MOBILE CRISIS
RESPONSE TEAM FOR YOUTH

Mobile Crisis Intervention Services

FISCAL YEAR 2026 QUARTER 4 REPORT

Child Health and Development Institute

CONNECTICUT Children & Families

2·1·1 Connecticut

United Way United Way of Connecticut

Mobile Crisis Performance Improvement Center

Child Health and Development Institute

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For our interactive Mobile Crisis dashboard, please visit:
https://www.chdi.org/resource-library/qi-reports/mobile-crisis/mobile-crisis-

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.

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.

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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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.

This Quarterly 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 described below. 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.

SFY 2026 Q4 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.

Program Expenditures: Estimated SFY 2025	State Funding: $13,654,662

How Much Did We Do?

Figure 1. Race and ethnicity of children served.

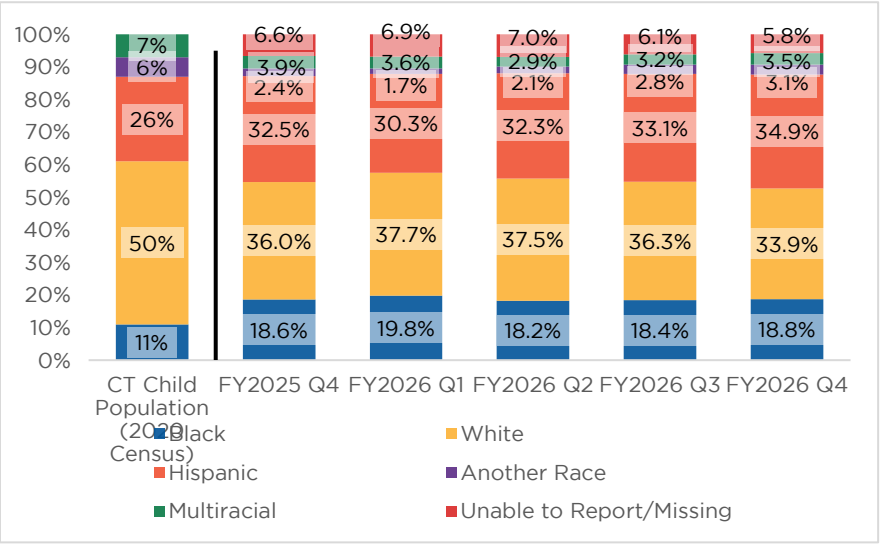


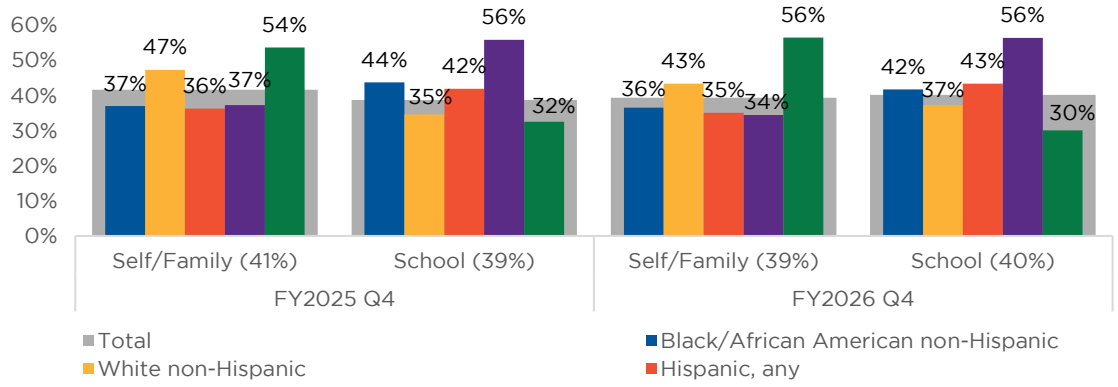
Table 1. Call and episode volume over time.

	FY2025 Q4	FY2026 Q1	FY2026 Q2	FY2026 Q3	FY2026 Q4
Mobile Crisis Episode	2948	2027	3318	3161	3114
2-1-1 Only	954	835	1184	1104	1232
Total	3902	2862	4502	4265	4346

Story behind the baseline: In SFY 26 Q4, there were 4,346 total calls to the 2-1-1 Call Center resulting in 3,114 episodes of care. Compared to the same quarter in SFY 25 this was a 11.4% increase in call volume and a 5.6% increase in mobile crisis episodes. The percentages of both Black and Hispanic children served continues to be higher than the statewide population, while the percentage of White children is lower.

Trend: →

Figure 2. Differences in referral source by race and ethnicity.



Story behind the baseline: In SFY26 Q4, 39% of referrals came from self/family and 40% came from schools. There was statistically significant variation in groups by referral source, with a trend of Hispanic youth having lower rates of self/family referrals compared to White youth. There is some fluctuation in the referral sources for children of another race and multiracial children, but these numbers should be interpreted with caution due the small number of children included in these groups.

Trend: →

SFY 2026 Q4 RBA Report Card: Mobile Crisis Intervention Services

Table 2. Episodes per child.

	Quarterly Breakdown					Past Year: FY26 Q1 - FY26 Q4		
	FY2025 Q4	FY2026 Q1	FY2026 Q2	FY2026 Q3	FY2026 Q4	Total	DCF	Non-DCF
1	2222 (87.2%)	1523 (87.1%)	2433 (86.1%)	2337 (86.6%)	2314 (87.0%)	6310 (76.1%)	538 (64.4%)	4430 (73.9%)
2	264 (10.4%)	186 (10.6%)	321 (11.4%)	283 (10.5%)	273 (10.3%)	1271 (15.3%)	183 (21.9%)	998 (16.6%)
3	55 (2.2%)	30 (1.7%)	60 (2.1%)	58 (2.1%)	51 (1.9%)	394 (4.8%)	55 (6.6%)	320 (5.3%)
4 or more	8 (0.3%)	9 (0.5%)	11 (0.4%)	20 (0.7%)	21 (0.8%)	315 (3.8%)	59 (7.1%)	247 (4.1%)

Story behind the baseline: In SFY 26 Q4, of the 2,659 children served by Mobile Crisis 87.0% (2,314) received only one episode of care, and 97.3% (2,587) received one or two episodes of care. These numbers are similar to SFY 25 Q4 which had 87.2% (2,222) and 97.6% (2,486) respectively. The proportion of children with four or more episodes is slightly higher than SFY 25 Q3. Over the past year, of the 8,290 children served, 76.1% (6,310) had only one episode while 91.4% (7,581) had only one or two episodes. The data indicates that most children and families require only one episode of care.

Trend: →

How Well Did We Do?

Figure 3. Statewide responses under 45 minutes.

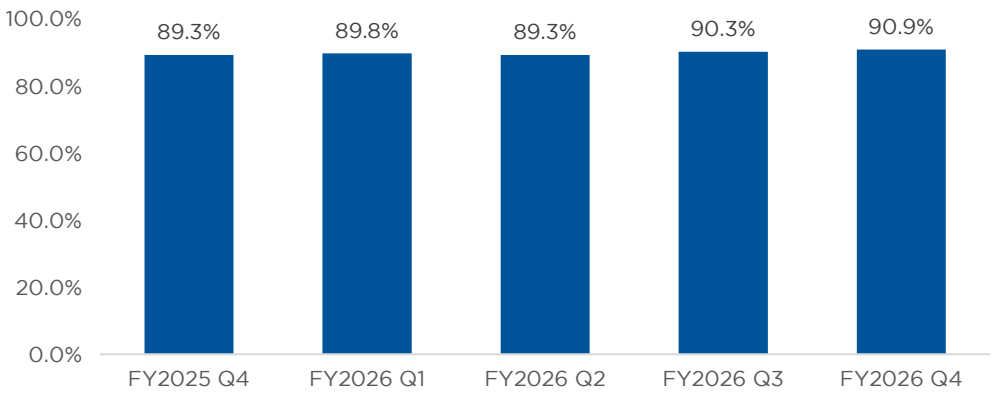
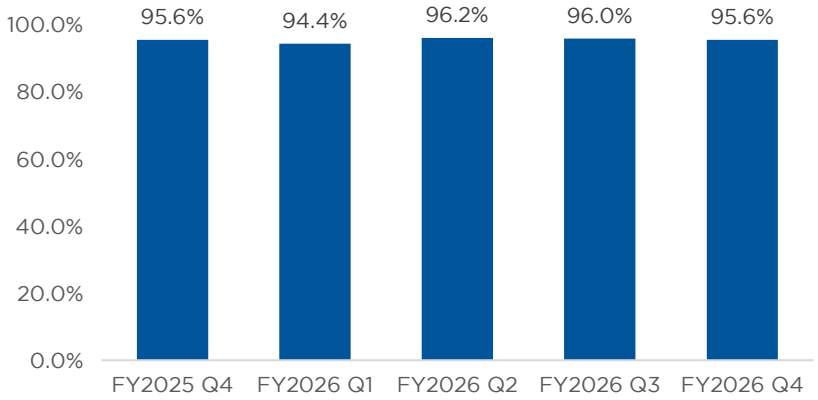


Figure 4. Statewide mobility rate.



Story behind the baseline: In SFY 26 Q4, 90.9% of all mobile responses achieved the 45-minute mark compared to 89.3% for SFY 25 Q4. **The median response time for SFY 26 Q4 was 29 minutes.** Mobile Crisis continues to be a highly responsive statewide service system that responds rapidly to help deescalate a crisis and works to meet the needs of the child and family in their home and community.

Trend: →

Story behind the baseline: In SFY 26 Q4, the statewide mobility rate was 95.6%, consistent with SFY25 Q4. Mobile Crisis continues to provide children and families with a face-to-face response at a high rate.

Trend: →

SFY 2026 Q4 RBA Report Card: Mobile Crisis Intervention Services

Is Anyone Better Off?

Figure 5. Improvement in functioning as measured by the Ohio Scales.

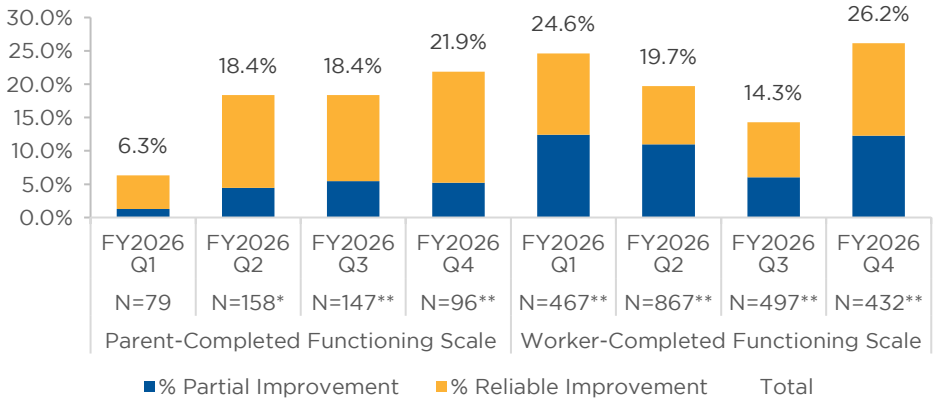
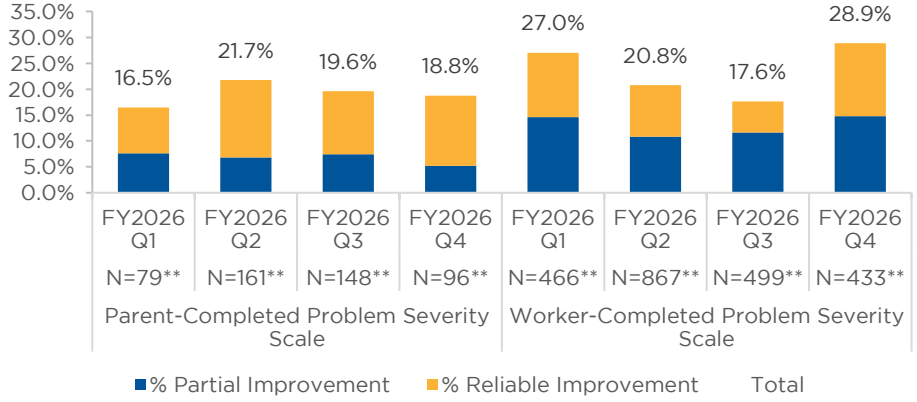


Figure 6. Improvement in problem severity as measured by the Ohio Scales.



Story Behind the Baseline: The Ohio Scales demonstrated statistically significant positive changes for children following a Mobile Crisis response. For SFY 26 Q4, Ohio worker scales had statistically significant change for 26.2% of episodes in Functioning and 28.9% in Problem Severity. Both of these numbers are higher than rates in recent quarters. Parent-completed scales had statistically significant change for 21.9% of episodes in Functioning and 18.8% in Problem Severity, both within similar range of recent quarters. Despite the relative short time of service engagement, the Ohio Scales reflect the continued effectiveness of Mobile Crisis in defusing the immediate crisis and supporting the positive growth and success of youth.

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.
- Plan outreach activities with a lens towards health equity and promoting equitable access to Mobile Crisis across referral sources, including identifying outreach strategies to target self/family referrals.

Data Development Agenda:
- Explore Mobile Crisis data to assess utilization and delivery of services across racial and ethnic groups and to identify opportunities to improve health equity.
- Work with existing data and propose new data elements to better capture the stabilization phase.

Access

How many youth were served?

During the second quarter of FY2026, there were 3,114 episodes of care for Mobile Crisis. This is a 5.6% increase in volume compared to the same quarter last year (2,948 episodes in FY25 Q4). Episode volume for each region ranged from 344 (Eastern) to 756 (Hartford). Statewide, there were 4.2 episodes per 1,000 children in Connecticut. Four of the six regions were within one standard deviation (0.8) of the statewide average, with the Hartford region being more than one standard deviation above and the Southwestern region being more than one standard deviation below.

Figure 7. Number of episodes by region.

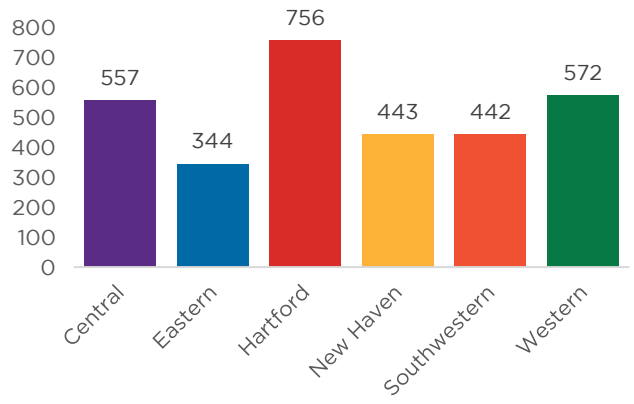
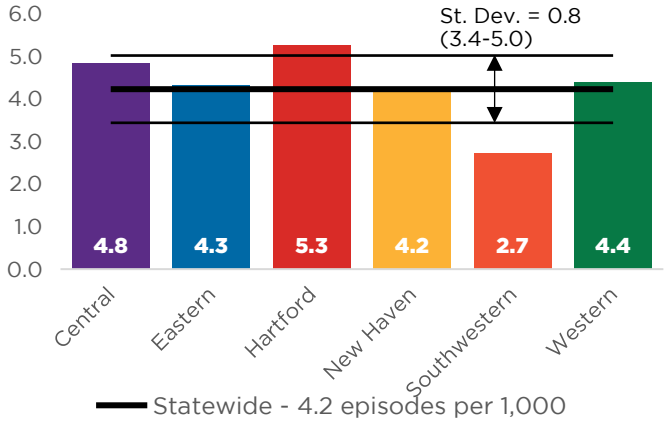


Figure 8. Episodes per 1,000 children.

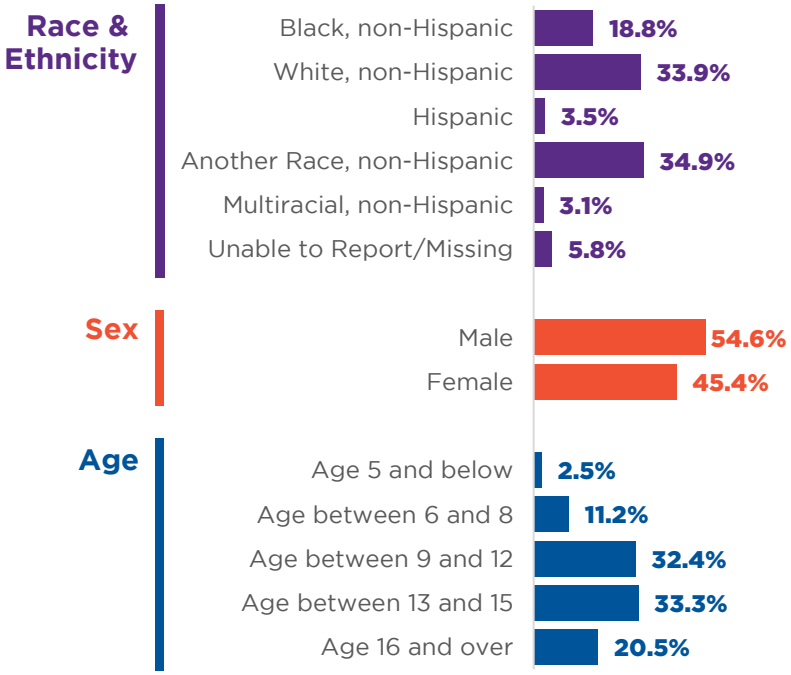


Who is being served?

Demographics of children[1] served this quarter were consistent with ongoing trends:

- Black and Hispanic children were served at higher rates than they appear in the CT population (see statewide RBA).
- There were more male youth served than female children.
- 1.8% of children identified as transgender.
- 65.7% of children were between ages 9 and 15.
- Most commonly children served are covered by Medicaid (48.4%) and many (18.0%) have private insurance. A significant number of children (27.5%) did not provide information on coverage.
- 11.3% of children were reported to be involved with DCF.

Figure 9. Demographics of children served.



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

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

Statewide, 38.2% of children reported a history of trauma. The most common type of trauma reported was Disrupted Attachment (44.6%). Notably, 38.0% of children reported trauma that did not fit into one of the categories captured in PIE.

Figure 10. Children reporting a history of trauma at intake.

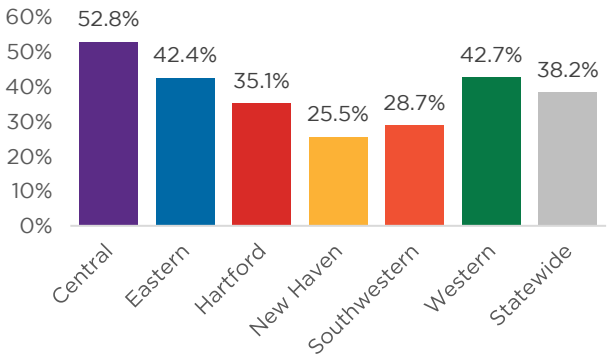
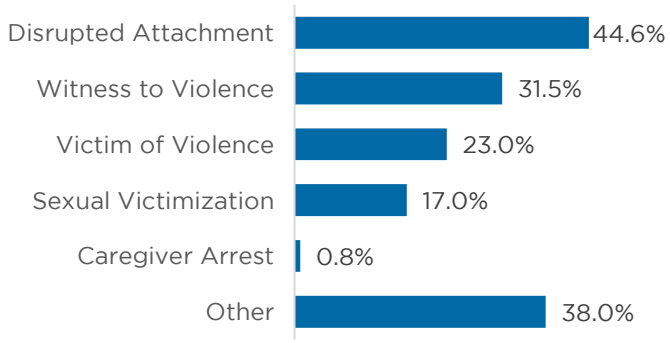


Figure 11. Types of trauma reported at intake.

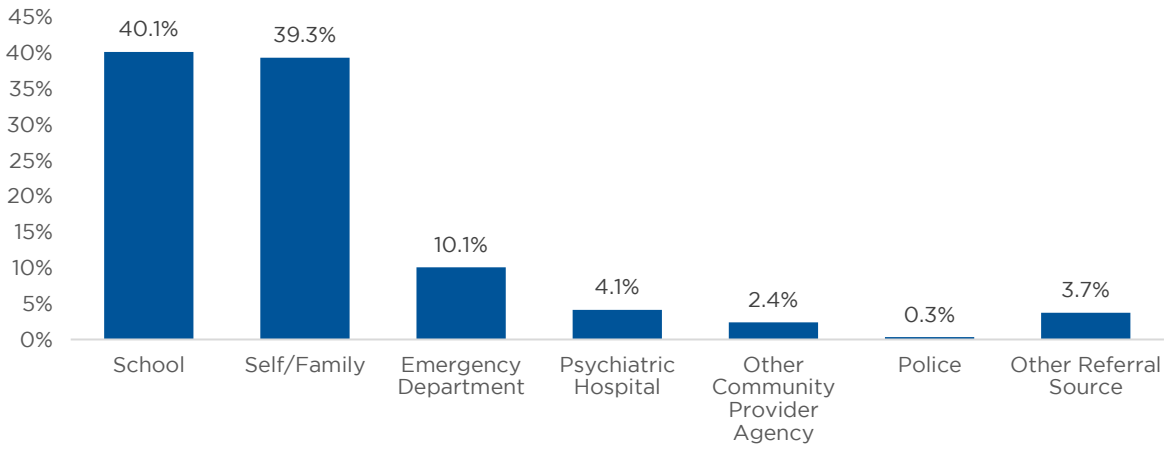


Some children served by Mobile Crisis have previous experience with high-end behavioral health crisis services. This quarter, 15.7% of children served reported visiting the ED for behavioral health reasons in the previous 6 months. A smaller number of children had experienced psychiatric inpatient hospitalization in the previous 6 months (8.4%), while 14.7% had experienced inpatient hospitalization at some point in their lifetime. About a third of children served are missing data for these questions, with the remainder reporting having not had these experiences during the given timeframe.

Who is making the call?

Callers to Mobile Crisis are consistent with the previous quarters. Most calls to Mobile Crisis came from either schools (40.1%) or self/family (39.3%), with an additional 10.1% coming from emergency departments (EDs).

Figure 12. Caller Type.



Why did they call?

Callers will reach out to Mobile Crisis for a variety of reasons, with consistent trends in presentation from quarter to quarter. The most common presenting concerns for children served by Mobile Crisis this quarter were harm/risk of harm to self (29.6%) and disruptive behavior (22.0%). Due to the short nature of a Mobile Crisis episode, data on presenting problems are typically more relevant than diagnosis. The top diagnoses among youth who had a diagnosis listed in PIE (n=2,076) were depressive disorders (28.8%), adjustment disorders (25.4%), and anxiety (12.3%).

Figure 13. Top presenting problems.

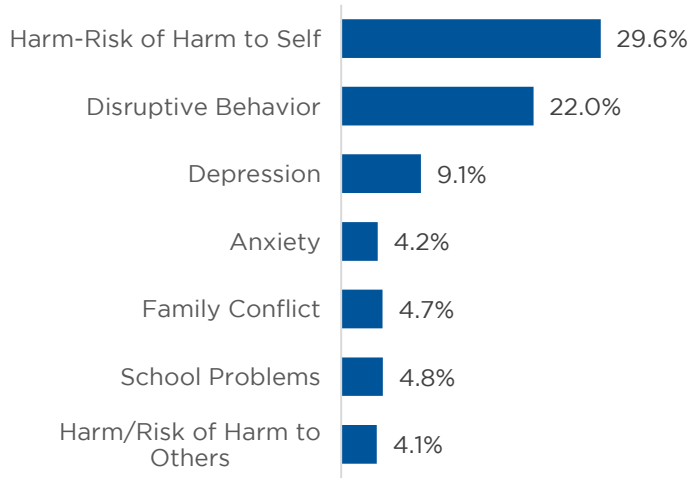
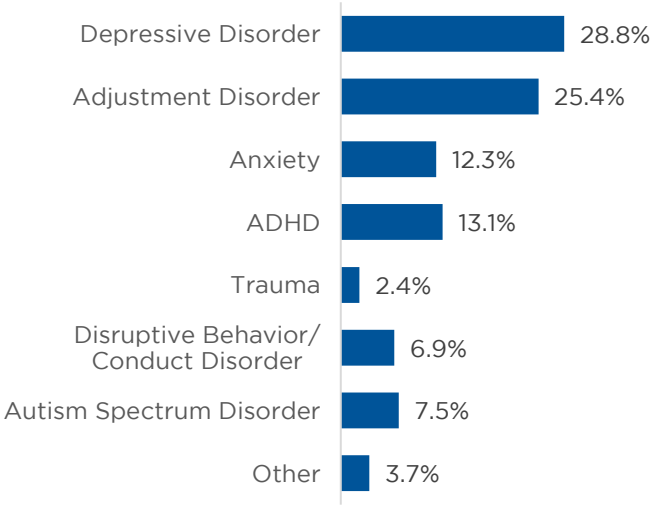


Figure 14. Top diagnoses.



Quality

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

Statewide, the mobility rate in FY2026 Q4 was 95.6%. All six regions and all 14 provider sites exceeded the 90% benchmark. 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 received a mobile or deferred mobile response from a Mobile Crisis provider. In calculating this rate, the PIC excludes 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 provider's control.

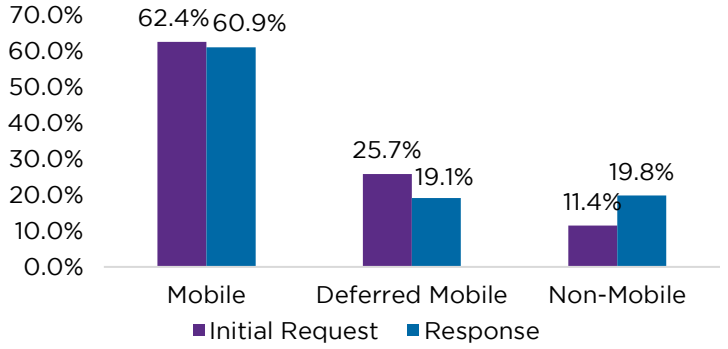
When someone calls 2-1-1 requesting Mobile Crisis support, there are three types of responses from the Mobile Crisis provider:

- 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.

Most requests are for either a mobile (62.4%) or deferred mobile (25.7%) response. While the rate of non-mobile responses is higher than the rate of non-mobile requests, there are a number of reasons that the response type might change after the initial conversation with 2-1-1. The ultimate goal is always to prioritize the needs of the child and family.

Figure 15. Initial requested response vs. actual response.



The majority of episodes received a response that was consistent with the request of the caller (81.4%). For the remaining episodes:

- 4.7% received a more enhanced response than what was originally requested
- 2.3% requested a Mobile and received a Deferred Mobile
- 10.2% requested a Mobile or Deferred Mobile response and received a non-mobile response.

Of the responses that changed to non-mobile, 88.4% were because the family later declined a mobile response or was unable to be reached. An additional 3.5% involved the original third-party caller cancelling the request.

Figure 16. Mobility rate by region.

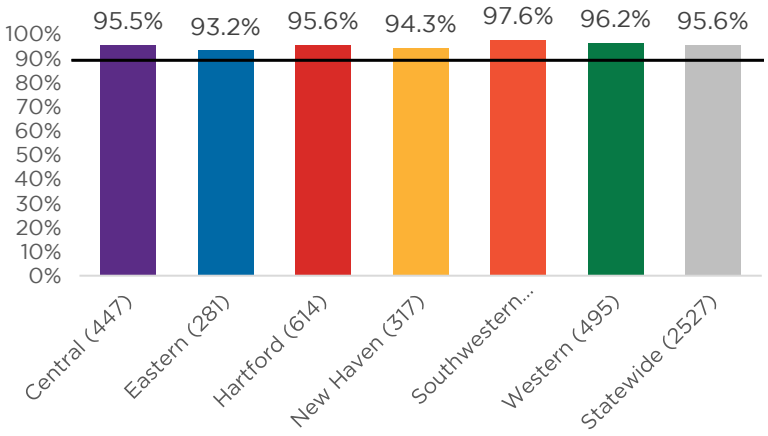
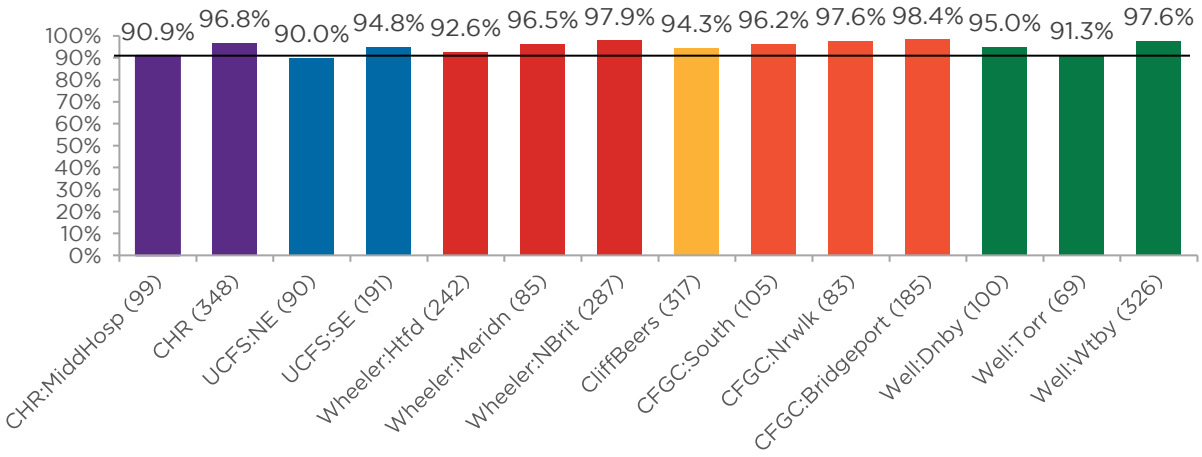


Figure 17. Mobility rate by provider.



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

Goal=90%

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

The median response time in FY2026 Q4 was 29 minutes. Of the 1,825 episodes that received an immediate mobile response, **90.9% received a response within 45 minutes**. All six regions and 13 of 14 providers exceeded the 80% benchmark.

Figure 18. Response time under 45 minutes by region.

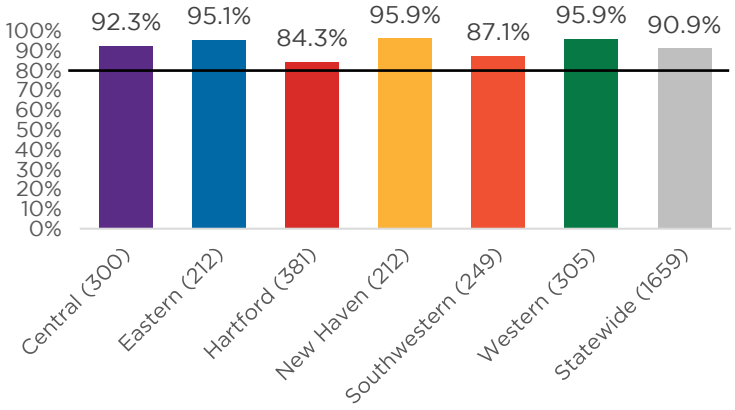
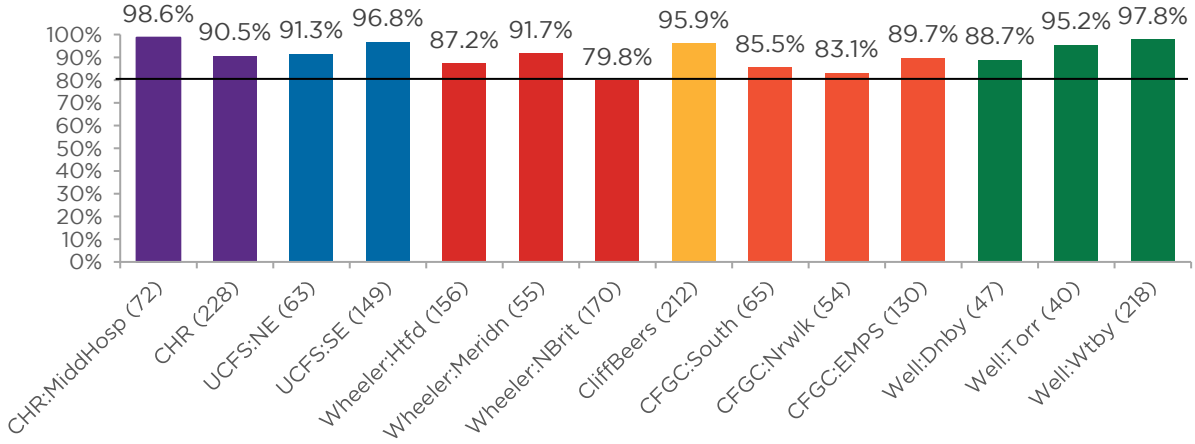


Figure 19. Response time under 45 minutes by provider.



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

Goal=90%

What level of services are children and families receiving from Mobile Crisis?

There are a number of different Mobile Crisis intervention types, which were updated with new titles and definitions in FY2026 Q2. The first three types, highlighted in blue, involve a face-to-face assessment with the child.

- **Face to Face: Evaluation Only** - Indicates cases in which there is face-to-face contact with the client and family for the initial assessment, but no further work with the family. This may include cases where there is a delay in getting in contact with the family following the assessment, but the family does not engage in further services and no referrals are made.
- **Face-to-Face: Connect to Care** - Indicates cases in which there is face-to-face contact with the client and family for the initial assessment, and Mobile Crisis works to provide case management and get the child and family linked to additional services. No further face-to-face contact takes place. The episode should be wrapped up within 14 days, or transitioned to "Treatment and Connection to Care"
- **Face to Face: Extended Support** - Indicates cases in which there is face-to-face contact with the client and family for the initial assessment, and additional face-to-face contact with the child occurs. These cases involve ongoing clinical work with the child, providing treatment, case management, and other services until the child and family are connected to services. During these cases, every effort should be made to see the child once a week, in person.
- **Crisis Response: Phone Only** - Indicates cases in which contact with the client and family was limited to the initial MCIS call without face-to-face contact.
- **Face-to-face: Consultation Only** - In some cases, a Mobile Crisis clinician may provide face-to-face consultation without seeing or assessing the child. This may occur when a school calls Mobile Crisis, but the child's parent declines the service. Mobile Crisis providers can still respond to the school and provide them with consultation regarding the situation. There may be face-to-face contact with caregivers, school staff, etc.; but there is no face-to-face contact with the child.

In FY2026 Q4, **2,390 of 3,241 total discharged episodes (73.8%) involved a face-to-face assessment with the child**. Of these episodes, 13.3% ended after the initial assessment and 22.9% involved ongoing support, including additional face-to-face contact with the child.

Table 3. Crisis Response Type.

Crisis Response Type	N	%	FTF Assessments
Face-to-Face: Eval Only	317	**9.8%**	13.3%
Face-to-Face: Connect to Care	1525	**47.1%**	63.8%
Face-to-Face: Extended Support	548	**16.9%**	22.9%
Crisis Response: Phone Only	633	**19.5%**	
Face to Face: Consultation Only	217	**6.7%**	
Total	3240		

How long are youth and families involved with Mobile Crisis?

Statewide, the median length of service for discharged episodes was 5 days for Evaluation Only episodes, 13 days for Connect to Care episodes, and 23 days for Extended Support episodes. 65.3% of Evaluation Only episodes exceeded five days, 43.3% of face-to-face episodes exceeded 14 days, and **5.5% of Extended Support episodes exceeded 45 days, slightly exceeding the statewide benchmark of less than 5%.**

Table 4. Length of service for discharged episodes.

		Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Face-to-Face: Evaluation Only	**N**	12	14	92	111	71	17	**317**
	Median (Days)	2	1	1	11	5	0	**5**
	Exceeding 5 days	2.3%	15.8%	13.8%	136.1%	38.5%	3.9%	**28.5%**
Face-to-Face: Connect to Care	**N**	383	238	261	172	134	337	**1525**
	Median	20	7	9	18	19	11	**13**
	Exceeding 14 days	67.9%	10.9%	19.5%	60.5%	61.9%	40.7%	**43.3%**
Face-to-Face: Extended Support*	**N**	86	38	196	61	91	76	**548**
	Median	27	22	19	19	36	17	**23**
	Exceeding 45 days	4.7%	2.6%	1.5%	11.5%	13.2%	3.9%	**5.5%**

*Previously named 'Treatment and Connection to Care'.

Among open episodes of care, the median length of service was 60 days for Evaluation Only episodes, 48 days for Connect to Care episodes, and 47 days for Extended Support episodes. 5.5% of Evaluation Only episodes exceeded five days, 83.1% of Connect to Care episodes exceeded the 14-day benchmark, and 54.4% of Extended Support 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.

Table 5. Length of service for open episodes (as of 12/31/25).

		Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Face-to-Face: Evaluation Only	**N**	0	0	6	3	13	0	22
	Median (Days)	.	.	145	28	60	.	60
	Exceeding 5 days	N/A	N/A	100.0%	66.7%	100.0%	N/A	95.5%
Face-to-Face: Connect to Care	**N**	47	1	35	45	53	44	225
	Median	27	12	77	1551	48	23	48
	Exceeding 14 days	72.3%	0.0%	91.4%	97.8%	88.7%	68.2%	83.1%
Face-to-Face: Extended Support*	**N**	24	5	30	4	38	13	114
	Median	299	5	49	21	46	75	47
	Exceeding 45 days	75.0%	40.0%	53.3%	0.0%	50.0%	53.8%	54.4%

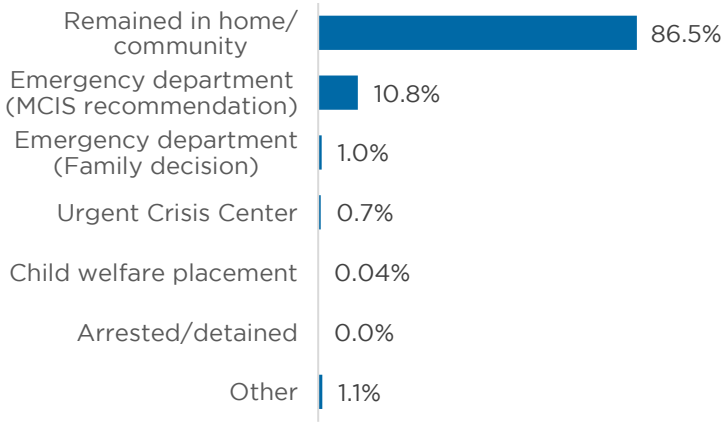
*Previously named 'Treatment and Connection to Care'.

Outcomes

Where did the child go after the initial assessment?

One of the goals of Mobile Crisis is to help children experiencing behavioral health crises remain in their homes and communities whenever possible, reducing the utilization of more restrictive levels of care. Beginning in FY2026 Q2, a question was added to PIE to gather data on where the child was at the end of the initial assessment. This data is missing for 11.7% of episodes that involved a face-to-face assessment. Of those that had data, **86.5% of children remained in their home/community following the initial assessment.**

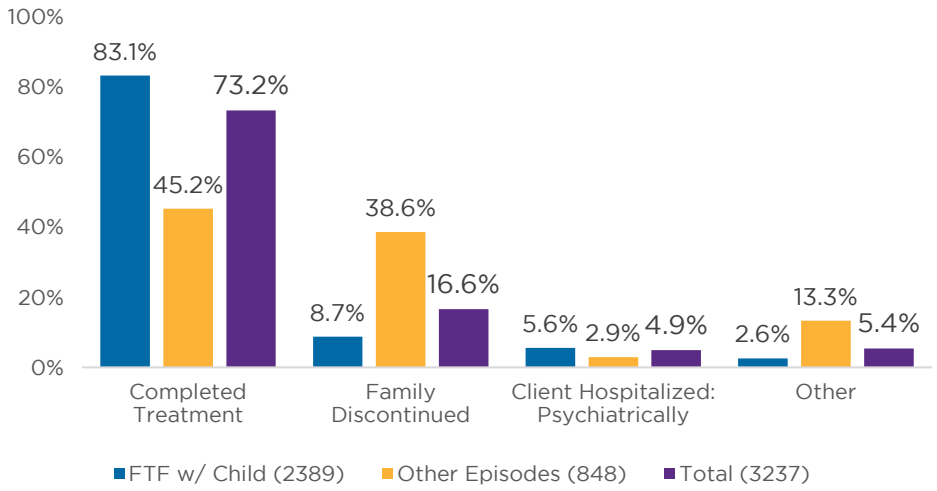
Figure 20. Initial assessment outcome.



Why were youth discharged?

Across all episodes, the majority of youth (73.2%) were discharged for completing their treatment with Mobile Crisis. The rate of treatment completion was higher for episodes that involved a face-to-face assessment with the child (83.1%). 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 16.6% of the time for all episodes, and only 8.7% of the time for episodes with face-to-face assessments. Episodes that don't involve face-to-face assessment of the child provide a different level of engagement, typically based on the wishes of the child or family.

Figure 21. Reason for discharge by episode type.



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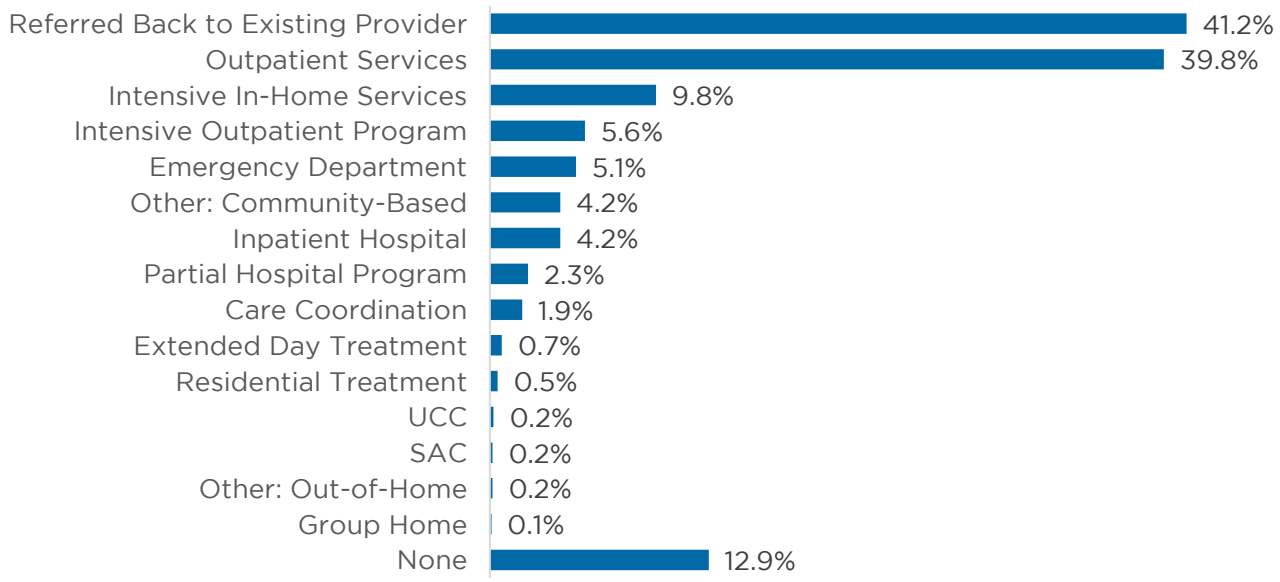
What other services are youth being referred to?

Statewide, **the most common referrals made upon discharge from Mobile Crisis were to outpatient services (39.08% of children) and back to an existing provider (41.2%)**. Mobile Crisis referrals to the ED were rare, occurring for only 5.1% of children. Children can receive referrals to more than one service, which was the case for 33.7 percent of children. Sixty-nine percent of children who were referred back to an existing provider also received at least one additional referral. A small portion of children (12.9%) did not receive any referrals at discharge. Nearly half (47.0%) of these children did not complete their treatment with Mobile Crisis. Of the children who received a face-to-face assessment and completed treatment, 92.4% 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.

Figure 22. Services referred to at discharge.



Are families and other referrers satisfied with the service?

Table 6. Satisfaction with Mobile Crisis services.

2-1-1 Items*	Clients (n=67)	Referrers (n=69)
The 2-1-1 staff answered my call in a timely manner	4.67	4.90
The 2-1-1 staff was courteous	4.87	4.99
The 2-1-1 staff was knowledgeable	4.79	4.86
My phone call was quickly transferred to the EMPS provider	4.70	4.84
Sub-Total Mean: 2-1-1	**4.76**	**4.89**
Mobile Crisis Items*		
Mobile Crisis responded to the crisis in a timely manner	4.69	4.72
The Mobile Crisis staff was respectful	4.76	4.72
The Mobile Crisis staff was knowledgeable	4.69	4.81
The Mobile Crisis staff spoke to me in a way that I understood	4.70	4.88
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)	4.60	X
The services or resources my child and/or family received were right for us	4.54	X
The child/family I referred to Mobile Crisis was connected with appropriate services or resources upon discharge from Mobile Crisis	X	4.75
Sub-Total Mean: Mobile Crisis	**4.66**	**4.78**
Overall, I am very satisfied with the way that Mobile Crisis responded to the crisis **This question is rated on a 1 to 10 scale, while the others are rated from 1 to 5*	**8.81**	**9.23**

*** 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:

- The mobile crisis unit did an amazing job in an impossible situation. My only complaint was that the local police department sent an unnecessary amount of cars for the situation which made it more of a spectacle in the neighborhood after the team was very discrete.
- 45 minutes is too long for a child that is in crisis.
- I appreciated two women came to talk to my female child. She felt more comfortable to open up. I didn't feel uncomfortable at all while they were present in my home or talking privately with my child. They were able to get more information from my child than I was able to get.
- I feel more confident managing future challenges.
- The most important aspect is that our granddaughter was very receptive to the provider. However, as legal guardians we were not really informed of next steps or any further advice for us. We had 4 visits this week and our granddaughter still never left her room or went to school

Referrer Comments:

- The team worked collaboratively with school staff and community partners.
- This crisis was complicated and difficult. Our provider stuck with us as we navigated multiple agencies and challenges. We really appreciate the support!
- I would have appreciated more updates throughout the intervention process.
- Both members of the team were a good fit for our school setting & made connections with the youth & guardians. Thank you!
- There were delays that impacted the overall experience.
- Based on this experience, I have confidence in referring future students to this program.

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 are currently twelve regular training modules being offered, and a number of additional recommended trainings. The most commonly completed training is *Crisis Assessment, Planning, and Intervention* (69%). Across full-time staff employed at least a year, completion rates for required trainings ranges from 40% to 69%.

Table 7. Statewide training completion rates.

		All Staff	Full Time staff employed at least 1 year
Core Trainings	Crisis Assessment, Planning and Intervention	69%	65%
	Emergency Certificate	56%	63%
	Assessing Violence Risk in Children and Adolescents	56%	61%
	Traumatic Stress and Trauma-Informed Care	54%	60%
	21st Century Culturally Responsive Mental Health Care	55%	62%
	Columbia Suicide Severity Rating Scale	45%	40%
Required Trainings	A-SBIRT (Adolescent Screening, Brief Intervention, and Referral to Treatment	64%	62%
	Autism, Families, and Severe Behavior	48%	54%
	Overview of Developmental Disabilities	51%	60%
	Disaster Behavioral Health Response Network	56%	61%
	Problem Sexual Behavior	55%	62%
	School Refusal	64%	61%
Recommended Trainings	Autism Spectrum Disorders: An Overview of Characteristics, Misconceptions, and Community Resources (advanced course)*	17%	22%
	Clinical and Behavioral Effectiveness with Developmental Disabilities: Demystifying Conceptualization & Advancing Positive Behavior Support (advanced course)*	23%	29%
	Question, Persuade, and Refer (QPR)	18%	19%
	Effective Family Engagement**	7%	5%
	Race and Mental Health (2 Parts)**	6%	5%
	Psychopharmacology	7%	9%

*These trainings were offered for the first time in FY2025.
**These trainings became available at the end of FY26 Q1.

Full-time Mobile Crisis clinicians are required to complete six core trainings in their first year. Of the 95 full-time staff who have been with Mobile Crisis at least a year, 45% have completed all six core trainings. The remaining six required trainings are completed by the end of the second year. Of the 77 full-time staff who have been with Mobile Crisis at least 2 years, 38% have completed all 12 required trainings.

Table 7. Staff trained by region.

	Total Staff	Full Time staff employed at least 1 year	Core Trainings Completed	Full Time staff employed at least 2 years	Core Trainings Completed	All Required Trainings Completed
Central	38	13	77%	12	83%	33%
Eastern	21	9	89%	7	86%	86%
Hartford	53	34	6%	27	7%	4%
New Haven	15	12	75%	12	75%	67%
Southwestern	25	9	56%	7	57%	43%
Western	59	18	50%	12	75%	58%
Statewide	211	95	45%	77	52%	38%

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 (outreaches to audiences other than school or ED staff). 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 FY2026 Q4, providers conducted 55 formal outreaches to the community.** Performance ranged from 2 outreaches (New Haven) to 18 outreaches (Eastern).

Table 8. Formal outreaches completed by region and provider.

	Q1 FY26	Q2 FY26	Q3 FY26	Q4 FY26	Total
Central	**3**	**5**	**5**	**7**	**20**
CHR: Middlesex Health	2	2	4	3	11
CHR	1	3	1	4	9
Eastern	**10**	**6**	**6**	**18**	**40**
UCFS:NE	0	3	4	4	11
UCFS:SE	10	3	2	14	29
Hartford	**6**	**3**	**12**	**6**	**27**
Wheeler: Hartford	3	3	2	1	9
Wheeler: Meriden	0	0	5	1	6
Wheeler: New Britain	3	0	5	4	12
New Haven	**2**	**3**	**0**	**2**	**7**
Clifford Beers	2	3	0	2	7
Southwestern	**11**	**6**	**7**	**6**	**30**
CFGC: South	1	1	0	2	4
CFGC: Norwalk	0	0	0	1	1
CFGC: Bridgeport	10	5	7	3	25
Western	**4**	**4**	**5**	**16**	**29**
Wellmore: Danbury	0	0	0	0	0
Wellmore: Torrington	0	0	0	0	0
Wellmore: Waterbury	4	4	5	16	29
Statewide	**36**	**27**	**35**	**55**	**153**