MOBILE CRISIS
RESPONSE TEAM FOR YOUTH

Mobile Crisis Intervention Services

FISCAL YEAR 2025 ANNUAL REPORT

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

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Mobile Crisis Performance Improvement Center

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

Acknowledgements

We wish to acknowledge the following CHDI staff and partners that have worked on the Mobile Crisis PIC and this report:

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Executive Summary

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

This report summarizes episode-level Mobile Crisis data for State Fiscal Year 2025. The report presents data and progress on key indicators of access, quality, and outcomes for Mobile Crisis in Connecticut. Equity is cross-cutting theme, addressed throughout each section of the report, and is a central focus of our work both in Mobile Crisis services and in our quality improvement activities.

During FY2025, Mobile Crisis continued to exceed major performance benchmarks, providing services for children and families all across the state. The data shows that the service continues to meet the high standards that have been established over the past 15 years.

In addition to a comprehensive overview of data, this report outlines the activities undertaken by CHDI, Mobile Crisis providers, and DCF to continuously enhance the system. Through our data analysis and quality improvement activities, we have identified a number of areas to focus on in FY 2026:

- Equitably increasing utilization of Mobile Crisis
- Setting goals for improvement that incorporate an equity lens
- Assessing the value of training enhancements made in FY2025
- Continuing to focus on data quality and analyzing data resulting from changes made in FY2025
- Working with system partners to enhance the relationship between 988, Mobile Crisis, and the overall behavioral health crisis system

KEY FINDINGS FY25:

Mobile Crisis had **11,608** episodes of care serving **8,428** children.

42% of callers to Mobile Crisis were schools, and **40%** were the family or child themselves.

39% of children received ongoing stabilization services from Mobile Crisis.

Children were most commonly presenting to Mobile Crisis with Harm/Risk of Harm to Self (**30%**) and Disruptive Behavior (**26%**).

Mobile Crisis had a **95.8% mobility rate**, and responded to **88.0%** of mobile episodes in **under 45 minutes.**

72% of children were discharged after completing their treatment with Mobile Crisis

41% of children were referred to outpatient services, and **36%** were referred back to an existing provider. **29%** of children received referrals to multiple services.

Introduction

Overview of Mobile Crisis and PIC

Mobile Crisis Intervention Services (Mobile Crisis) is a face-to-face intervention for children and adolescents experiencing a behavioral or mental health need or crisis, where a clinician meets the child and family in their home or community. Mobile Crisis is available to any child and family across the state, free of charge. Mobile Crisis is funded by the Connecticut Department of Children and Families (DCF) and is accessed by calling 2-1-1 or 988. The statewide Mobile Crisis network is comprised of over 200 trained mental health professionals who can respond in-person within 45 minutes when a child is experiencing an emotional or behavioral crisis. The purposes of the program are to serve children in their homes, schools, and communities; reduce the number of visits to hospital emergency rooms; and divert children from high-end interventions (such as hospitalization or arrest) if a lower level of care is a safe and effective alternative. Mobile Crisis is implemented by six primary contractors, most of whom have satellite offices or subcontracted agencies. A total of 14 Mobile Crisis sites collectively provide coverage for every town and city in Connecticut.

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

The FY2025 Annual Report summarizes 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.

Goals of Mobile Crisis

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

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

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

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

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

Figure 1. Goals of the Performance Improvement Center.

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

FY2025 Focus

In FY2025, the PIC focused on improving data quality and documentation for Mobile Crisis. Through the development of the FY2024 annual report, we identified key data metrics that were being used inconsistently across providers – most notably, how stabilization episodes were being defined and what it meant to complete treatment. We saw significant variation between providers on these data elements and believed it was due in part to a lack of clear data definitions. Over the course of several conversations among CHDI, DCF, and providers, we gathered information about how each provider was operating as well as their perspectives on what data definitions would align with best practices. We have developed a new system for categorizing episodes in the data system to more clearly indicate what level of follow-up and stabilization families are receiving, and to create clearer guidelines for when a family has completed treatment in each phase.

In addition to clarifying definitions, it was important to create better documentation to ensure this information was readily available for providers. CHDI reviewed definitions that are currently available in the data system, many of which were missing or generalized across behavioral health services. CHDI spent this year creating a comprehensive data dictionary for Mobile Crisis, which will be finalized and sent out once the updated data elements have been added to PIE. CHDI and DCF also worked with providers to update the Mobile Crisis practice standards for the first time since 2013. This ensures that the practice standards reflect the current work, and that we are collecting data that aligns with them.

How many youth were served?

This year, 15,678 calls came into the Mobile Crisis line at 2-1-1, resulting in **11,608 episodes of care.** This was a 3.2% increase in call volume compared to FY2024, and a 2.3% increase in episode volume. Episode volume remained 24.2% lower than FY2019, prior to the pandemic. In FY2025, a data element was added to PIE to capture when calls come through 988 instead of 2-1-1. There were 252 episodes (2%) that were initiated through 988. The 11,608 episodes this year served **8,428 unique children.** Most children served only had one episode of care this year (77.0%), with 23.0% having two or more episodes of care within the year. Most youth with multiple episodes of care only had two episodes (65.6%). The pattern of episode volume from month to month was similar to last year, with summer seeing the lowest volume and peak volume being seen in October, March and May. The bulk of the increase in volume compared to FY2024 occurred in September and October, with increases of 23% and 15% respectively.

Figure 2. Call and episode volume over time.

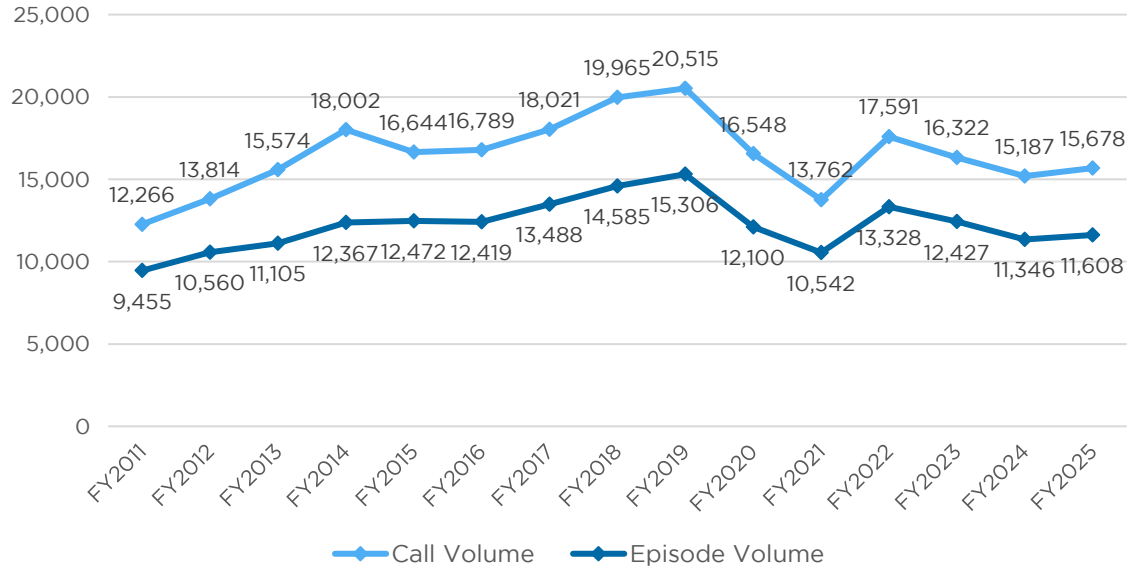
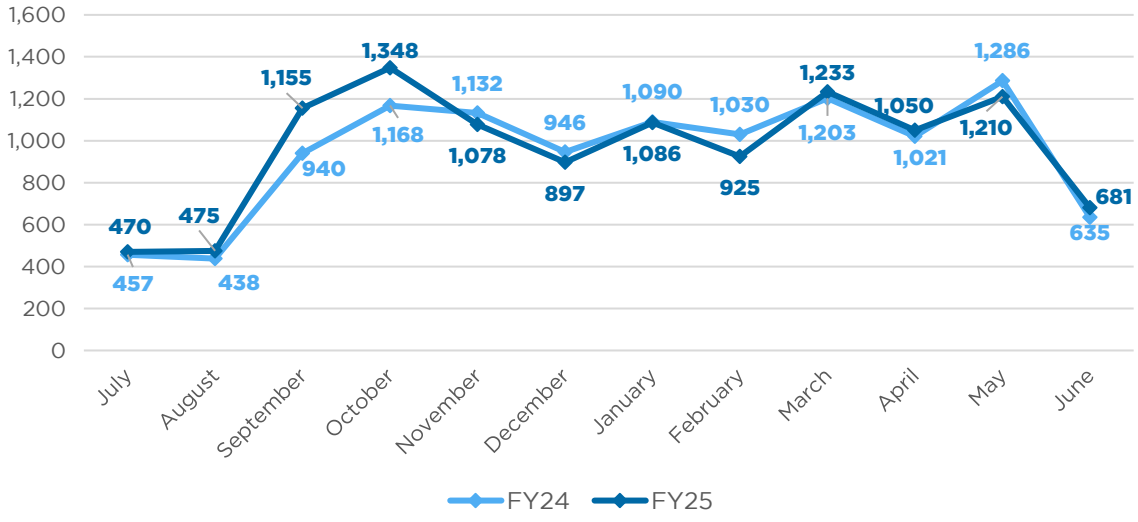


Figure 3. Number of episodes per month.



Episode volume for each region ranged from 1,409 (Eastern) to 2,891 (Hartford). **The statewide service reach rate was 15.8 episodes per 1,000 children in Connecticut.** Four of the six regions were within one standard deviation (3.1) of the statewide average (15.7). The Hartford region was more than one standard deviation above the statewide average, while the Southwestern region was more than one standard deviation below.

Figure 4. Number of episodes by region.

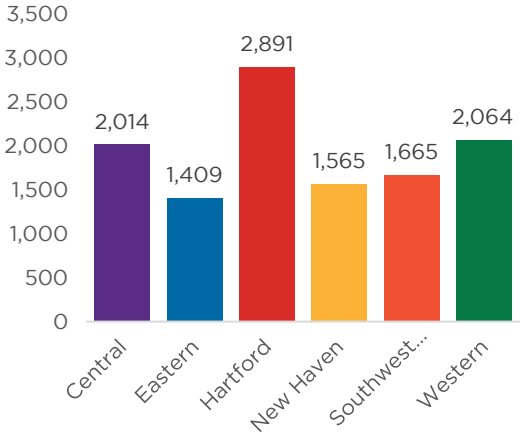


Figure 5. Episodes per 1,000 children.

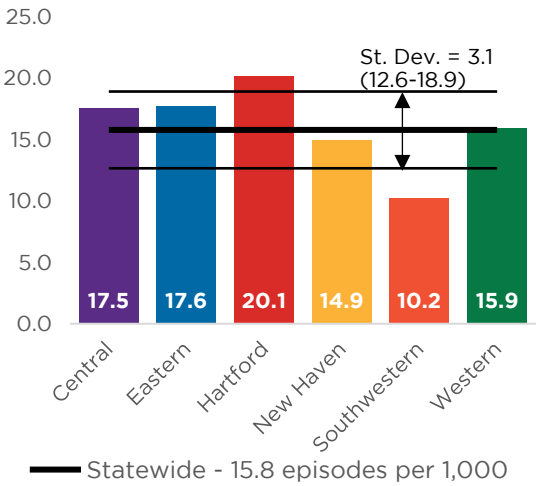
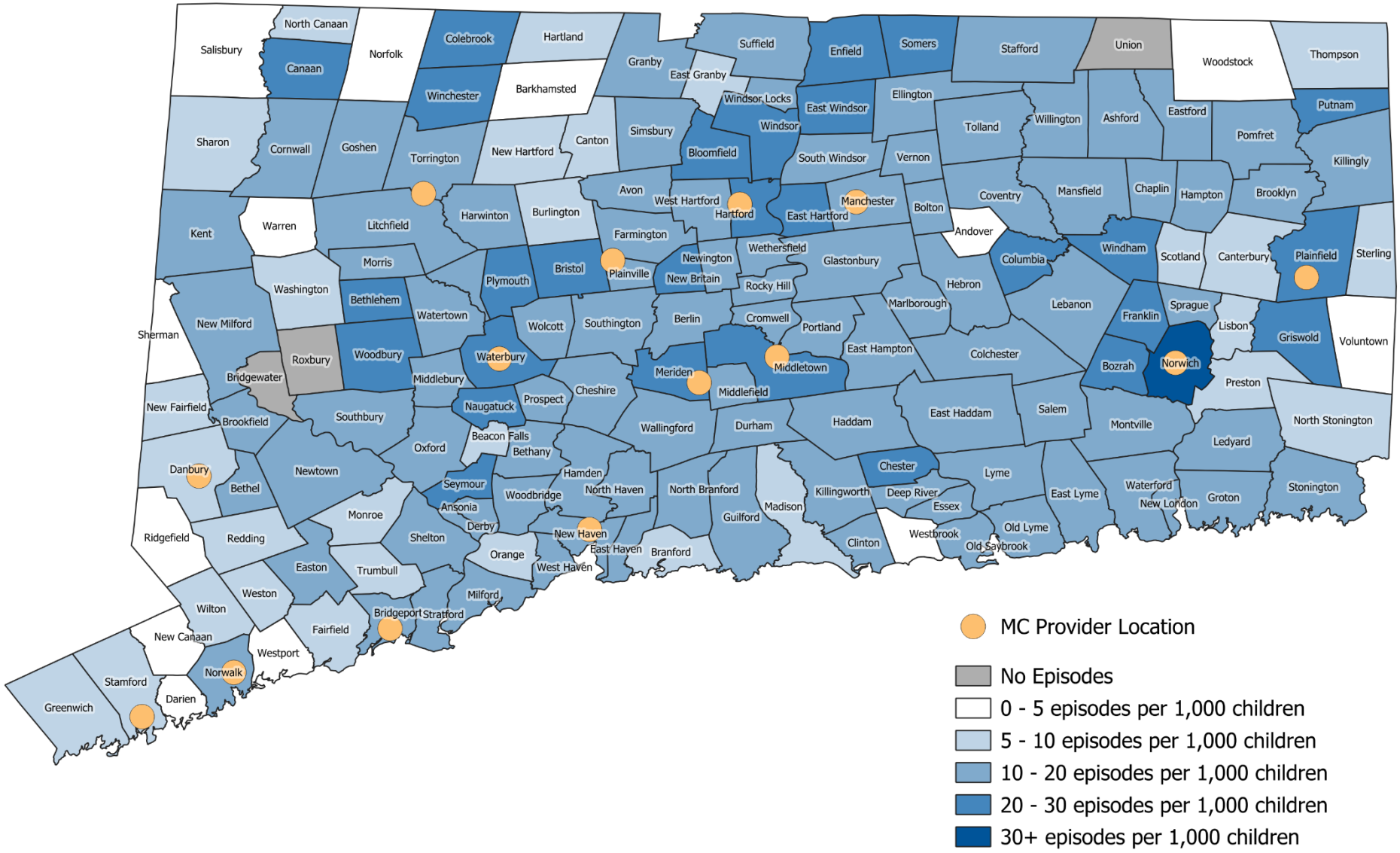


Figure 6 provides a visual representation of Mobile Crisis episode volume across the state. The map indicates the rate of Mobile Crisis episodes in each town during FY2025, relative to each town's child population (episodes per 1,000 children). There were three towns that didn't have a Mobile Crisis episode compared to two towns without an episode in FY2024. The major cities of Hartford and Waterbury each had over 750 episodes this year, while Bridgeport and New Haven each had over 500 episodes.

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



When did calls come in?

The majority of episodes (70.8%) resulted from calls that came in Monday-Friday between 7 a.m. and 5 p.m. An additional 16.6% of episodes were initiated on weekdays between 5 p.m. and midnight, and 10.6% came in at any time over the weekend. Only 2.6% of episodes were initiated between midnight and 7 a.m. In January 2023, Mobile Crisis expanded to 24-hour mobile availability. Previously, mobile hours were from 6 a.m. to 10 p.m. during the week and from 1 p.m. to 10 p.m. on weekends and holidays. In FY2025, 7.6% of all episodes were initiated during these additional mobile hours. Of the calls during these hours, the majority came in either between 10 p.m. and midnight on any day of the week (37.2%) or between 6 a.m. and 1 p.m. on the weekends (38.2%). The pattern of call times is very similar to FY2024.

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

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
0:00-0:59	12	14	20	8	8	13	10	**85**
1:00-1:59	12	10	6	8	3	5	5	**49**
2:00-2:59	3	6	4	7	6	4	1	**31**
3:00-3:59	4	1	3	1	3	3	3	**18**
4:00-4:59	2	2	1	1	2	0	3	**11**
5:00-5:59	1	4	4	5	3	2	3	**22**
6:00-6:59	2	19	16	10	16	15	4	**82**
7:00-7:59	2	57	73	74	47	45	8	**306**
8:00-8:59	9	119	135	127	117	111	15	**633**
9:00-9:59	33	173	209	187	171	189	26	**988**
10:00-10:59	32	231	223	255	257	214	45	**1257**
11:00-11:59	36	213	231	226	225	210	41	**1182**
12:00-12:59	39	182	227	211	223	196	43	**1121**
13:00-13:59	46	198	193	188	218	201	46	**1090**
14:00-14:59	45	182	190	163	133	171	43	**927**
15:00-15:59	48	143	148	127	135	135	46	**782**
16:00-16:59	50	108	100	105	109	76	47	**595**
17:00-17:59	46	80	91	90	79	78	43	**507**
18:00-18:59	49	79	76	104	79	79	43	**509**
19:00-19:59	42	74	63	72	66	55	33	**405**
20:00-20:59	27	54	70	72	54	56	29	**362**
21:00-21:59	31	39	53	46	35	34	36	**274**
22:00-22:59	21	35	38	30	23	28	24	**199**
23:00-23:59	22	21	20	11	20	17	16	**127**
	614	**2044**	**2194**	**2128**	**2032**	**1937**	**613**	**11562**

Who is being served?

Mobile Crisis has consistently served Black and Hispanic youth at higher rates than the Connecticut population. Children served this year were 52% female and 48% male. The rates of each racial and ethnic group served were consistent for both sexes. The majority of children served were between ages 9 and 15 (63%). These demographics are all consistent with past years

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

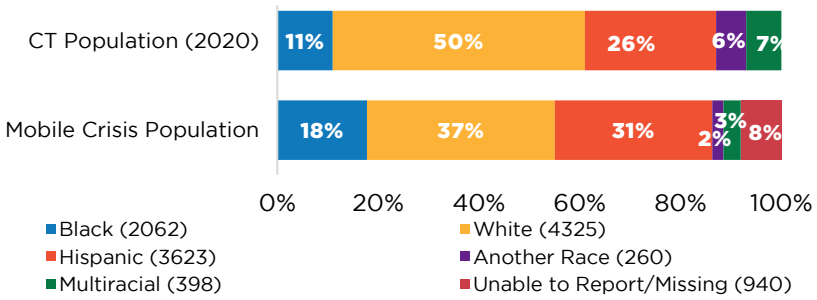
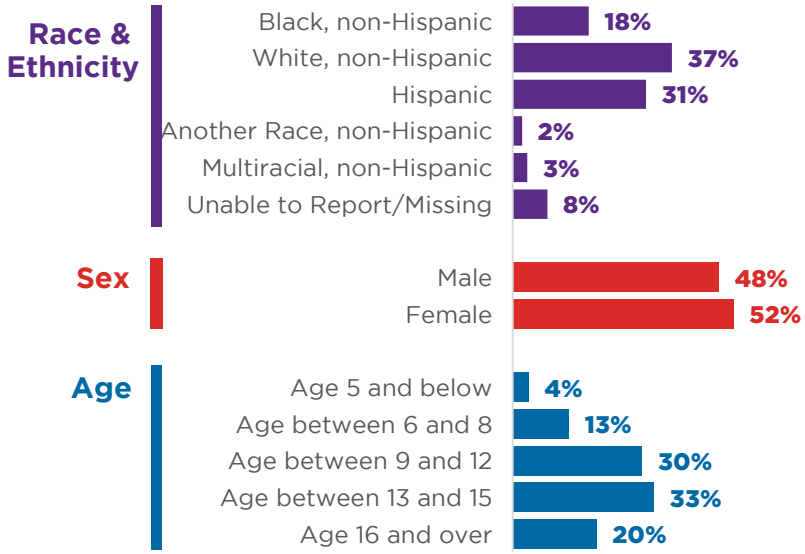


Figure 8. Demographics of children served.



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

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

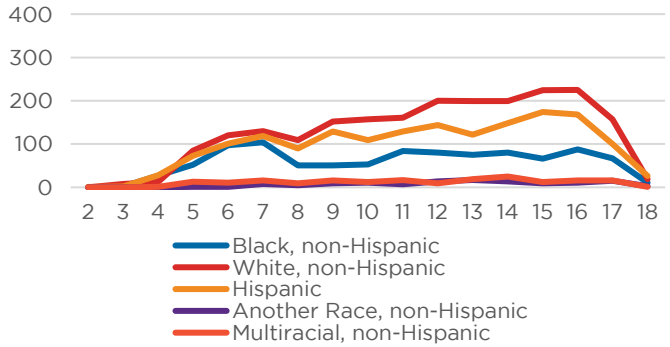
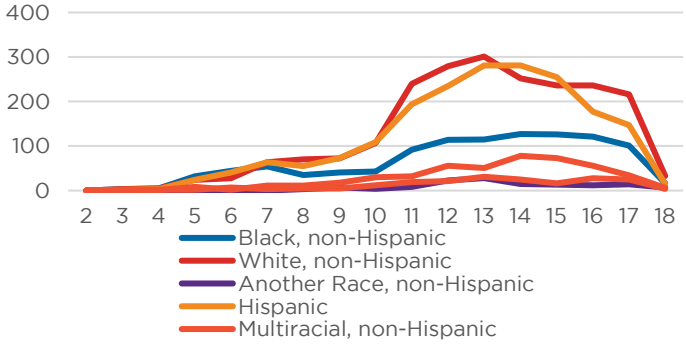


Figure 10. Female children served by race/ethnicity and age.

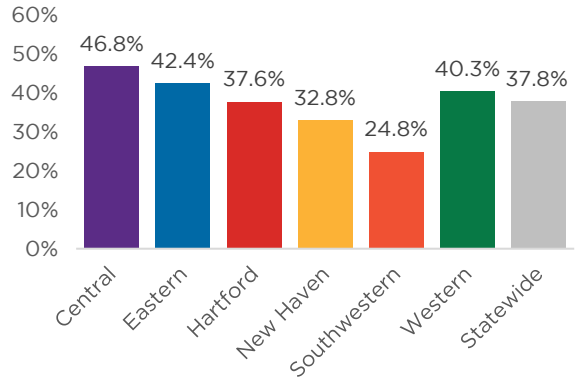


The majority of children served were covered by **Medicaid (62.3%)** or **private health insurance (27.8%)**. Additionally, **86.2% of children did not have an active case with DCF.**

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

Statewide, **37.8% of children[1] served by Mobile Crisis reported a history of trauma**, compared to 38.2% in FY2024. It is important to note that 28.9% were missing data on these variables; it is unclear whether this missing data indicates not having experienced trauma or the question not being asked/answered. The remaining 33.3% of children reported not having experienced trauma. PIE asks about five specific types of trauma. Of the children who reported any type of trauma, the most reported type was disrupted attachment (40%). Thirty percent reported being a witness to violence, 25% reported being a victim of violence, and 18% reported sexual victimization. A small number reported the recent arrest of a caregiver (0.9%). Additionally, 43% of youth who reported trauma indicated experiencing another type of trauma not specified in PIE.

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



As part of their assessment, Mobile Crisis providers ask the child and their family about the child's history, particularly surrounding behavioral health crises. In the 6 months prior to the Mobile Crisis episode, 15.1% of children report having visited the emergency department for psychiatric concerns, consistent with 15.5% of children in FY2024. This data was missing for 29.3% of children, while 55.6% reported not having been to the ED. Additionally, 8.6% report an inpatient stay in the last 6 months, similar to FY2024 (8.5%). This data was missing for 29.3% of children, while 62.0% said no. A small number of children served reported being arrested (1.6%) or detained (0.8%) in the year prior to their episode of care. Alcohol and Drugs were not commonly reported, with 6.2% of children reporting alcohol and/or drug use in their lifetime, and 5.9% reporting use in the prior 6 months. Approximately 9% of children reported having been suspended from school in the past year. Sixty percent of children reported having issues at school, most commonly citing emotional issues (41%), behavioral issues (33%), social issues (28%), and academic issues (19%).

Table 2. Child history.

Child History	Lifetime	Prior 6 months
Emergency Department Psych		15.1%
Inpatient Psych	15.6%	8.6%
Out-of-Home Psych	3.0%	1.7%
Alcohol and Drugs	6.2%	5.9%
		Prior 12 months
Arrested		1.6%
Detained		0.8%
Suspended from School		9.4%

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

Who is making the call?

Statewide, **schools were the top caller to Mobile Crisis (41.5%)** followed closely by self/family (39.9%). In contrast to the rest of the state, the Eastern region had families as the top callers. Only about 2% of self/family calls were from the youth themselves. Emergency Departments are the third most common caller statewide (9.4%), which varies significantly by region ranging from 21.1% of calls in the Western region to only 1.1% in the Southwestern region.

Table 3. Caller type by region.

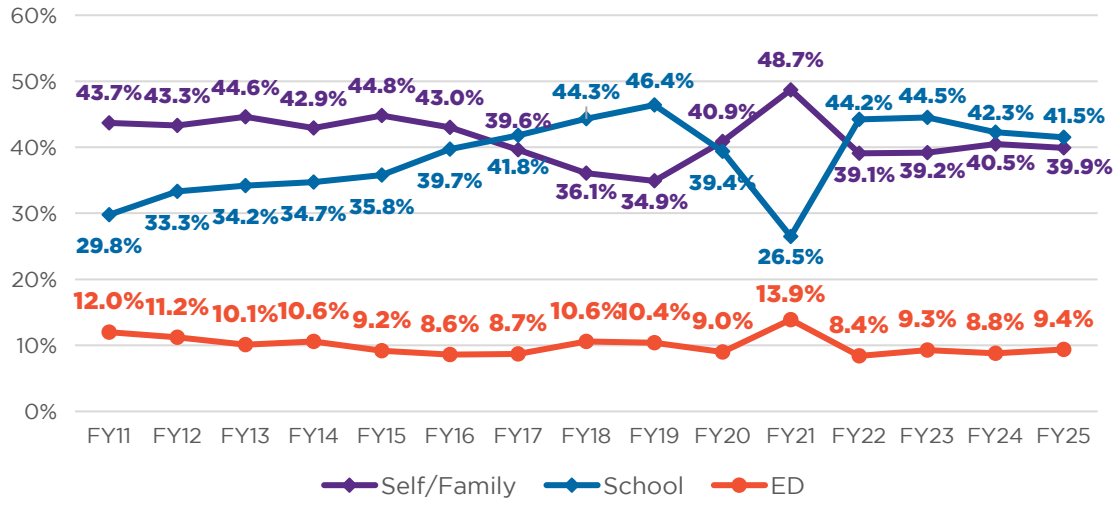
Caller type	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
School	40.6%	40.8%	40.7%	43.3%	48.7%	36.8%	**41.5%**
Self/Family	39.8%	47.3%	37.2%	43.0%	42.8%	34.2%	**39.9%**
Emergency Department	8.2%	1.8%	11.0%	8.1%	1.1%	21.1%	**9.4%**
Psychiatric Hospital	3.7%	4.4%	4.0%	1.3%	1.1%	2.4%	**3.0%**
Other Referral Source	2.5%	2.3%	2.6%	2.5%	3.0%	2.4%	**2.6%**
Other Community Provider Agency	2.5%	1.9%	2.4%	1.1%	1.9%	2.0%	**2.0%**
Other Program Within Agency	1.7%	0.5%	0.5%	0.2%	0.9%	0.4%	**0.7%**
Police	0.5%	0.6%	1.3%	0.3%	0.4%	0.6%	**0.7%**
Foster Parent	0.4%	0.4%	0.3%	0.2%	0.1%	0.1%	**0.3%**

How has caller type changed over time?

The top three caller types are consistent with recent years. Outside of the peak of the COVID-19 pandemic, **schools have been the top callers since FY2017**, largely in response to the development of MOAs between Mobile Crisis and Connecticut school districts.

The top referring EDs in FY2025 were CCMC (40.1% of ED referrals), St. Mary's Hospital (37.6%), and Yale-New Haven Hospital (14.8%). The number of calls from CCMC increased 66% compared to FY2024, when they had seen a significant decline. The number of calls from St. Mary's and Yale both decrease slightly (12% and 6% respectively). Overall, calls from EDs increased by 9% compared to last year.

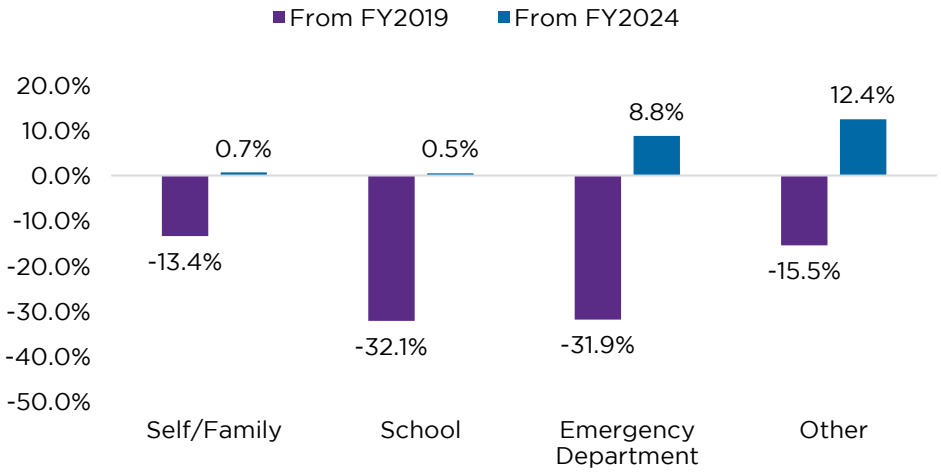
Figure 12. Caller type over time.



How has the decline in volume varied by caller type?

After beginning to rebound from the effects of the pandemic in FY2022, episode volume declined in FY2023 and FY2024. This year, volume is slightly higher than FY2024. Compared to last year, **calls from emergency departments and other (not school or self/family) referral sources increased** by 8.8% and 12.4% respectively. The number of calls from schools and self/family remained stable. Calls from schools (-32.1%) and EDs (-31.9%) continue to have the greatest declines from pre-pandemic, though the gap is shrinking for ED calls. It is important to consider that smaller overall rates of calls from EDs and other sources create more dramatic fluctuations in percentage change.

Figure 13. Change in volume by caller type.

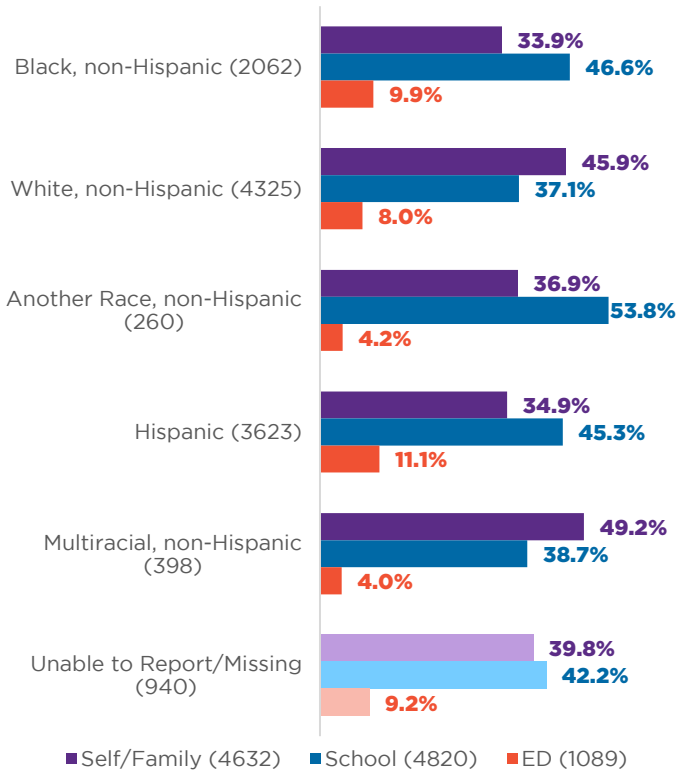


Did different referrers call at the same rates for all youth?

The people making calls to Mobile Crisis are a key determinant of who has access to the service. As such, it is important to monitor whether referrals are being made equitably. Notable findings from FY2025 include:

- White youth and Multiracial youth had higher rates of self/family referrals than Black and Hispanic youth.
- Black youth, Hispanic youth, and youth identifying as another race all had higher rates of calls from schools than White youth.
- Black and Hispanic youth have the highest rates of ED referrals – both groups have significantly higher rates than Multiracial youth and youth identifying as another race, while Hispanic youth have a significantly higher rate than White youth.
- These differences are statistically significant, but the effect size[2] is small ($p<.001$; $C=.137$). **This means that while the differences can be reliably detected, due in part to large sample sizes, the practical significance (measured by effect size) is limited.** Small effect sizes suggest this trend is one to continue to monitor but to be cautious in interpreting as representing meaningful differences.

Figure 14. Caller type by race and ethnicity.



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

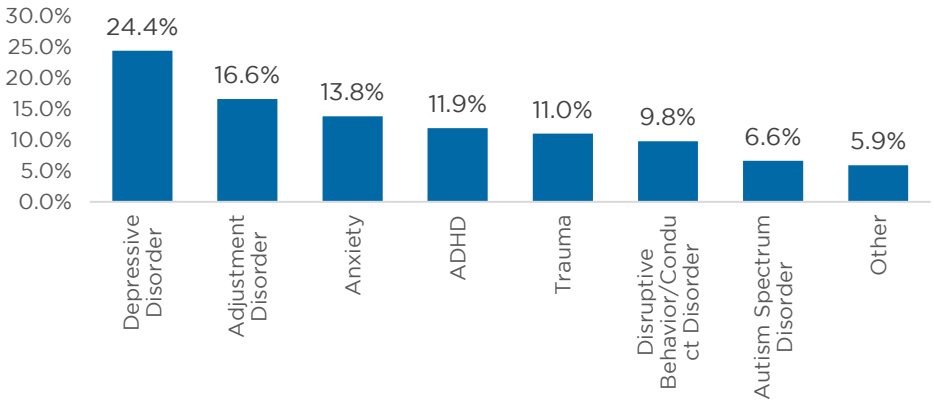
Why did they call?

The top presenting problems statewide were Harm/Risk of Harm to Self (30.2%) and Disruptive Behavior (25.5%). This varied among regions, with disruptive behavior being the top presenting problem by a small margin in the Hartford, Southwestern, and Western regions. Due to the short nature of a Mobile Crisis episode, data on presenting problems are typically more relevant than diagnosis. The top diagnoses are depressive disorders (24.4%), adjustment disorders (16.6%), and anxiety (13.8%).

Table 4. Top presenting problems by region.

Presenting Problem	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Harm-Risk of Harm to Self	42.1%	37.0%	23.7%	31.1%	25.6%	26.6%	**30.2%**
Disruptive Behavior	23.7%	20.3%	26.6%	26.6%	27.0%	27.6%	**25.5%**
Depression	6.9%	7.1%	13.7%	10.0%	11.8%	14.0%	**11.1%**
Other	4.4%	10.1%	12.0%	8.3%	12.5%	9.7%	**9.7%**
Anxiety	4.9%	6.6%	10.4%	5.5%	5.9%	7.4%	**7.2%**
Family Conflict	6.3%	4.4%	4.3%	7.8%	7.4%	6.1%	**5.9%**
School Problems	5.8%	5.6%	5.1%	4.3%	6.9%	5.1%	**5.4%**
Harm/Risk of Harm to Others	5.9%	8.9%	4.1%	6.4%	2.9%	3.4%	**5.0%**

Figure 15. Top diagnoses.



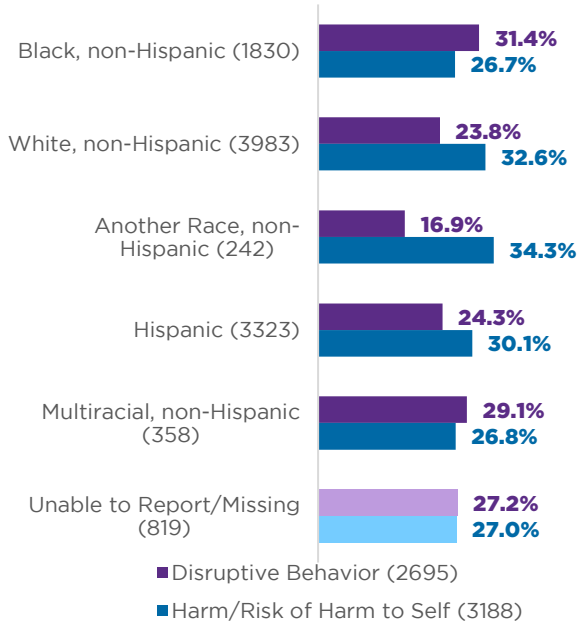
Were children referred for similar reasons across race and ethnicity?

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

Notable findings from FY2025 include:

- Harm/risk of harm to self is the top presenting problem among all racial and ethnic groups except for Black children and Multiracial children, who are most commonly referred for disruptive behavior.
- Disruptive behavior drives 31.4% of referrals for Black children, compared to 24.3% for Hispanic children and 23.8% for White children.
- Children identifying as a race or ethnicity outside of the three major categories are also less likely to be referred for disruptive behavior, which only makes up 16.9% of their referrals.
- White youth had significantly higher rates of referral for harm/risk of harm to self compared to Black youth.
- **The above differences are statistically significant, but with a negligible effect size (p<.001; C=.080), indicating that in practical terms, there is no meaningful difference between groups.**

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



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

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

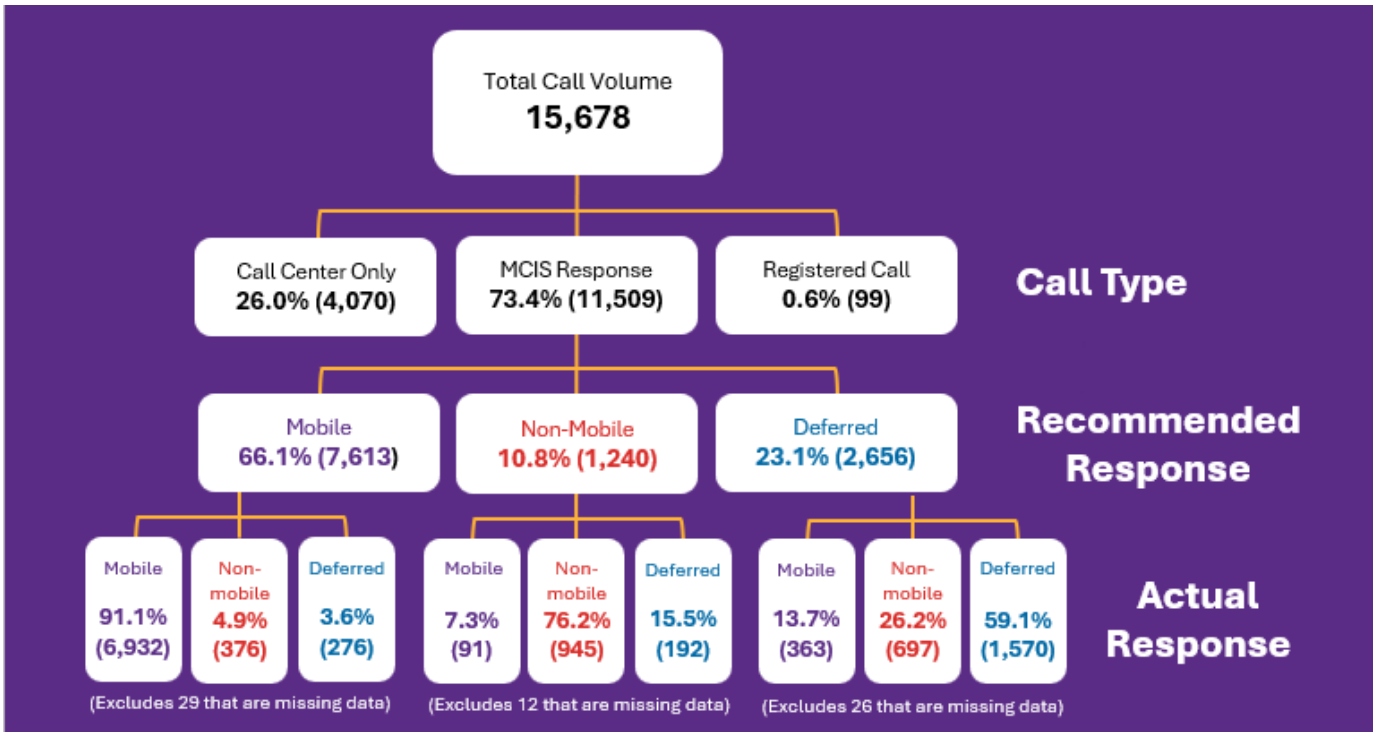
Statewide, the mobility rate in FY2025 was 95.8% -- higher than last year's rate of 94.4% and exceeding the 90% benchmark.

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

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

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

The 2-1-1 call specialist will discuss the options with the caller to identify the type of response that is recommended to the provider. This recommendation should be based on the needs and wishes of the child and family. The response that is actually provided is typically consistent with the recommendation, though there are some episodes where the response type will change upon further discussion with the family or due to changing circumstances. In FY2025, 89.2% of callers requested a Mobile (66.1%) or Deferred Mobile (23.1%) response. An additional 10.8% requested non-mobile phone support. For the actual response by Mobile Crisis providers, 64.5% received a Mobile response, 18.0% received a Deferred Mobile response, and 17.5% received a non-mobile response.



Most episodes received a response that was consistent with the request of the caller (82.6%), with an additional 5.7% receiving a more enhanced response than what was originally requested. A small number of callers (2.4%) requested a Mobile and received a Deferred Mobile, while 9.4% requested a Mobile or Deferred Mobile response and received a non-mobile response. Of these responses that changed to non-mobile, 92.9% were because the family later declined a mobile response or was unable to be reached. An additional 3.7% involved the original third-party caller cancelling the request.

Table 5. Non-mobile reason by provider (when original request was for face-to-face response).

	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Family Declined Mobile	73.3%	69.4%	75.5%	80.5%	67.9%	76.2%	**75.2%**
Family Not Available	21.4%	19.8%	19.0%	13.3%	15.1%	15.6%	**17.7%**
EMPS Decision	1.6%	1.8%	3.3%	2.9%	11.3%	5.7%	**3.4%**
Third Party Cancelled	3.7%	9.0%	2.2%	3.3%	5.7%	2.5%	**3.7%**

Did mobility rates vary by provider or region?

All six regions exceeded the benchmark, with performance ranging from 90.6% (New Haven) to 97.5% (Western). Among individual providers, all 14 exceeded the 90% benchmark, with performance ranging from 90.6% (Clifford Beers) to 98.6% (CFGC: Bridgeport). **Most mobile responses took place in homes (49.7%) or schools (42.3%)**. A small percentage took place in a hospital emergency department (6.0%) or other community location (1.9%).

Figure 18. Mobility rate by region.

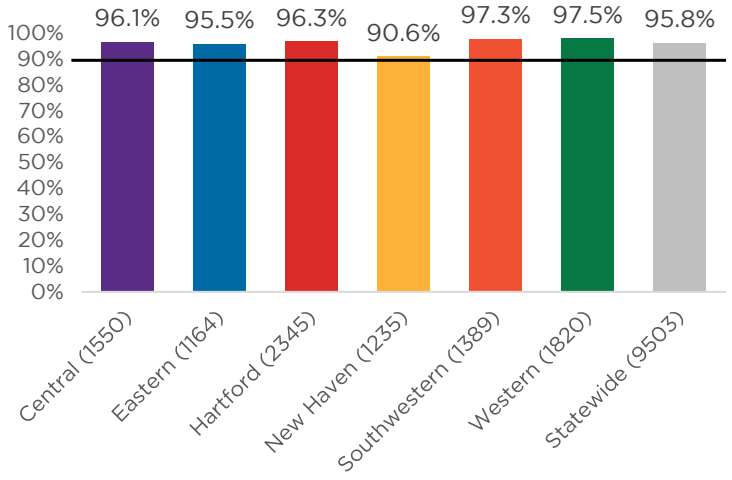
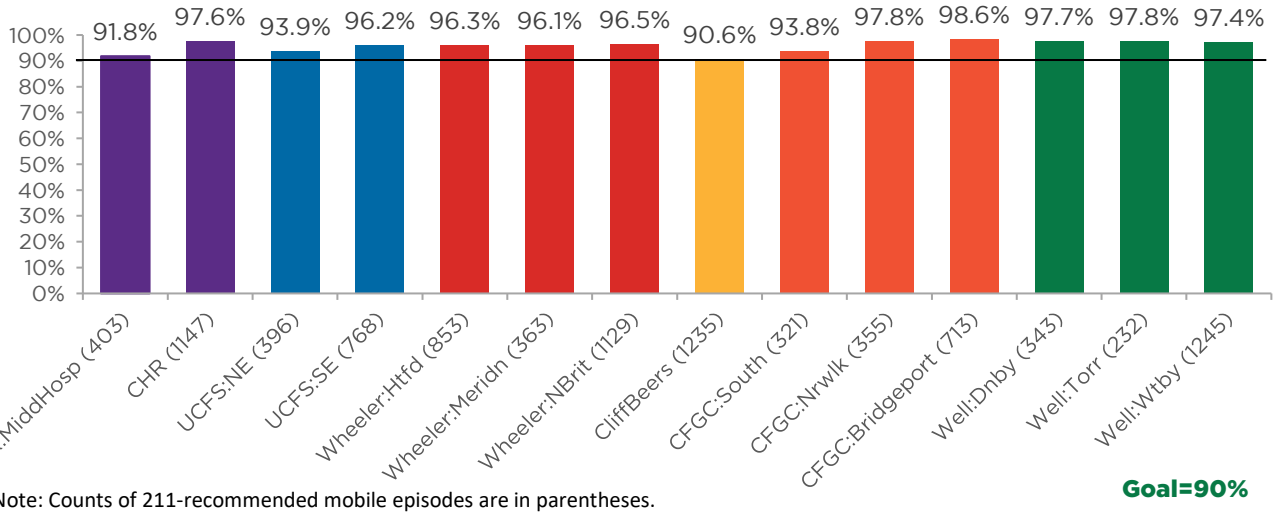


Figure 19. Mobility rate by provider.

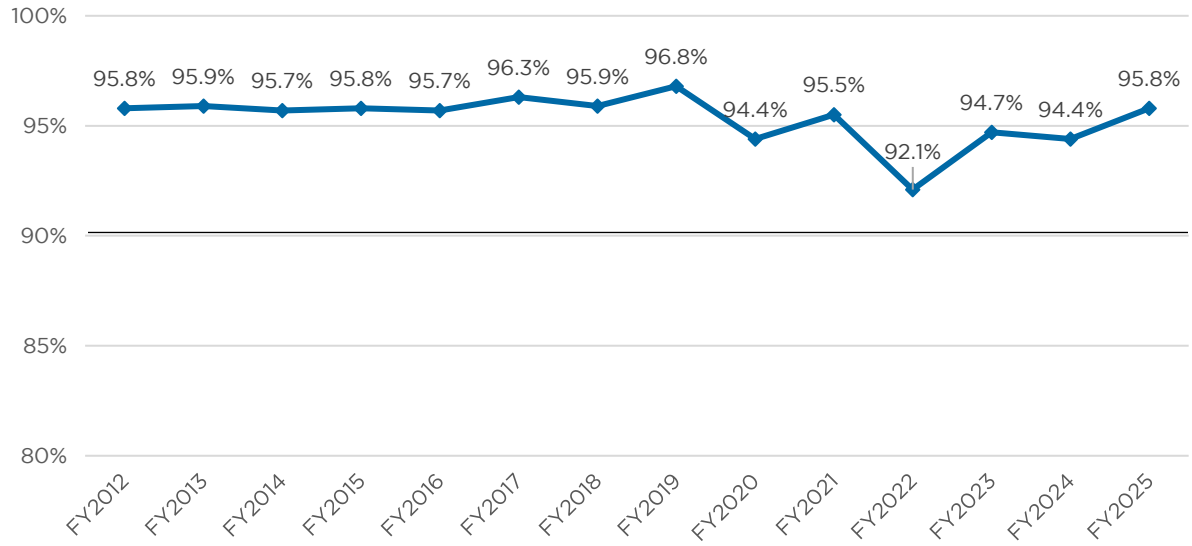


Note: Counts of 211-recommended mobile episodes are in parentheses.

How have mobility rates changed over time?

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

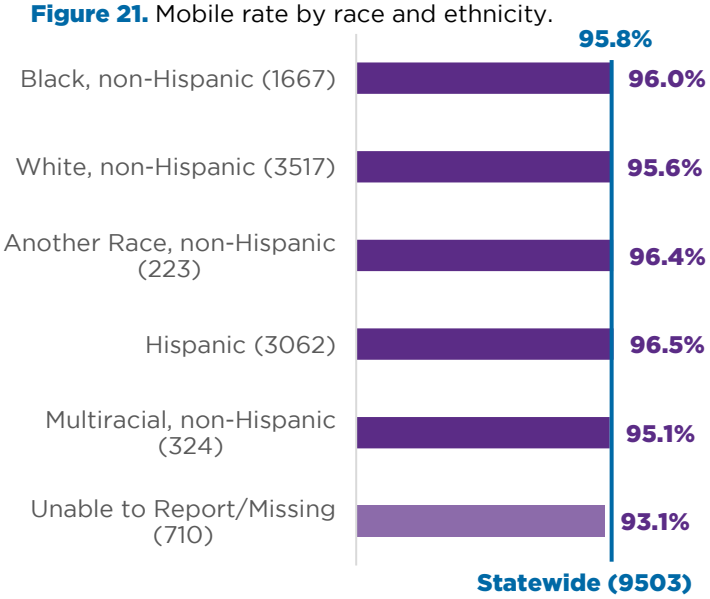
Figure 20. Statewide mobility rate over time.



Do mobility rates vary by race and ethnicity?

While it is a good sign that Mobile Crisis has consistently exceeded the 90% mobility benchmark on a statewide level, it's important to ensure that all children are receiving the same quality service. There is minimal variation in mobility rate between racial and ethnic groups, with the only significant difference being a higher mobility rate for Black and Hispanic youth than for youth whose race is not reported; however, the effect size is negligible (p=.003; C=.044), suggesting there is no meaningful difference between groups in receipt of mobile responses.

Figure 21. Mobile rate by race and ethnicity.



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

The median response time in FY2025 was 30 minutes. This is comparable to FY2024, when it was 29 minutes. Of the 7,137 episodes that received an immediate Mobile response, **88.0% received a response within 45 minutes**, exceeding the 80% benchmark and higher than 86.6% in FY2024. **All six regions exceeded the benchmark**, with performance ranging from 81.4% (Hartford and Western) to 97.2% (New Haven). Eleven of the fourteen individual providers met or exceeded the 80% benchmark, with performance ranging from 51.1% (Wellmore: Danbury) to 98.5% (CHR: Middlesex). The median response time for deferred mobile episodes was 3.9 hours.

Figure 22. Response time under 45 minutes by region.

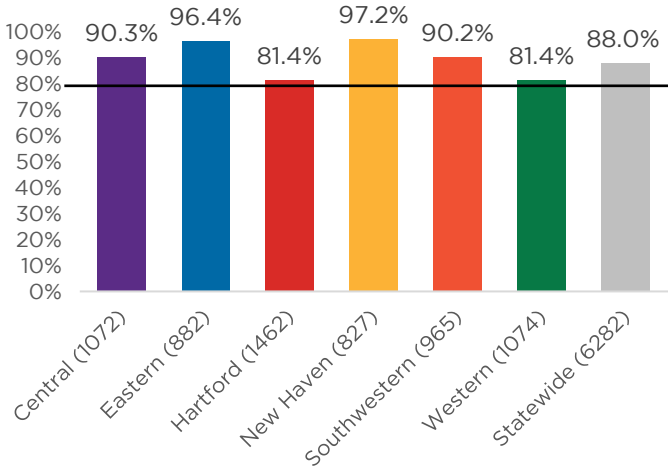
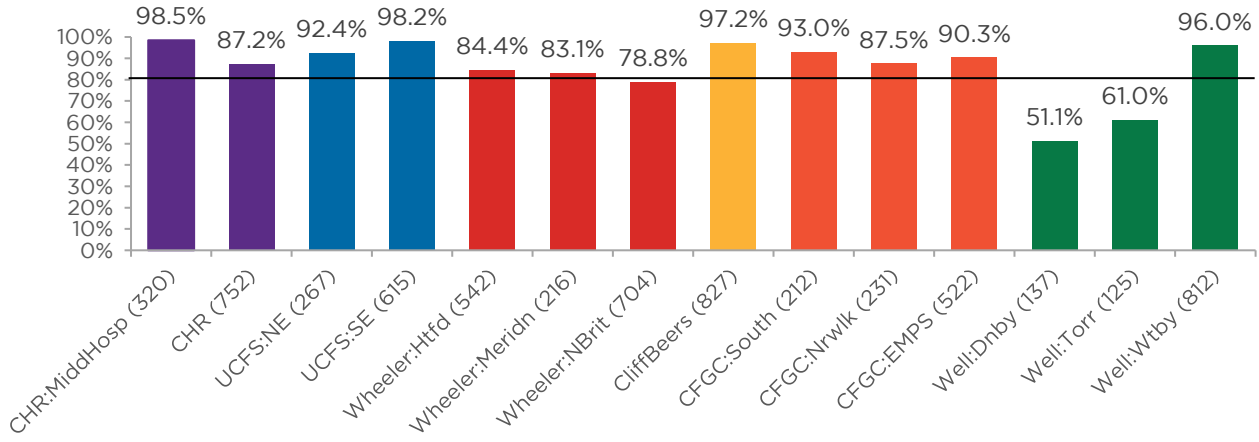


Figure 23. Response time under 45 minutes by provider.



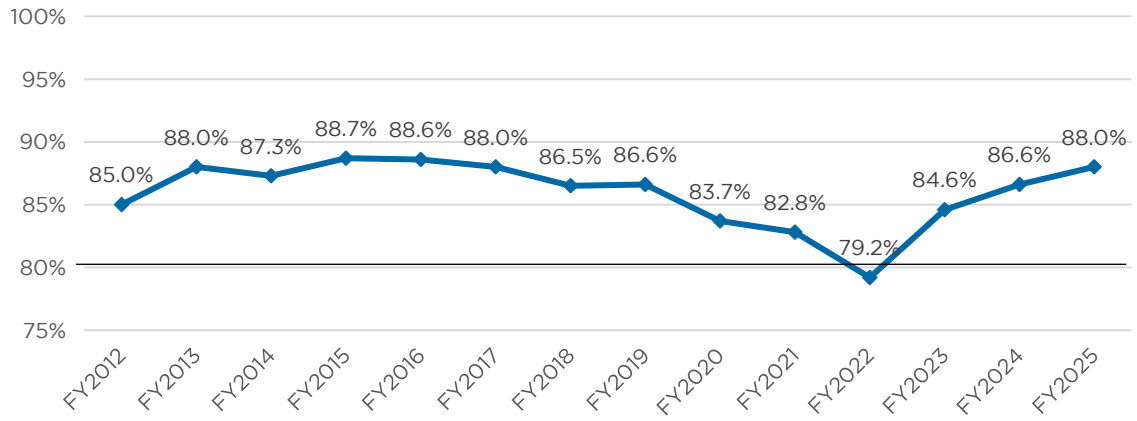
Note: Counts of mobile episodes under 45 minutes are in parentheses

Goal=80%

How has response time changed over time?

The only year that the response time benchmark was not met statewide was FY2022, when it was slightly below 80% due to significant workforce shortages. **The percentage of responses provided in 45 minutes or less has increased over the last two years, with FY2025 having the highest rate since FY2017**.

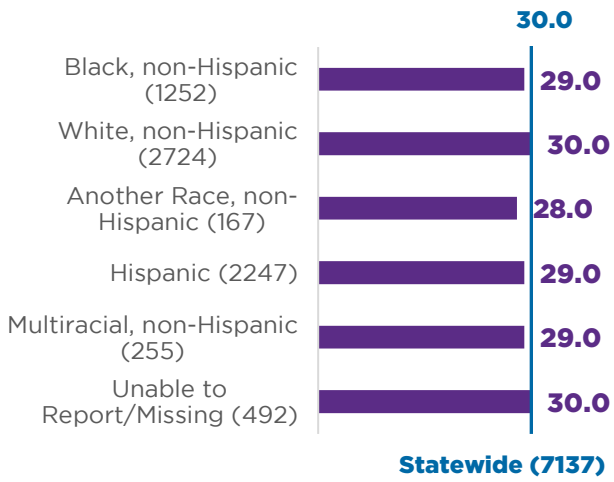
Figure 24. Statewide response time under 45 minutes over time.



Did response time vary by demographic group?

While it is a good sign that Mobile Crisis has consistently exceeded the 80% mobility benchmark on a statewide level, it's important to ensure that all children are receiving the same quality service. There is minimal variation in median response time between racial and ethnic groups, and no statistically significant differences between groups. The slight variation that does exist is likely related to the demographics of towns closer to Mobile Crisis offices, which are more likely to have larger populations of Black and Hispanic youth; compared to towns on the outskirts of Connecticut that tend to have larger populations of White youth.

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



How often are youth receiving ongoing stabilization services?

Statewide, **40.8% of episode include stabilization services**. Use of stabilization services varied significantly by region, with New Haven providing stabilization services for 8.2% of episodes, and Central providing stabilization services for 71.1% of episodes. This variability suggests this is also a data element that appears to be used inconsistently across providers and needs a clearer definition (this work was undertaken in FY2025). Children receiving stabilization services received an average of 1.6 face-to-face contacts per episode.

There are a number of different Mobile Crisis intervention types:

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

Table 6. Crisis response type by region.

	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Crisis Response Plus Stabilization Follow-Up	71.1%	12.4%	55.1%	8.2%	10.3%	60.0%	**40.8%**
Crisis Response: Face-to-Face	6.2%	63.2%	21.3%	56.2%	56.6%	16.7%	**32.7%**
Crisis Response: Phone Only	20.6%	23.8%	21.8%	26.5%	15.4%	14.1%	**20.2%**
Face to Face: Consultation Only	2.1%	0.4%	1.7%	9.1%	17.7%	9.2%	**6.2%**
Telehealth	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	**0.1%**

How long are youth and families involved with Mobile Crisis?

Statewide, the median length of service for discharged episodes was less than one day for a phone only response, 5 days for a face-to-face response, and 17 days for a plus stabilization follow-up response. 24.7% of phone only episodes exceeded one day, 45.7% of face-to-face episodes exceeded 5 days, and **2.1% of plus stabilization follow-up episodes exceeded 45 days, meeting the statewide benchmark of less than 5%**.

Table 7. Length of service for discharged episodes.

		Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Phone Only	**N**	407	336	621	414	254	252	**2284**
	Median (Days)	2	0	0	0	0	0	**0**
	Exceeding 1 day	54.3%	9.5%	27.4%	7.2%	8.7%	35.3%	**24.7%**
Face to Face	**N**	115	887	601	868	864	338	**3673**
	Median	2	4	2	18	18	2	**5**
	Exceeding 5 days	17.4%	15.3%	22.0%	83.2%	74.0%	9.2%	**45.7%**
Plus Stabilization Follow Up	**N**	1367	167	1561	129	157	1196	**4577**
	Median	20	22	15	28	39	15	**17**
	Exceeding 45 days	1.8%	4.8%	0.1%	13.2%	10.2%	2.6%	**2.1%**

Among open episodes of care, the median length of service was 44 days for phone only episodes, 31 days for face-to-face episodes, and 25 days for plus stabilization follow-up episodes. 96.6% of phone only episodes exceeded the one day benchmark, 89.4% of face-to-face episodes exceeded the five day benchmark, and 30.7% of plus stabilization follow-up episodes exceeded the 45 day benchmark. Cases that remain open for services for long periods of time can impact responsiveness as call volume continues to increase and can compromise accurate and timely data entry. It is also likely that many Phone Only and Face-to-Face cases that are open significantly past benchmarks are due to data entry errors or delays in closing the case in PIE. Additionally, updated categories and data definitions for episode types to be implemented in FY2026 should improve rates of open cases beyond the benchmark.

Table 8. Length of service for open episodes (as of 6/30/25).

		Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Phone Only	**N**	8	0	9	1	2	39	**59**
	Median (Days)	91.5	N/A	44	188	80.5	34	**44**
	Exceeding 1 day	87.5%	N/A	88.9%	100.0%	100.0%	100.0%	**96.6%**
Face to Face	**N**	10	4	14	11	78	6	**123**
	Median	41	7	31	23	36	14.5	**31**
	Exceeding 5 days	100.0%	75.0%	85.7%	81.8%	92.3%	66.7%	**89.4%**
Plus Stabilization Follow Up	**N**	65	8	33	0	14	43	**163**
	Median	48	38.5	21	N/A	21	20	**25**
	Exceeding 45 days	52.3%	25.0%	21.2%	N/A	7.1%	14.0%	**30.7%**

How often were more restrictive services used during the episode?

Mobile Crisis also collects data on how often children utilize a more restrictive crisis services during the episode of care. In FY2025, 7.5% of families reported visiting the ED during their Mobile Crisis episode. No utilization of the ED during the episode was reported by 30.8% of families, while 61.7% were missing data. While it is likely that many of the missing responses represent a lack of ED utilization, we cannot be certain. Of the children who did visit the ED during their Mobile Crisis episode, 10.5% received a referral to the ED from Mobile Crisis. Admission to an inpatient psychiatric hospital during the episode was reported by 3.1% of children. No inpatient utilization was reported by 35.2% of families, while 61.7% were missing data. Of the children who did have an inpatient admission, 53.4% received a referral to inpatient from Mobile Crisis.

Did youth experience clinical improvement?

The Ohio Scales are intended to be completed at intake and discharge by parents and Mobile Crisis clinicians, for stabilization plus follow-up episodes in which children are seen in person for multiple sessions over a timeframe of at least 5 and up to 45 days.

In FY2025, collection rates[3] of all Ohio scales increased slightly compared to FY2024. The Western region had the highest collection rates of worker Ohio scales at both intake and discharge. The Eastern region had the highest collection rate of parent Ohio scales at intake, and the Southwestern region had the highest collection rates of parent Ohio scales at discharge.

Figure 26. Ohio scale collection rates over time.

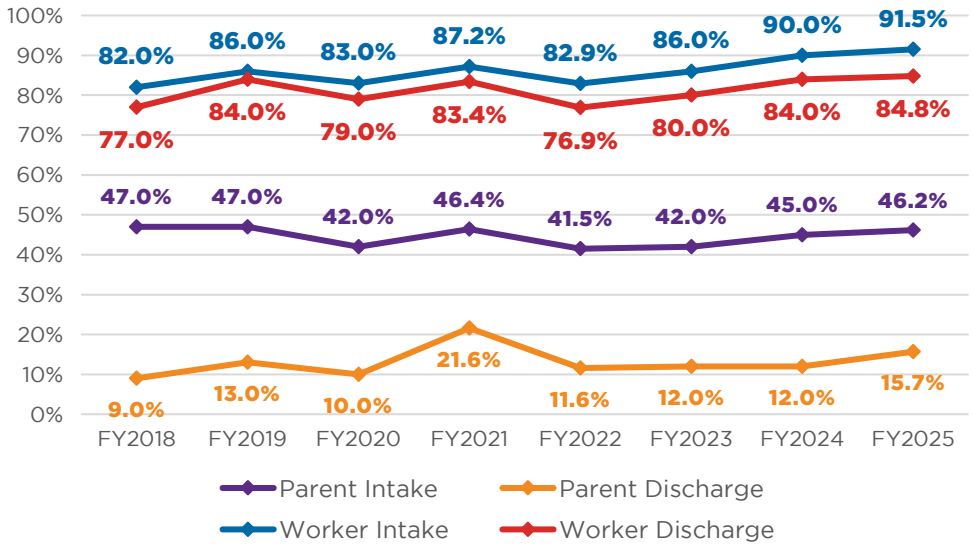


Figure 27. Ohio scale collection at intake by region.

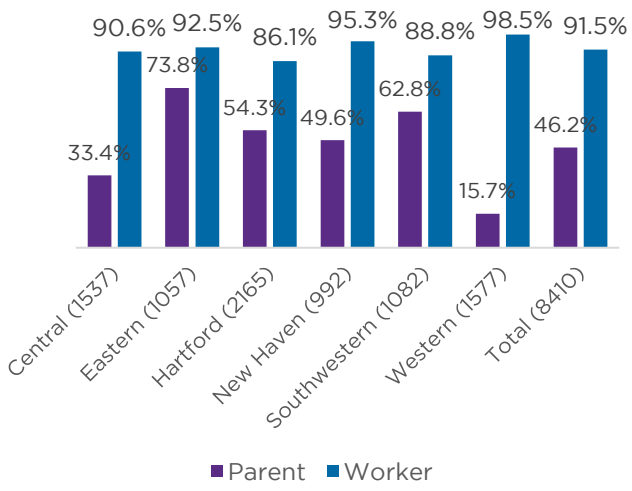
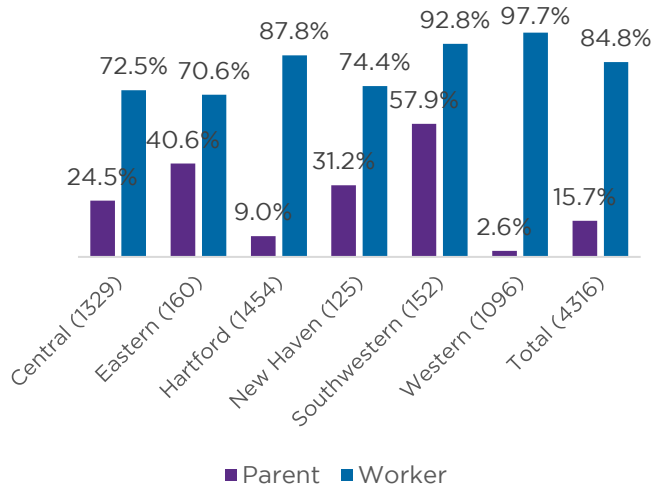


Figure 28. Ohio scale collection at discharge by region.



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

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

Compared to FY2024, rates of improvement[4] from intake to discharge decreased across all Ohio scales. Rates of improvement vary across regions, with the Western and Eastern regions generally seeing the highest rates of improvement. There was no consistent variation in improvement by race and ethnicity.

Figure 29. FY2024 - Any improvement on Ohio Scales Reliable Change Index.

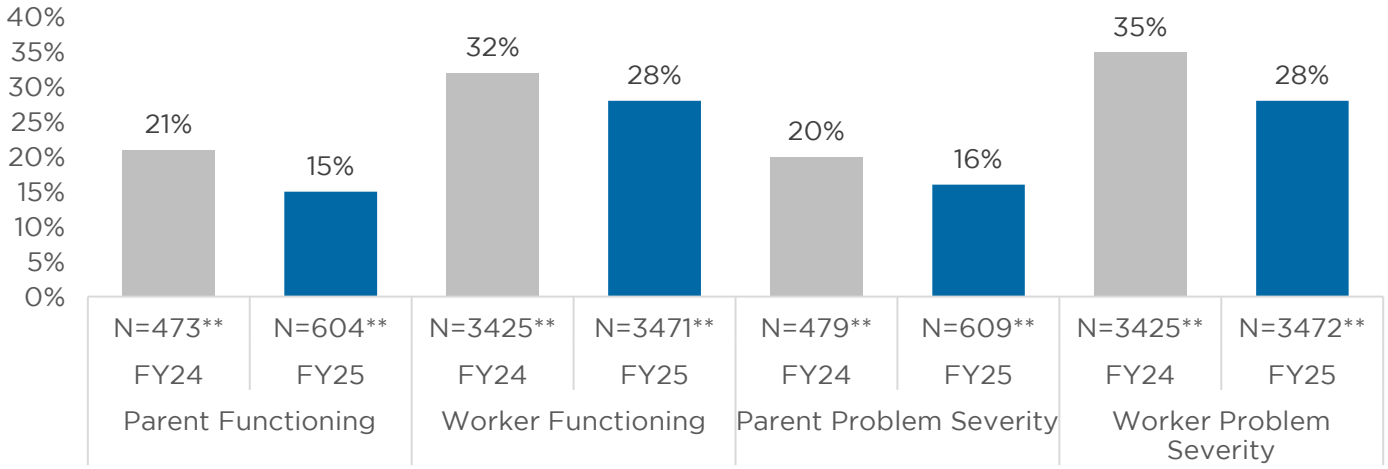


Table 9. Any improvement on Ohio Scales Reliable Change Index by region.

	Central	Eastern	Hartford	New Haven	Southwestern	Western
Parent-Completed Functioning Scale	4% N=286	47% N=62**	16% N=117	5% N=39	35% N=77†	30% N=23**
Worker-Completed Functioning Scale	11% N=968**	38% N=111**	16% N=1285**	15% N=96	24% N=141*	59% N=1140**
Parent-Completed Problem Severity Scale	5% N=286*	35% N=63**	19% N=120**	3% N=39	33% N=78**	52% N=23**
Worker-Completed Problem Severity Scale	9% N=968**	40% N=111**	17% N=1285**	22% N=96**	27% N=141**	55% N=1141**

[4]Beginning in FY2019, the Mobile Crisis PIC began using the Reliable Change Index (RCI) to measure additional levels of change in Ohio Scale scores (See Statewide RBA). RCI is a method for taking change scores on an instrument and interpreting them in easily understandable categories. Using the properties of a specific instrument (the mean, standard deviation, and reliability), RCI identifies cut-offs for which there is reasonable confidence that the change is not merely due to chance.

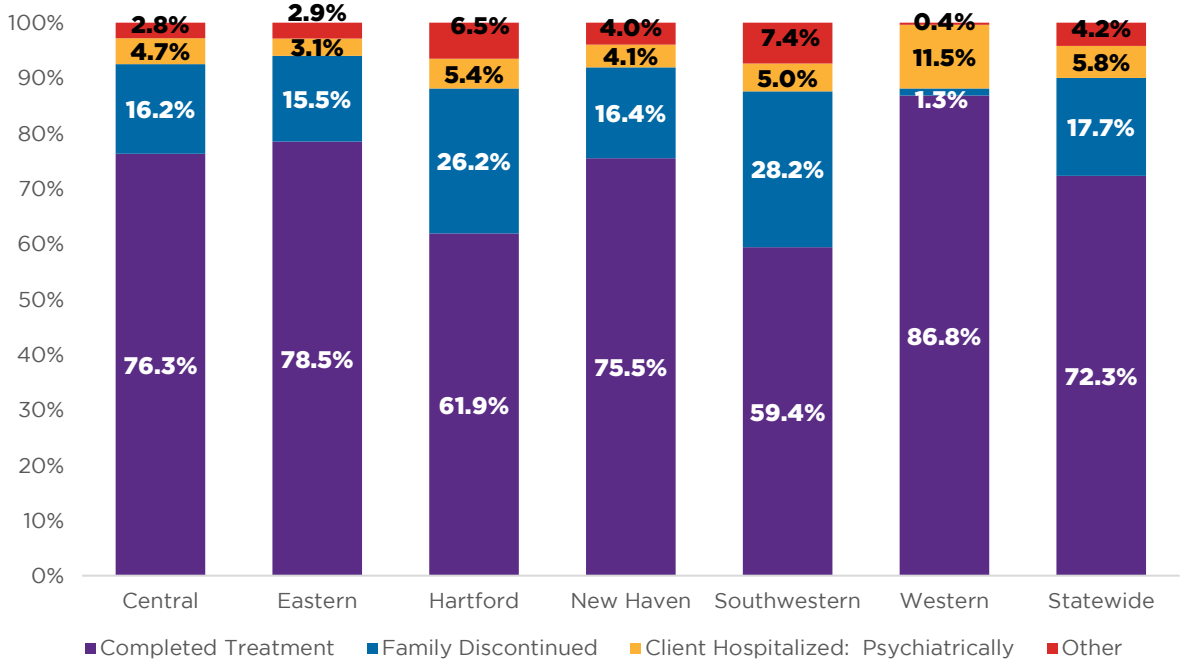
Table 10. Any improvement on Ohio Scales Reliable Change Index by race and ethnicity.

	Black, non-Hispanic	White, non-Hispanic	Another Race, non-Hispanic	Hispanic	Multiracial, non-Hispanic	Unable to Report/Missing
Parent-Completed Functioning Scale	18%	16%	20%	16%	10%	10%
	N=80	N=243**	N=20	N=177*	N=22	N=62
Worker-Completed Functioning Scale	21%	31%	25%	30%	30%	26%
	N=619**	N=1361**	N=76**	N=1257**	N=121*	N=307**
Parent-Completed Problem Severity Scale	14%	16%	11%	16%	14%	16%
	N=80†	N=244**	N=21	N=179**	N=23	N=62
Worker-Completed Problem Severity Scale	24%	29%	25%	29%	26%	30%
	N=620**	N=1361**	N=76**	N=1257**	N=121**	N=307**

Why were youth discharged?

Statewide, **the majority of youth (72.3%) were discharged for completing their treatment with Mobile Crisis.** For Mobile Crisis, completing treatment generally means that the clinician and family worked together to develop a safety plan, follow-up was provided as needed, and the family has been connected with other services or is no longer in need of services. As a short-term intervention, families could be involved with Mobile Crisis for only that initial face-to-face assessment and still have "completed treatment" if their needs were met. Families also sometimes make the choice to discontinue services or stop engaging with Mobile Crisis, which happened 17.7% of the time in FY2025. This varied among regions, ranging from 1.3% in the Western region to 28.2% in the Southwestern region. An additional 5.8% of children were discharged because they are hospitalized for psychiatric treatment, and 4.2% are discharged for reasons not previously mentioned. This is another data element where the PIC has identified a need for a clear and consistent definition among providers. As such, some of the variation between regions may be due to differing data definitions rather than differing outcomes.

Figure 30. Reason for discharge by region.



Were there differences in treatment completion rates across groups?

There is slight variation in rate of treatment completion by race and ethnicity – Black children have lower rates of treatment completion and higher rates of families discontinuing service. However, while differences were statistically significant the effect size was negligible (p<.001; C=.072) indicating no meaningful difference.

We also wanted to explore whether reason for discharge, particularly families discontinuing vs. completing treatment, varied when families self-referred or were referred by someone else. Families referred by the ED, who have higher rates of discontinuing services and lower rates of completing treatment when compared to those self-referred or referred by schools. This difference is statistically significant with a small effect size (p<.001; C=.151). This is a change from FY2024, when rates of families discontinuing services were consistent among the top three referral sources.

Figure 31. Families completing treatment by race and ethnicity.

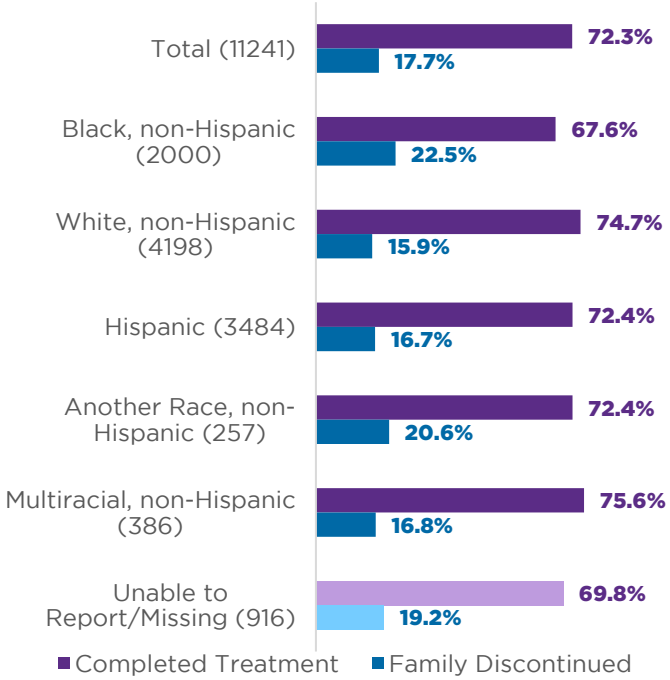
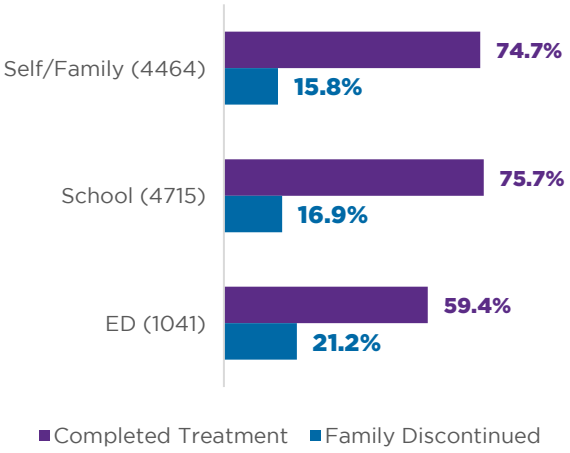


Figure 32. Families completing treatment by referral source.



What other services are youth being referred to?

Statewide, **the most common referrals made upon discharge from Mobile Crisis were to outpatient services (41.3% of children) and back to an existing provider (35.8%)**. Mobile Crisis referrals to the ED were rare, occurring for only 5.1% of children, ranging from 2.2% (Western region) to 9.7% (Southwestern region). Children can receive referrals to more than one service and, in fact, 29% of children had multiple referrals. Table 11 displays referrals by region; if children were referred to more than one service, they are duplicated in the table. Sixty-four percent of children who were referred back to an existing provider also received at least one additional referral. A small portion of children (13.4%) did not receive any referrals at discharge. Fifty-two percent of these children did not complete their treatment with Mobile Crisis. Of the children who completed treatment, 91% received at least one referral. It is also important to note that not all families will need a referral to formal services, and that the data does not capture connections to natural community supports that are frequently made by Mobile Crisis. Statewide, there were 1,072 episodes of care where at least one desired referral was unavailable. Cumulatively, there were 1,247 referrals reported as unavailable. The most common unavailable referrals were Outpatient Services (41%), Intensive In-Home Services (22%), Other: Community-Based (8%), and Intensive Outpatient Program (8%).

Table 11. Services referred to by region.

	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Outpatient Services	49.8%	48.0%	37.0%	26.8%	40.9%	45.6%	**41.3%**
Referred Back to Original Provider	21.6%	42.9%	42.7%	51.0%	32.9%	26.2%	**35.8%**
Intensive In-Home Services	13.5%	11.1%	8.8%	6.6%	3.9%	9.4%	**9.0%**
Emergency Department	4.9%	4.8%	3.8%	7.0%	9.7%	2.2%	**5.1%**
Intensive Outpatient Program	10.2%	4.3%	4.4%	2.8%	3.7%	2.9%	**4.8%**
Other: Community-Based	7.6%	4.3%	3.9%	4.0%	3.8%	2.4%	**4.4%**
Inpatient Hospital	3.3%	1.3%	3.0%	1.7%	3.0%	10.5%	**4.0%**
Psychiatric provider for medication	0.7%	3.8%	4.2%	2.7%	3.0%	0.0%	**2.4%**
Care Coordination	3.1%	1.6%	2.3%	0.8%	0.8%	1.1%	**1.7%**
Partial Hospital Program	3.0%	7.6%	0.8%	0.1%	0.1%	0.2%	**1.7%**
Extended Day Treatment	1.3%	0.1%	2.1%	0.9%	0.7%	0.5%	**1.1%**
Residential Treatment	0.4%	0.0%	0.6%	0.2%	0.2%	0.6%	**0.4%**
UCC	0.7%	0.2%	0.3%	0.0%	0.1%	0.7%	**0.4%**
Other: Out-of-Home	0.4%	0.3%	0.2%	0.2%	0.6%	0.1%	**0.3%**
Group Home	0.1%	0.1%	0.0%	0.0%	0.1%	0.3%	**0.1%**
SAC	0.0%	0.0%	0.4%	0.2%	0.0%	0.0%	**0.1%**
No Care Referral	10.2%	16.7%	14.2%	14.3%	16.9%	9.4%	**13.4%**

Are families and other referrers satisfied with the service?

Each quarter, 2-1-1 surveys a sample of families and other referrers on their experience with Mobile Crisis. Each question is measured on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree). In FY2025, 259 clients/families and 253 other referrers were surveyed regarding their satisfaction with the service; clients/families gave favorable ratings to 2-1-1 and Mobile Crisis services. On a 5-point scale, clients' average ratings of 2-1-1 and Mobile Crisis were 4.70 and 4.63. Among other referrers (e.g. schools, hospitals, DCF, etc.), the average ratings of 2-1-1 and Mobile Crisis were 4.76 and 4.73, respectively. Qualitative comments (see Section X) varied from very satisfied to dissatisfied.

Table 12. Satisfaction with Mobile Crisis services.

2-1-1 Items	Clients (n=259)	Referrers (n=253)
The 2-1-1 staff answered my call in a timely manner	4.66	4.74
The 2-1-1 staff was courteous	4.81	4.82
The 2-1-1 staff was knowledgeable	4.70	4.77
My phone call was quickly transferred to the EMPS provider	4.65	4.70
Sub-Total Mean: 2-1-1	**4.70**	**4.76**
Mobile Crisis Items		
Mobile Crisis responded to the crisis in a timely manner	4.64	4.74
The Mobile Crisis staff was respectful	4.77	4.83
The Mobile Crisis staff was knowledgeable	4.67	4.81
The Mobile Crisis staff spoke to me in a way that I understood	4.76	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)	4.50	X
The services or resources my child and/or family received were right for us	4.47	X
The child/family I referred to Mobile Crisis was connected with appropriate services or resources upon discharge from Mobile Crisis	X	4.54
Overall, I am very satisfied with the way that Mobile Crisis responded to the crisis	4.59	4.73
Sub-Total Mean: Mobile Crisis	**4.63**	**4.73**
Overall Mean Score	**4.66**	**4.77**

Client Comments:

- "Your counseling services have been a great help, supporting my daughter between her therapy appointments. We are grateful for your assistance."
- "I appreciate your support in soothing my child and providing them a safe space to express themselves."
- "Everyone was nice, but the service was unable to find a provider for my child."
- Caller reports that she is thankful to EMPS for contacting her throughout the week after the incident.
- "The services have improved. The EMPS response time is better than in prior years. The services are great, supportive and very helpful."
- Parent reports that although she appreciated the visit, she felt that more follow-up would have helped maintain progress.

Referrer Comments:

- "Mental health support is crucial for overall well-being and thanks to you all it is easily accessible."
- Provider reports she is undecided about EMPS response time to the crisis as there are times that EMPS does not have someone to be sent right away.
- "Response was quick, and the clinician provided clear next steps, which helped reduce anxiety."
- Provider expressed concerns about not receiving follow-up information/treatment plans/safety plans from MCIS Clinicians
- Teacher noted that the student returned to class calmer and more focused after meeting with the MCIS staff.
- Provider was extremely happy to receive a follow up call from the clinician who did the assessment.
- Caller reports that the youth and family both expressed gratitude for the service and said they felt better equipped to handle future challenges.

Another way that satisfaction data is collected is through the Ohio satisfaction scales. Of the 993 responding parents and guardians, 81% feel somewhat to extremely capable of dealing with their child's problems upon discharge from Mobile Crisis. Of the 917 responding parents and guardians, 89% felt that their ideas were included in their child's treatment plan either "a great deal", "moderately", or "quite a bit". Of the 950 responding parents and guardians, 91% felt somewhat to extremely satisfied with the services their child received.

Figure 33. Upon discharge, how capable of dealing with the child's problems does the parent/guardian feel?

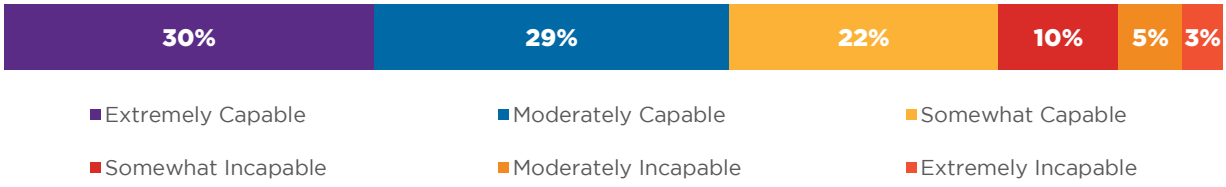


Figure 34. How does the parent/guardian rate the extent to which the child's treatment plan included their ideas about their child's treatment needs?

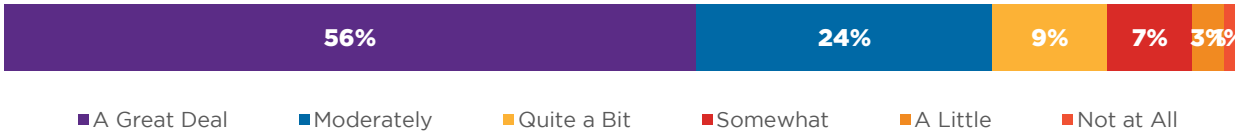


Figure 35. How satisfied is the parent/guardian with the mental health services the child has received?

Mobile Crisis Workforce

How many staff were trained?

The Mobile Crisis PIC is responsible for designing and delivering a standardized workforce development and training curriculum that addresses the core competencies related to delivering Mobile Crisis services in the community. Providers are required by contract to ensure that their clinicians attend these trainings. CHDI contracts with Wheeler Clinic's CT Clearinghouse to coordinate the logistics associated with implementing training events throughout the year. There were thirteen regular training modules offered in FY2025, 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

This year staff were also offered two advanced trainings on Autism and IDD. In FY2026, these will become regular offerings, replacing trainings 5 and 11 on the list above, which have been enhanced and will now be offered asynchronously.

1. Autism Spectrum Disorders: An Overview of Characteristics, Misconceptions, and Community Resources (19 staff trained)
2. Clinical & Behavioral effectiveness with Developmental Disabilities: Demystifying Conceptualization & Advancing Positive Behavior Support (34 staff trained)

The most frequently completed training is Crisis API, having been completed by 68% of staff. QPR training had the lowest completion rate (19%). Many years ago, the PIC had coordinated a staff member from each agency being trained as a trainer for QPR so that this training can be offered internally. However, a number of agencies no longer have a staff member who can provide the training. There were also discussions with DCF and providers indicating that QPR is not the most useful training for Mobile Crisis staff. While providers are still encouraged to have staff trained in QPR (through their agency or through community trainings), it will no longer be a required module in FY2026.

Evaluation forms indicated that participants were generally highly satisfied with the training modules and that the learning objectives were consistently met. Evaluation findings continue to be used to inform changes for FY2026. All module trainings were held online with one offering of each training in person. In addition, School Refusal and A-SBIRT trainings were offered for the first time in an online asynchronous format, allowing more staff to complete these trainings outside of the live offerings. Thirty-two staff have taken the asynchronous school refusal training, and 63 staff have taken the asynchronous A-SBIRT training.

Highlights from the Mobile Crisis PIC training component include the following:

- 26 training modules were held in FY2025 (Including the advanced Autism and IDD courses).
- There were 537 attendees across all Mobile Crisis trainings in FY2024, representing 164 unique individuals that attended at least one training this fiscal year (Including both live and asynchronous trainings).
- There have been 464 trainings (live – online or in person) in the sixteen years of Mobile Crisis PIC implementation, and 795 Mobile Crisis staff members have completed one or more trainings during that time (includes asynchronous).

In FY2024, the PIC began to track training attendance more closely and work with providers to increase training completion rates; this work has continued into FY2025. This year, half of staff who have been employed at least one year but less than 2 years have completed at least 6 trainings. Fifteen percent of staff

who have been employed longer than two years have completed all of the trainings, an increase from FY2024. Rates of staff having completed all 13 trainings have also improved. The Eastern and New Haven regions have the highest training completion rates across all metrics.

Table 13. Trainings completed by region.

	Total Staff	Completed all 13 trainings	Full Time Staff	Completed all 13 trainings	Staff employed between 1 and 2 years	Completed 6+ trainings	Staff employed 2+ years	Completed all 13 trainings
Central	43	5%	24	8%	5	40%	22	9%
Eastern	21	38%	17	47%	3	100%	16	50%
Hartford	55	0%	36	0%	12	67%	35	0%
New Haven	20	45%	16	50%	3	100%	16	56%
Southwestern	22	5%	11	9%	2	0%	16	6%
Western	62	0%	27	0%	16	31%	25	0%
Statewide	**223**	**9%**	**131**	**15%**	**42**	**50%**	**130**	**15%**
Statewide – FY2024	218	6%	127	10%	70	49%	104	13%

Updated training standards began in FY 2025 for newly hired staff. MCIS full-time staff will complete 6 identified trainings within the first year of employment:

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

Part-time or per-diem staff will complete the 6 identified trainings by 18 months of employment. The remaining trainings must be completed by the end of year 2 for full-time staff and by 2.5 years for part-time or per-diem staff. Each subsequent year, staff will attend a minimum of 2 trainings per year. These standards apply to staff who were hired in FY25. As such, we will begin tracking compliance with these standards in FY2026 as these employees reach one year of employment. We also provide each agency with a quarterly training report that shows detailed training data for each of their staff as well as overall training completion rates for their agency.

In addition to the standard training curriculum, CHDI, DCF, and providers work together to identify additional needs and offer ad hoc trainings throughout the year. In FY2025, CHDI assisted DCF in coordinating two suicide prevention trainings – an introductory course and an advanced course in light of increasing rates of suicide in the state. These trainings were held in both a live virtual format and asynchronously. A key element of these trainings was a focus on being culturally responsive in suicide prevention and management.

Beginning a couple of years ago, CHDI assisted DCF, the Department of Developmental Services (DDS), and the Department of Mental Health and Addiction Services (DMHAS) with a federal grant application for the Transformation Transfer Initiative (TTI) for the state of Connecticut, which was awarded. DCF asked CHDI to develop and enhance training modules for Mobile Crisis. CHDI attended meetings with TTI grantees and provided updates to DCF. CHDI worked with DCF and developed two advanced trainings on Autism and Intellectual Development Disabilities and Positive Behavior Supports, and began the work in enhancing the

current introductory trainings. In FY 2025, the enhancements on the two existing MCIS trainings on Autism and Intellectual Development Disabilities were completed. We also developed two new trainings - one on Effective Family Engagement and another on The Impact of Racism and Mental Health: Uncovering the Links to Enhance Clinical Treatment Effectiveness. These trainings will be offered asynchronously.

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, 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, or can be taken when offered in the community.

How did providers educate the community about Mobile Crisis?

Mobile Crisis providers play a significant role in creating awareness and increasing utilization of the service by conducting outreaches and building relationships in their communities. Providers conduct a variety of formal outreach activities, including presentations at schools, police departments, and hospitals, as well as participation in community events to reach families.

Starting in FY2025 Q3, the PIC is incentivizing community-based outreaches (not schools or EDs). The goal of this incentive is to encourage providers to conduct outreaches with less common referral sources, in the hopes of reaching those who do not typically use Mobile Crisis. This aligns with the overall program goal to increase referrals to Mobile Crisis and to do so with a lens towards equity.

In FY2025, providers conducted 188 formal outreaches to the community, compared to 149 in FY2024. Performance ranged from 13 outreaches (Hartford and New Haven regions) to 75 outreaches (Eastern region).

Table 14. Formal outreaches completed by region and provider.

	Q1 FY24	Q2 FY24	Q3 FY24	Q4 FY24	Total
Central	6	4	3	9	22
CHR: Middlesex Health	0	1	2	5	8
CHR	6	3	1	4	14
Eastern	30	11	12	22	75
UCFS:NE	4	2	3	6	15
UCFS:SE	26	9	9	16	60
Hartford	1	3	3	6	13
Wheeler: Hartford	0	1	0	1	1
Wheeler: Meriden	0	0	3	1	3
Wheeler: New Britain	1	2	0	4	3
New Haven	6	2	2	3	13
Clifford Beers	6	2	2	3	13
Southwestern	9	4	5	5	23
CFGC: South	3	0	3	2	8
CFGC: Norwalk	1	1	0	1	3
CFGC: Bridgeport	5	3	2	2	12
Western	6	19	9	8	42
Wellmore: Danbury	2	0	0	0	2
Wellmore: Torrington	1	7	0	0	8
Wellmore: Waterbury	3	12	9	8	32
Statewide	**58**	**43**	**34**	**53**	**188**

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

In FY2025, 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. Examples of agency goals during FY2025 include community-based outreaches with those who are not frequent users of Mobile Crisis, increasing attendance at PIC trainings, and improving collection rates of Ohio scales.

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.

Legislative Requests: CHDI responded to several requests from the Transforming Children's Behavioral Health Policy and Planning Committee (TCB), via DCF, on utilization of Mobile Crisis. Presentations were made to the TCB as well as to the Services Workgroup to help inform plans around the crisis continuum of services.

Interactive Dashboards: A major project undertaken in FY2025 was the development of interactive data dashboards for Mobile Crisis using Microsoft Power BI. The goal of this project is to improve our public-facing data, allowing users to explore the data based on their needs. The dashboards include the ability to filter by time period, region, and provider site, and to see key metrics broken down by demographic groups. These dashboards are expected to be published on our website in FY2026.

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 health needs, and an alternative to law enforcement contact, arrest, and juvenile court referrals. CHDI is currently piloting SBDI-E, a version of SBDI that has been adapted for use with elementary schools. This initiative uses Mobile Crisis data in a similar way to SBDI, tracking whether participating schools increase their utilization of Mobile Crisis.

Juvenile Justice: CHDI continues to be part of the Juvenile Justice Policy and Oversight Committee (JJPOC) and continues to provide data on Mobile Crisis as needed. This is of interest to the committee as they continue work to divert youth from arrest and instead address unmet behavioral health needs.

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.

The PIC had a strong focus on model standardization and development this year, as described at the beginning of this report. This process was focused on updating Mobile Crisis practice standards, clarifying and updating data definitions, and creating improved data documentation.

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 provides 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). CHDI, DCF, and providers for all three programs are having ongoing discussions about the role of each service, the partnership between them, and the needs of children and families in crisis.

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. Work during FY2025

included conducting provider focus groups and providing TA around workforce development and program operations.

CHDI completed a contract with Meadows Mental Health Policy Institute to consult on the early implementation of Youth Crisis Outreach Teams (YCOT) in Texas. In FY2024, CHDI participated in a best-practice implementation summit where we provided training on the fundamental values and principles underlying YCOT based on national MRSS best practices, using data for quality improvement, considerations for safety planning with children and families, and strategies for a confident and competent workforce. This year, CHDI worked with Meadows to develop a virtual learning community for the eight YCOT teams focused on implementation support.

Collaboration among Mobile Crisis partners

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

Monthly Meetings: Monthly meetings include representatives from the Mobile Crisis PIC, DCF, Mobile Crisis managers and supervisors, 211-United Way, Carelon, and other stakeholders. The meetings are held to review Mobile Crisis practice and policy issues. Since COVID-19, meetings have been held virtually.

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

The School-Based Diversion Initiative (SBDI): SBDI is a school-based initiative that seeks to reduce rates of school-based arrest, expulsion, and out-of-school suspension through professional development, revisions to school disciplinary policies, and access to mental health services and supports in the school and community. The initiative emphasizes enhanced school utilization of Mobile Crisis as a “front end” diversion to school-based arrest, which disproportionately affects students with behavioral health needs.

Client and Referrer Satisfaction: 211-United Way and the Mobile Crisis PIC worked together to measure and report family and referrer satisfaction with Mobile Crisis services.

Annual Meetings: Typically, Mobile Crisis Providers, clinicians, DCF and other stakeholders attend a year-end annual meeting. This year’s annual meeting was held at the Meriden Public Library and our Keynote speaker was Yanique Grant-Buchanan, LCSW. She presented on Racial/Race-Based Trauma: Road to Healing. The purpose of the annual meeting is to recognize Mobile Crisis’s accomplishments throughout the year.

MOA Development with School Districts: Mobile Crisis PIC staff provided technical assistance and support to Mobile Crisis managers to develop MOAs with school districts as one element of Connecticut Public Act 13-178. To date, the PIC has collected MOAs from 201 of 206 districts. Staff from 211-United Way sent outreach mailings to school administrators, and the Mobile Crisis PIC facilitated contact between Mobile Crisis providers and school personnel. The responsibility for acquiring the remaining MOAs shifted in 2017 to the State Department of Education. Staff from 211-United Way posted MOA information and signed MOAs on their website (http://www.empsct.org/moa/). Additionally, a brief video highlighting the mutual benefits that students and schools receive by collaborating with Mobile Crisis service providers was developed and disseminated to school administrators.There are ongoing discussions with CT State Department of Education on how to best increase schools use of Mobile Crisis services.

Recommendations and Goals for FY2026

Improving Utilization and Equity

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

Data Quality and Documentation

3. Pending data system updates, CHDI will work with DCF and providers to finalize a formal data dictionary to ensure consistent and accurate data entry across all Mobile Crisis providers.
4. CHDI will work with providers to implement data changes and reduce missing data.
    - CHDI will routinely analyze updated data elements and work with providers to determine whether these new data elements are operating as intended. Ultimately, this will lead to more accurate analysis of program metrics.

Workforce

5. CHDI will continue to work with MCIS trainers to enhance and improve training content through an equitable lens.
6. CHDI will monitor training completion by MCIS staff in accordance with the updated training standards.
7. CHDI will monitor utilization newly added asynchronous trainings and determine whether the asynchronous option increases training rates.

System Development

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