr	88.6%	0.6%	10.2%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Well-EMPS:Wtby	88.5%	0.5%	10.3%	0.3%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%

Table 13. Type of Services Client Referred at Discharge (relates to Figure 75)

	Referred Back to Original Provider	Outpatient Services	Intensive In-Home Services	Other: Community-Based	Inpatient Hospital	Partial Hospital Program	Intensive Outpatient Program	Extended Day Treatment	Care Coordination	Group Home	Other: Out-of-Home	Residential Treatment	None
STATEWIDE	27.0%	39.1%	6.6%	3.3%	2.9%	2.2%	4.6%	1.0%	1.7%	0.1%	0.7%	0.3%	10.4%
CENTRAL	18.7%	39.4%	7.9%	4.3%	2.4%	3.3%	7.5%	0.9%	2.3%	0.0%	0.4%	0.2%	12.5%
CHR/MiddHosp-EMPS	44.3%	30.3%	5.6%	3.1%	2.8%	1.3%	7.3%	0.9%	1.8%	0.0%	0.0%	0.2%	2.3%
CHR-EMPS	7.1%	43.6%	8.9%	4.9%	2.3%	4.2%	7.6%	0.9%	2.6%	0.0%	0.6%	0.2%	17.2%
EASTERN	25.4%	36.7%	7.6%	2.8%	1.1%	10.1%	1.8%	0.0%	2.7%	0.0%	0.0%	0.0%	11.8%
UCFS-EMPS:NE	25.0%	33.3%	8.0%	2.9%	1.1%	10.5%	2.1%	0.0%	2.9%	0.0%	0.0%	0.0%	14.2%
UCFS-EMPS:SE	25.6%	38.3%	7.4%	2.7%	1.1%	10.0%	1.6%	0.0%	2.6%	0.0%	0.0%	0.0%	10.7%
HARTFORD	31.4%	35.0%	6.6%	3.1%	2.1%	0.5%	6.8%	2.4%	1.3%	0.1%	2.0%	0.3%	8.6%
Wheeler-EMPS:Htfd	25.6%	34.5%	7.0%	2.8%	2.7%	0.7%	8.9%	2.6%	1.9%	0.1%	0.4%	0.2%	12.7%
Wheeler-EMPS:Meridn	32.0%	37.4%	5.7%	4.1%	1.2%	0.2%	4.4%	2.3%	1.1%	0.0%	2.7%	0.4%	8.5%
Wheeler-EMPS:NBrit	35.2%	34.7%	6.5%	3.0%	2.0%	0.4%	6.0%	2.2%	0.9%	0.1%	2.8%	0.3%	5.8%
NEW HAVEN	47.0%	28.7%	2.6%	4.4%	1.9%	0.0%	2.2%	0.4%	0.9%	0.0%	0.4%	0.1%	11.4%
CliffBeers-EMPS	47.0%	28.7%	2.6%	4.4%	1.9%	0.0%	2.2%	0.4%	0.9%	0.0%	0.4%	0.1%	11.4%
SOUTHWESTERN	28.7%	41.4%	5.0%	3.8%	2.5%	0.1%	3.8%	0.6%	2.3%	0.0%	0.8%	0.6%	10.3%
CFGC/South-EMPS	34.0%	39.0%	4.4%	3.6%	3.3%	0.4%	4.0%	0.0%	2.3%	0.0%	0.2%	1.5%	7.3%
CFGC-EMPS:Nrwlk	33.1%	39.6%	4.5%	3.0%	2.4%	0.0%	4.3%	1.2%	1.4%	0.0%	1.0%	0.0%	9.6%
CFGC-EMPS	23.4%	43.8%	5.6%	4.3%	2.2%	0.0%	3.5%	0.6%	2.8%	0.0%	0.9%	0.4%	12.3%
WESTERN	13.6%	54.1%	8.8%	1.8%	7.3%	0.2%	3.0%	0.7%	0.8%	0.5%	0.0%	0.5%	8.6%
Well-EMPS:Dnby	13.1%	61.9%	5.8%	1.1%	3.4%	0.0%	3.7%	1.3%	0.9%	0.0%	0.0%	0.7%	8.0%
Well-EMPS:Torr	19.6%	47.0%	7.5%	3.2%	7.1%	0.4%	3.9%	0.4%	1.1%	0.4%	0.0%	0.4%	9.3%
Well-EMPS:Wtby	12.5%	52.5%	10.2%	1.8%	8.9%	0.2%	2.6%	0.5%	0.7%	0.8%	0.1%	0.4%	8.7%

Table 14. Performance Improvement Plan Goals and Results for Fiscal Year 2023

Service Area	Performance Goals and Relevant Quarter(s)	Goal Achieved	Positive Progress Toward Goal	No Positive Progress
Central	Recruit Staff for 24/7 contract expansion (Q1,Q2,Q3,Q4))		Q2, Q3,Q4	Q1
	Provide trainng to new hires on mobile (Q1,Q2,Q3,Q4)	Q1	Q2,Q3,Q4	
	Improve CHR mobile crisis response time (Q1)	Q1		
	Recruit Overnight staff (Q2,Q3,Q4)		Q2,Q3,Q4	
Eastern	Increase the numbe of worker discharge Ohio's by 60% (Q1,Q2,Q3,Q4)	Q2,Q3	Q4	Q1
	To increase self- care amongst and with MCI team members (Q1,Q2,Q3,Q4)		Q1,Q2,Q3,Q4	
	Increase the number of Parent discharge Ohio's to 60% (Q4)		Q4	
	Increase the number of Youth Services Survey for families (YSS-F) to 60% (Q3,Q4)		Q3,Q4	
Hartford	Focus on meeting the statewide benchmark on mobility (Q1)	Q1		
	Improve the overall functioning of staff reports of the MCIS program (Q1, Q2)	Q2	Q1	
	Develop protocols, procedures, recruit over- night staff (Q1,Q2,Q3,Q4)	Q3	Q1,Q2 ,Q4	
	Focus on meeting the statewide benchmark on response time of 45 minutes (Q2,Q3,Q4)		Q2,Q3,Q4	
New Haven	Develop a strategic plan for the new scope of service regarding 24/7 mobile expectations (Q1,Q2,Q3)	Q1,Q2,Q3		
	Improve mobility and response time (Q1,Q2,Q3)	Q3	Q1, Q2	
	Focus on YSSF completion over the next 6-12 months (Q1,Q2,Q3,Q4)			Q1,Q2,Q3,Q4
	Focus on community responses to critical situation (Q1,Q2,Q3,Q4)		Q1,Q2,Q3,Q4	
	Increase the number of Parent Discharge Ohio's (Q1,Q2,Q3,Q4)		Q4	Q1,Q2,Q3,
	Montior the success and staffing of 24/7 (Q4)		Q4	
Southwestern	Increase the number of Worker Ohio scales obtained at discharge by 67% (Q1,Q2,Q3)	Q1,Q2,Q3		
	Increase number of Parent Ohio scales obtained at discharge by 30% (Q1,Q2,Q3,Q4)	Q1,Q2,Q3,Q4		
	Complete at least 80% of Worker Ohio scales obtained at discharge (Q3,Q4)	Q3	Q4	
Western	Increase the number of collected Parent Ohio's (Q1,Q2,Q3,Q4)		Q1,Q2,Q3,Q4	
	Improve training for new supervisors within MCIS program (Q1,Q2,Q3,Q4)	Q4	Q1, Q2,Q3	
	Improve response time of 45 minutes (Q1,Q2,Q3,Q4)		Q1, Q2,Q3	
	Imporve staff attendance and completion of PIC trainings (Q3,Q4)		Q3,Q4	

Total Goals=74 (includes duplicate counts of goals if continued across multiple quarters); Number of goals achieved (during at least one quarter): 20 of 74 (27%); Number of goals with positive progress (during at least one quarter): 45 of 74 (61%); Number of goals with no positive progress 9 of 74 (12%)