MOBILE CRISIS
RESPONSE TEAM FOR YOUTH

Mobile Crisis Intervention Services

FISCAL YEAR 2026 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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Note: This report was created with data pulled mid-July, 2026. Numbers may differ slightly from our public-facing dashboard, which is updated with a fresh data pull every month – check out the dashboard anytime for the most up-to-date information on key metrics at https://www.chdi.org/resource-library/qi-reports/mobile-crisis/mobile-crisis-dashboard

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Executive Summary

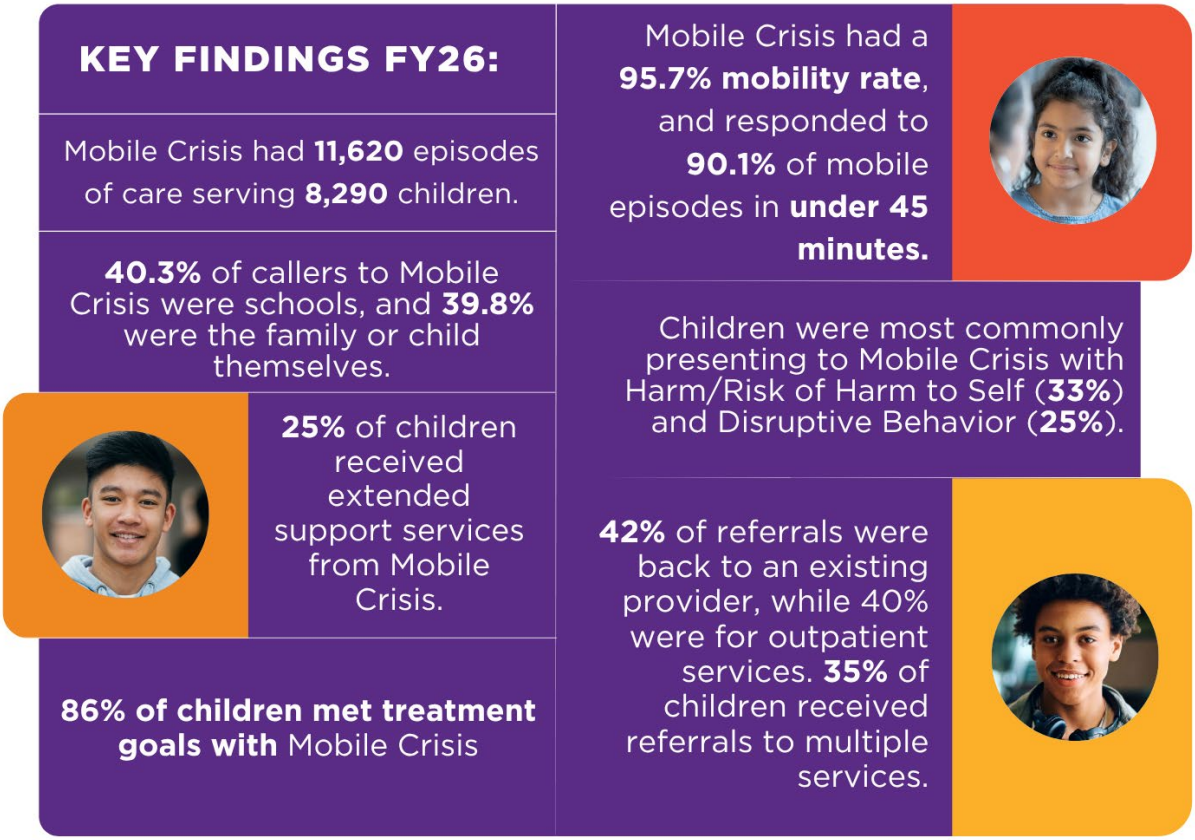
The Child Health and Development Institute (CHDI) serves as the Performance Improvement Center for Connecticut's Mobile Crisis Intervention Services. Mobile Crisis provides youth and families with a community-based, face-to-face response for behavioral health crises, with the goal of keeping children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

This report summarizes episode-level Mobile Crisis data for State Fiscal Year 2026 (July 1, 2025 – June 30, 2026). The report presents data and progress on key indicators of access, quality, and outcomes for Mobile Crisis in Connecticut. Equity is a 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 (QI) activities.

During FY2026, Mobile Crisis continued to exceed key performance benchmarks, demonstrating that the service continues to meet the high standards that have been established over the past 17 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 QI activities, we have identified a number of areas to focus on in FY 2027:

1. Increasing utilization and setting goals for improvement that incorporate an equity lens
2. Identify best practices for the extended support/stabilization phase
3. Deepen analysis of outcomes using new and enhanced data elements
4. Focus on increasing training completion, ensuring manageable training expectations, and identifying additional training needs
5. Working with system partners to enhance the relationship between 988, Mobile Crisis, and the overall behavioral health crisis system



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 FY2026 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.

FY2026 Focus

In FY2026, a primary focus was on improving data quality and documentation for Mobile Crisis, particularly around defining episodes that involved longer stabilization/support and episode outcomes. In recent years, we had observed significant variation between providers on these data elements and believed it was due in part to a lack of clear data definitions. Throughout this process, CHDI, DCF, and Mobile Crisis providers had many conversations to update data definitions and identify additional data collection to ensure we have high quality data informing our QI efforts. Preliminary changes in the data system were implemented during quarter 2 of FY2026, and we continued to refine definitions and data needs throughout the year. Appendix A presents the finalized list of changes that were made during this process, the last of which will be implemented in PIE in FY2027. CHDI also completed and distributed a comprehensive data dictionary for Mobile Crisis, as well as additional data documentation to ensure that all providers are following the same guidelines.

Another focus of FY2026 was improving the accessibility of Mobile Crisis data. The quarterly report was updated to a format similar to the annual report, with the goal of making these reports easier to understand, particularly for those who are less familiar with Mobile Crisis data. Another tool created to promote accessibility and usability of the Mobile Crisis data was an interactive dashboard. In October 2025, CHDI published a public-facing interactive dashboard that provides an overview of key Mobile Crisis performance metrics. These metrics can currently be viewed by month, quarter, or year back to FY2019 and can be viewed for specific regions and providers.

How many youth were served?

This year, 15,987 calls came into the Mobile Crisis line at 2-1-1, resulting in **11,620 episodes of care.** This was a 2.0% increase in call volume compared to FY2025, and a 0.05% increase in episode volume. In FY2025, a data element was added to PIE to capture when calls come through 988 instead of 2-1-1. There were 395 episodes (3.4%) that were initiated through 988. The 11,620 episodes this year served **8,290 unique children.** Most children served only had one episode of care this year (76.1%), with 23.9% having two or more episodes of care within the year. Most youth with multiple episodes of care only had two episodes (64.2%). 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.

Figure 2. Call and episode volume over time.

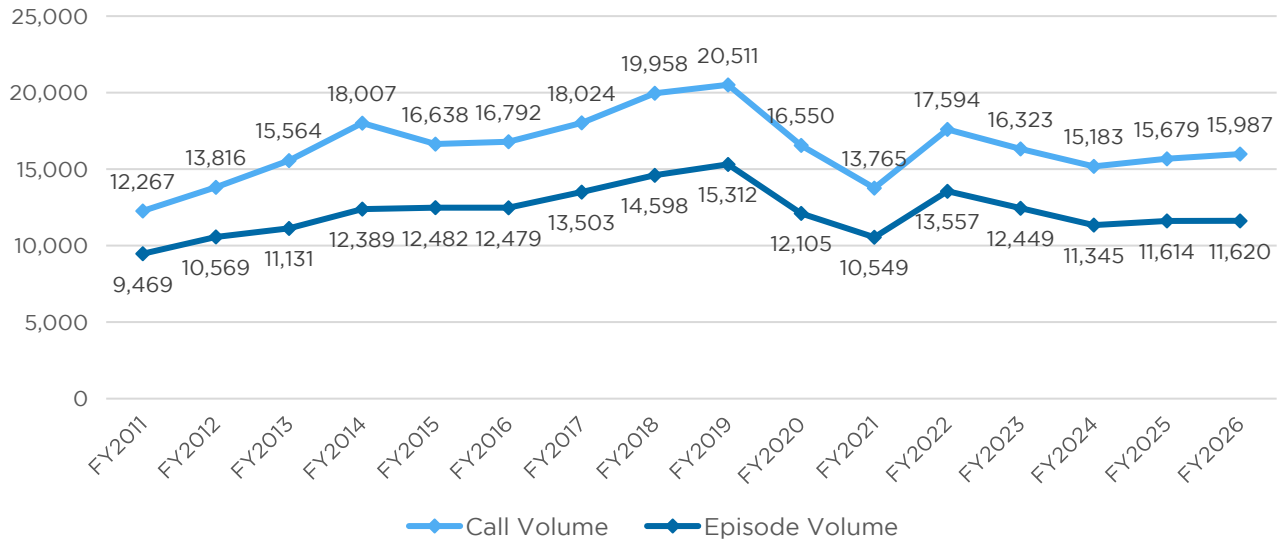
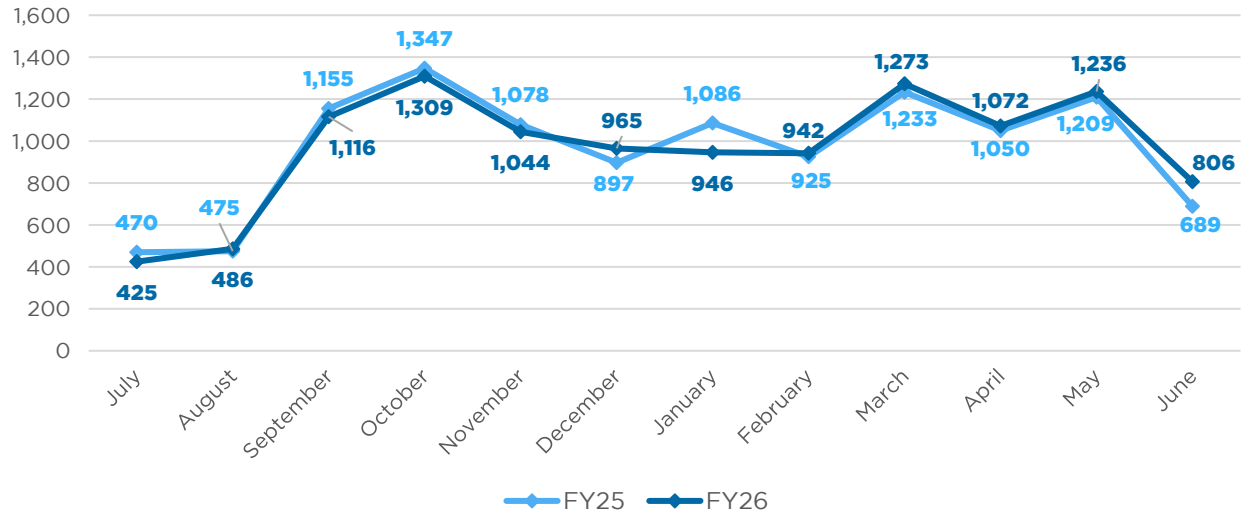


Figure 3. Number of episodes per month.



Episode volume for each region ranged from 1,373 (Eastern) to 2,944 (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 (3.3) of the statewide average (15.8). 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.

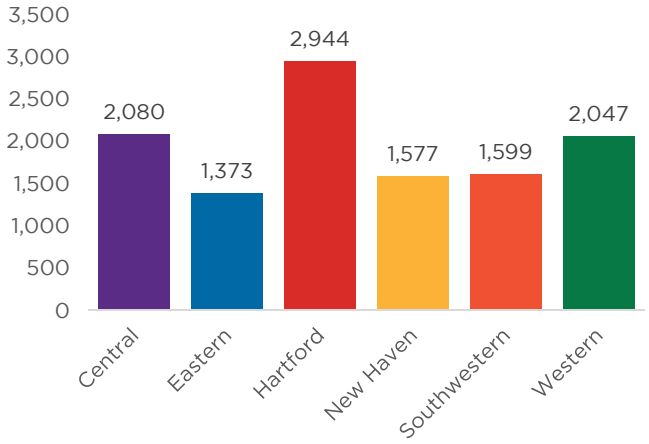


Figure 5. Episodes per 1,000 children.

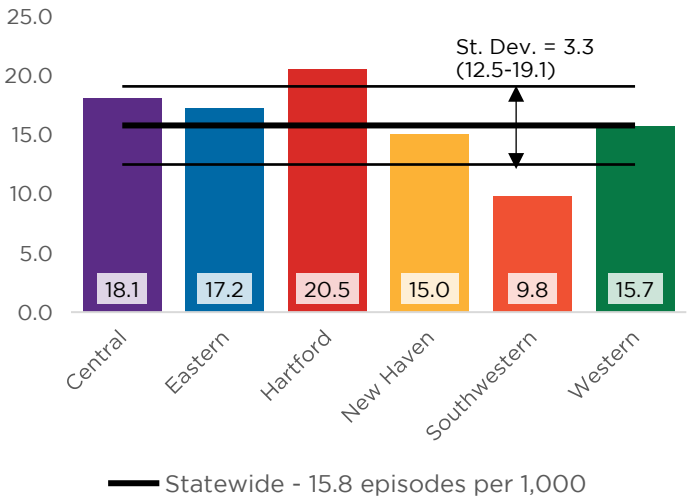
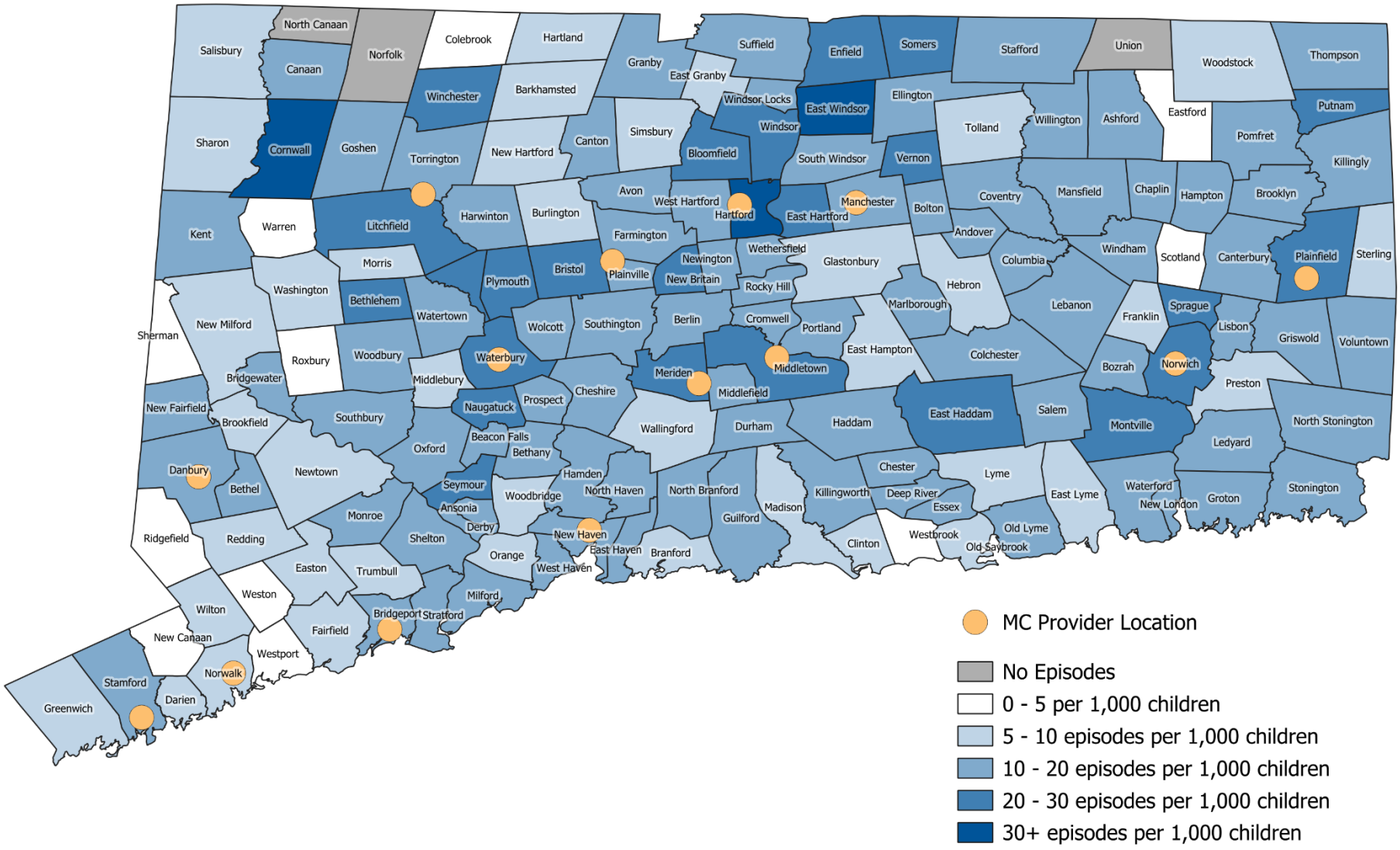


Figure 6 provides a visual representation of Mobile Crisis episode volume across the state. The map indicates the rate of Mobile Crisis episodes in each town during FY2026, relative to each town's child population (episodes per 1,000 children). There were three towns that didn't have a Mobile Crisis episode, the same number as FY2025 (only Union didn't have an episode either year). The major cities of Hartford and Waterbury each had over 750 episodes this year, while New Haven had over 500 episodes.

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



When did calls come in?

The majority of episodes (69.2%) resulted from calls that came in Monday-Friday between 7 a.m. and 5 p.m. An additional 17.0% of episodes were initiated on weekdays between 5 p.m. and midnight, and 11.0% came in at any time over the weekend. Only 3.5% 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 FY2026, 9.2% 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 (39.3%) or between 6 a.m. and 1 p.m. on the weekends (32.9%). The pattern of call times is very similar to last year.

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

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	**Total**
0:00-0:59	9	15	17	19	16	14	15	**105**
1:00-1:59	5	11	13	4	12	8	6	**59**
2:00-2:59	5	2	9	1	6	8	6	**37**
3:00-3:59	2	8	4	3	2	4	8	**31**
4:00-4:59	2	2	5	2	8	5	3	**27**
5:00-5:59	4	6	5	6	7	4	4	**36**
6:00-6:59	6	18	20	20	23	16	2	**105**
7:00-7:59	8	57	56	53	48	43	9	**274**
8:00-8:59	16	157	113	152	115	101	20	**674**
9:00-9:59	27	159	152	186	174	188	21	**907**
10:00-10:59	34	250	207	256	235	239	40	**1261**
11:00-11:59	39	235	206	263	271	194	44	**1252**
12:00-12:59	34	194	216	207	228	200	49	**1128**
13:00-13:59	39	205	203	224	182	166	47	**1066**
14:00-14:59	56	173	148	172	165	139	44	**897**
15:00-15:59	51	113	146	132	142	124	49	**757**
16:00-16:59	52	79	107	90	91	66	39	**524**
17:00-17:59	50	103	92	82	83	72	33	**515**
18:00-18:59	49	68	97	73	75	71	48	**481**
19:00-19:59	55	76	78	69	64	61	30	**433**
20:00-20:59	29	60	51	45	68	60	33	**346**
21:00-21:59	21	46	48	37	41	34	29	**256**
22:00-22:59	33	52	39	47	28	36	39	**274**
23:00-23:59	18	14	26	26	19	24	16	**143**
All Hours	**644**	**2103**	**2058**	**2169**	**2103**	**1877**	**634**	**11588**

Who is being served?

Black and Hispanic youth have consistently represented a larger share of youth served by Mobile Crisis than of Connecticut's population overall. Children served this year were 52% female and 48% male. A small percentage of youth identified as transgender or non-binary (1.8%). The rates of each racial and ethnic group served were similar across both sexes. The majority of children served were between ages 9 and 15 (64%). These demographics trends are consistent with previous years.

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

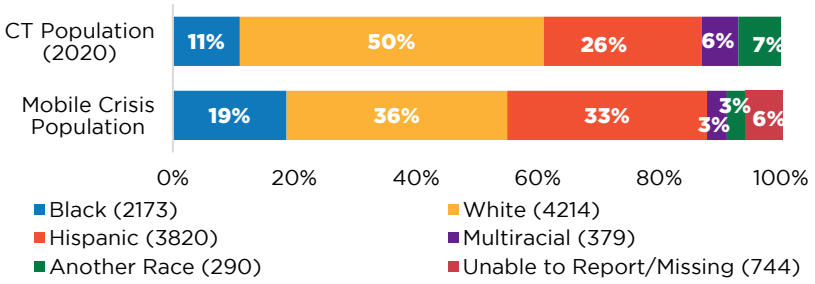
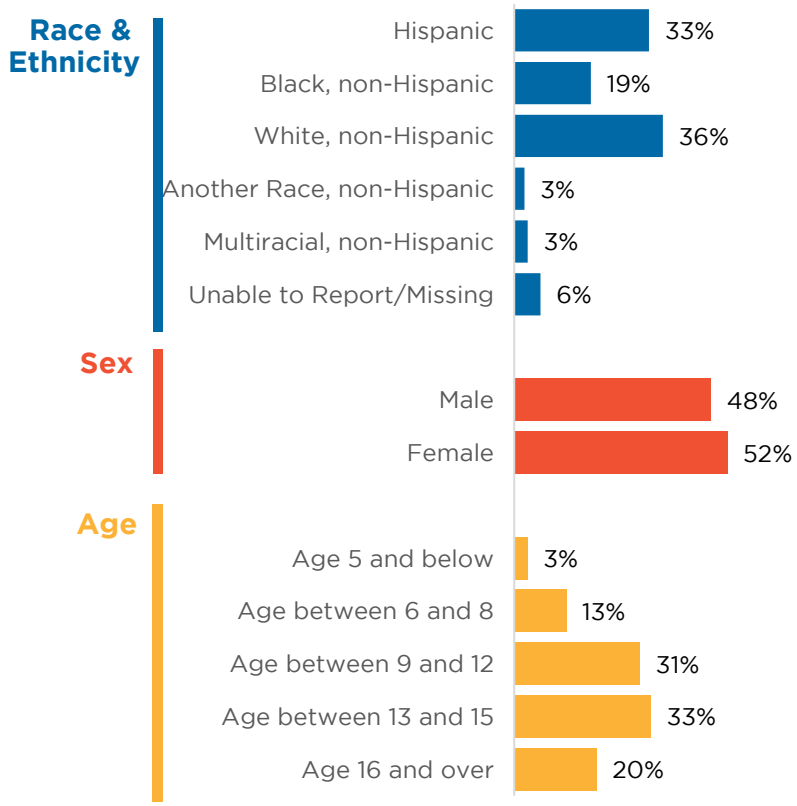


Figure 8. Demographics of children served.



Race and ethnicity are reported separately, and responses are combined into a single variable for most of our reporting so that each case has a single race/ethnicity category and can be compared to population data. However, combining responses in this way does miss the nuances of children who identify as more than one race or ethnicity. The charts below show race and Hispanic ethnicity separately, and include children who selected multiple races in each category they reported. Over half of children served identified as White (57.7%) and about a quarter identified as Black or African American (26.0%). Roughly one third (35.2%) reported Hispanic origin.

Figure 9. Race of children served.

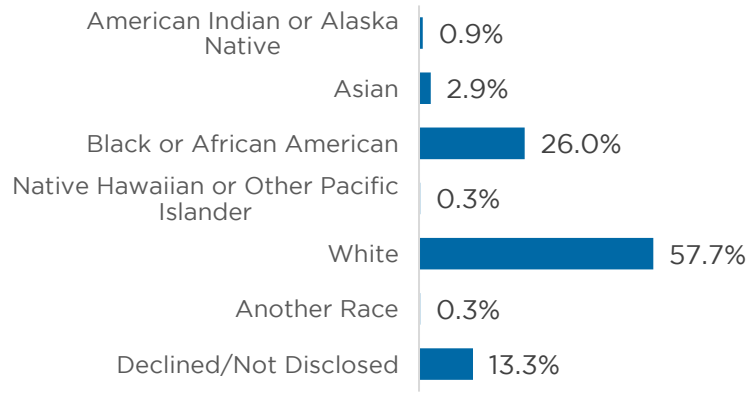
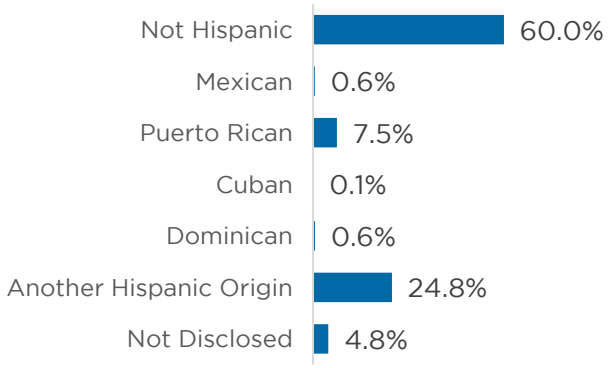


Figure 10. Ethnicity of children served.



Of the children who identified as Hispanic, 69.7% also reported at least one race. Hispanic youth most commonly identified as White (55.6%) or Black (14.4%), while 3.1% identified as some other race. Youth identifying as Multiracial, non-Hispanic most commonly reported being both Black and White (73.6%). 20.1% of Multiracial youth identified as White and another race, while 2.4% identified as Black and another race.

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 11. Male children served by race/ethnicity and age.

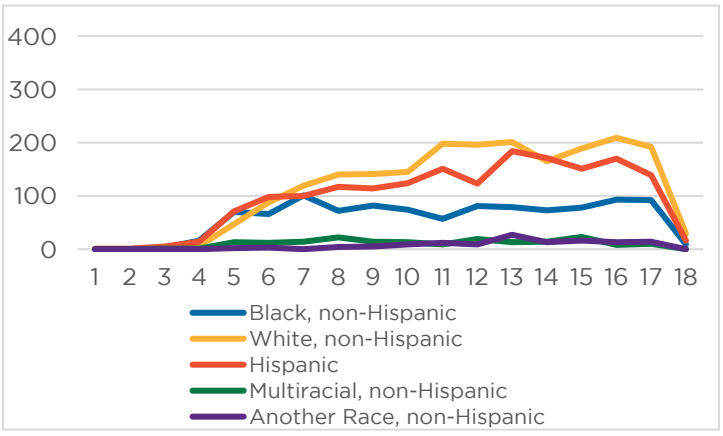
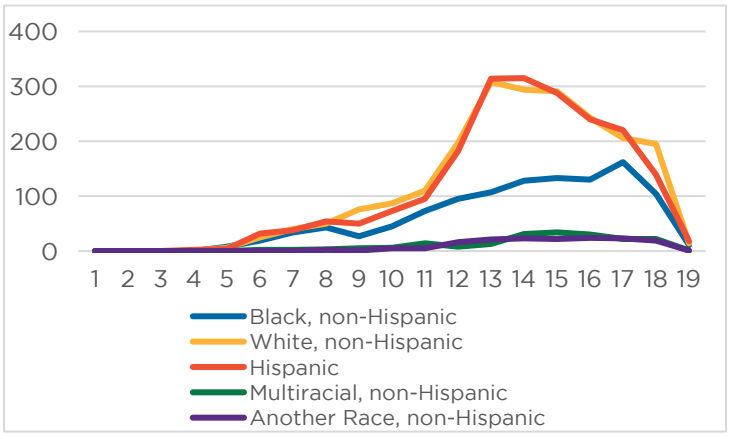


Figure 12. Female children served by race/ethnicity and age.

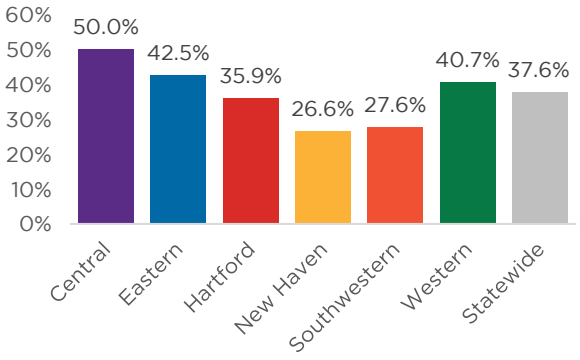


Most children served were covered by **Medicaid (48.2%)** or **private health insurance (19.0%)**. Data on insurance coverage was missing for 26.5% of children. Additionally, **10.4% of children were reported to be involved with DCF.** Data on DCF involvement was missing for 24.2% of children.

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

Statewide, **37.6% of children[1] served by Mobile Crisis reported a history of trauma**, compared to 37.8% in FY2025. It is important to note that 30.0% were missing data on these variables; it is unclear whether this missing data indicates not having experienced trauma or the question not being asked/answered. The remaining 32.3% 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 (41.5%). 30.9% reported being a witness to violence, 23.5% reported being a victim of violence, and 18.0% reported sexual victimization. A small number reported the recent arrest of a caregiver (0.8%). Additionally, 40.8% of youth who reported trauma indicated experiencing another type of trauma not specified in PIE.

Figure 13. 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, 16.2% of children report having visited the emergency department for psychiatric concerns, a slight increase from 15.1% of children in FY2025. This data was missing for 31.2% of children, while 52.6% reported not having been to the ED. Additionally, 8.4% report an inpatient stay in the last 6 months, similar to FY2024 (8.6%). This data was missing for 31.1% of children, while 60.5% said no. A small number of children served reported being arrested (1.4%) 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. Fifty-eight percent of children reported having issues at school, most commonly citing emotional issues (41%), behavioral issues (31%), social issues (27%), and academic issues (19%).

Table 2. Child history.

Child History	Lifetime	Prior 6 months
Emergency Department Psych		16.2%
Inpatient Psych	15.1%	8.4%
Out-of-Home Psych	2.9%	1.6%
Alcohol and Drugs	6.2%	5.9%
		Prior 12 months
Arrested		1.4%
Detained		0.8%
Suspended from School		9.0%

[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 (40.3%)** followed closely by self/family (39.8%). In contrast to the rest of the state, the Eastern and New Haven regions had families as the top callers. Only 6.5% of self/family calls were from the youth themselves (2.6% of all calls). Emergency Departments are the third most common caller statewide (10.9%), which varies significantly by region, ranging from 21.5% of calls in the Western region to only 1.3% in the Southwestern region.

Table 3. Caller type by region.

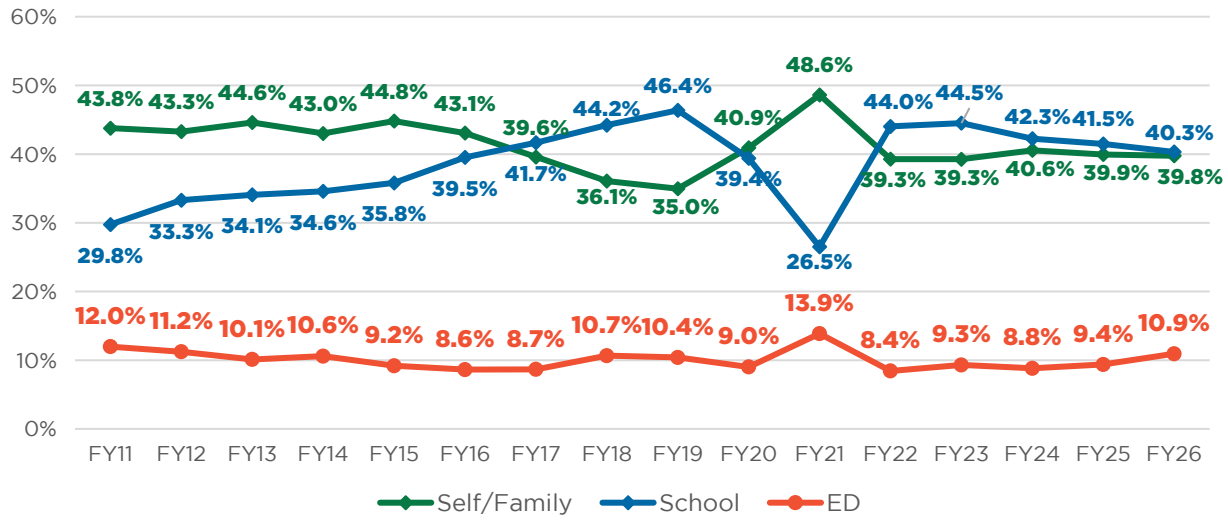
Caller type	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
School	40.4%	39.7%	37.4%	39.2%	53.1%	35.8%	**40.3%**
Self/Family	40.4%	48.8%	36.6%	43.8%	39.3%	34.8%	**39.8%**
Emergency Department	8.2%	1.5%	15.6%	10.2%	1.3%	21.5%	**10.9%**
Psychiatric Hospital	4.8%	3.6%	4.8%	1.8%	0.8%	2.9%	**3.3%**
Other Community Provider Agency	1.7%	2.3%	2.2%	1.9%	1.5%	1.8%	**1.9%**
Other Program Within Agency	1.4%	1.2%	0.5%	0.5%	0.6%	0.3%	**0.7%**
Foster Parent	0.3%	0.8%	0.3%	0.6%	0.3%	0.6%	**0.4%**
Police	0.6%	0.2%	0.5%	0.1%	0.6%	0.2%	**0.4%**
Other Referral Source	2.2%	2.0%	2.0%	1.9%	2.7%	2.1%	**2.1%**

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. While this remained true this year, the rates of school and self/family callers was closer than it has ever been before.

The top referring EDs in FY2026 were Connecticut Children's Medical Center (CCMC; 47.3% of ED referrals), St. Mary's Hospital (31.5%), and Yale-New Haven Hospital (15.9%). The number of calls from CCMC increased 38% compared to FY2025. Calls from Yale increase by 25%, while calls from St. Mary's remained stable (2% decrease). Overall, calls from EDs increased by 17% compared to last year.

Figure 14. Caller type over time.

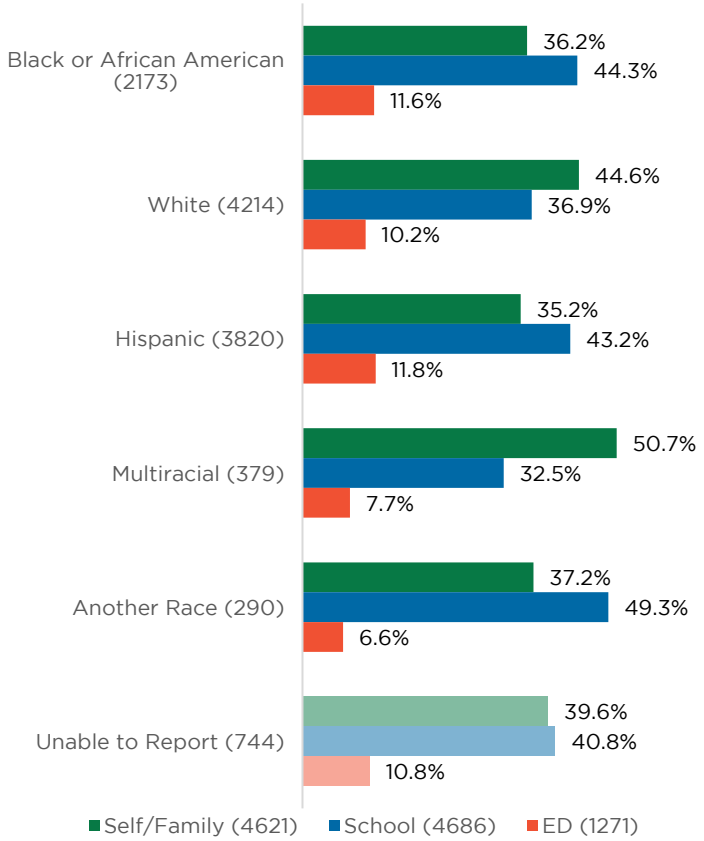


Did different referrers call at the same rates for all youth?

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 FY2026 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 both White and multiracial youth.
- There were no statistically significant differences between groups in ED referral rates.
- These differences are statistically significant, but the effect size[2] is small (p<.001; C=.111). **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 15. 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).

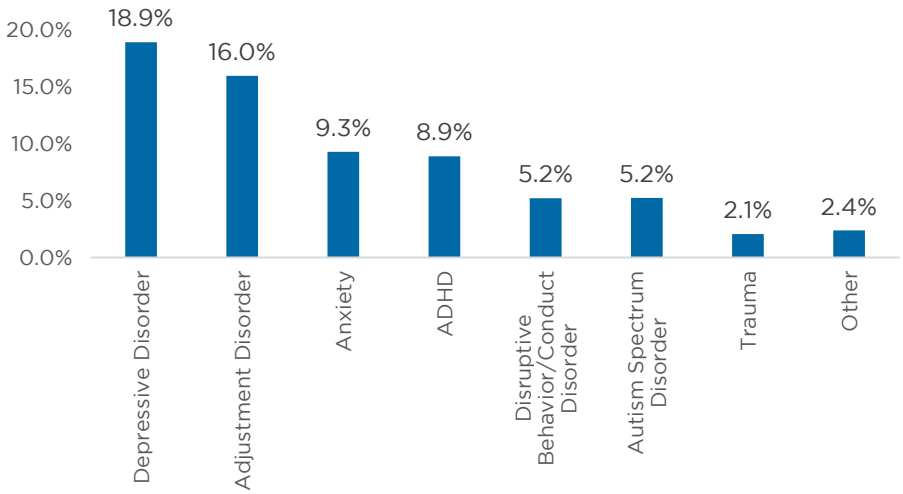
Why did they call?

The top presenting problems statewide were Harm/Risk of Harm to Self (32.7%) and Disruptive Behavior (24.7%). This varied among regions, with disruptive behavior being the top presenting problem by a small margin in the Hartford region. Due to the short nature of a Mobile Crisis episode, data on presenting problems are typically more relevant than diagnosis – 32.0% of children did not have a diagnosis reported. The top diagnoses were depressive disorders (18.9%), adjustment disorders (16.0%), anxiety (9.3%), and ADHD (8.9%).

Table 4. Top presenting problems by region.

Presenting Problem	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Harm-Risk of Harm to Self	38.3%	43.7%	26.2%	34.5%	29.4%	29.6%	**32.7%**
Disruptive Behavior	26.6%	21.2%	27.4%	22.3%	25.4%	23.4%	**24.7%**
Depression	7.0%	6.0%	12.0%	11.2%	11.9%	11.9%	**10.3%**
Family Conflict	7.3%	4.0%	5.6%	7.3%	6.0%	8.0%	**6.4%**
Anxiety	5.0%	3.1%	8.6%	4.5%	4.1%	6.8%	**5.8%**
Harm/Risk of Harm to Others	6.2%	11.1%	3.6%	5.1%	2.7%	4.1%	**5.2%**
School Problems	4.3%	4.0%	4.6%	4.1%	8.4%	5.9%	**5.1%**
Other Presenting Problem	5.3%	6.9%	12.0%	11.0%	12.2%	10.3%	**9.8%**

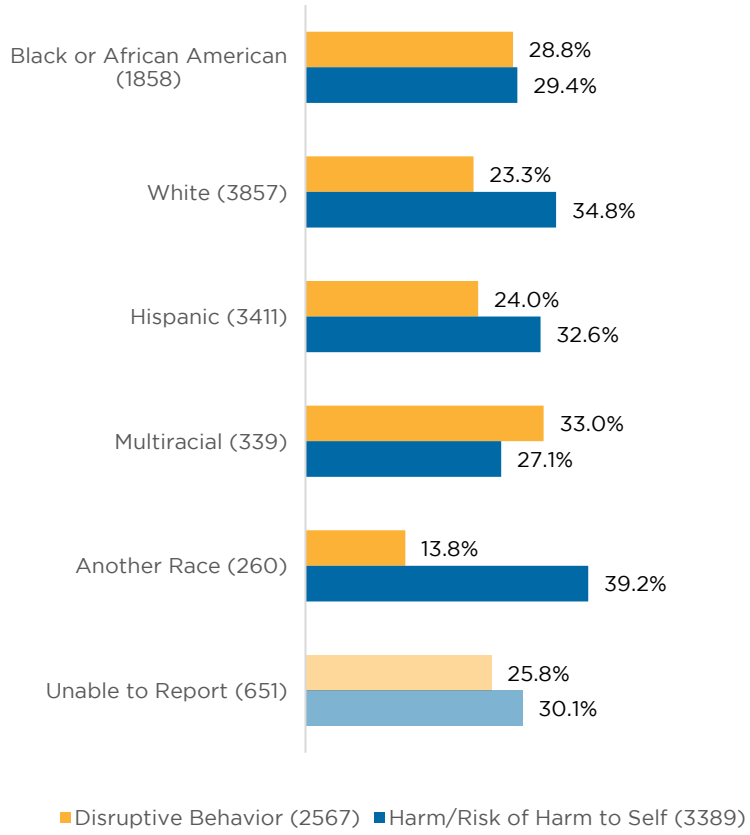
Figure 16. Top diagnoses.



Were children referred for similar reasons across race and ethnicity?

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

Figure 17. Most common presenting problem by race and ethnicity.



Notable findings from FY2026 include:

- Harm/risk of harm to self was the top presenting problem among all racial and ethnic groups except for Multiracial children, who are most commonly referred for disruptive behavior.
- Disruptive behavior drives a greater portion of referrals for Black and Multiracial youth when compared to White and Hispanic youth.
- 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 13.8% of their referrals.
- White youth had significantly higher rates of referral for harm/risk of harm to self compared to Black youth, while youth identifying as another race had significantly higher rates of referral for harm/risk of harm to self compared to Black and multiracial youth.
- **The above differences are statistically significant, but with a negligible effect size ($p<.001$; $C=.077$), indicating that in practical terms, there is no meaningful difference between groups.**

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 FY2026 was 95.7% - consistent with last year's rate of 95.8% and exceeding the 90% benchmark.

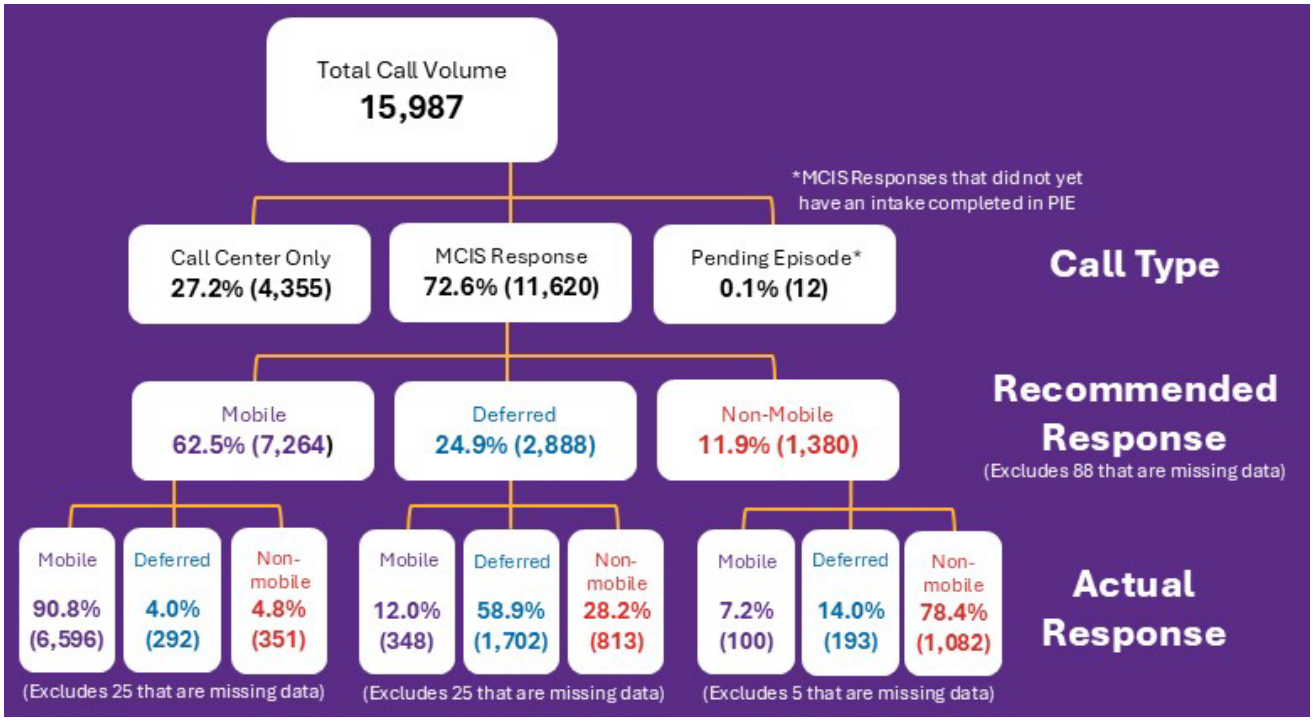
Mobile responsiveness is a key feature of Mobile Crisis service delivery. Since the beginning of PIC implementation, the established mobility benchmark has been 90%. To calculate the mobility rate, the Mobile Crisis PIC has historically examined all episodes for which the recommended response was mobile 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 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 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 FY2026, 87.4% of callers requested a Mobile (62.5%) or Deferred Mobile (24.9%) response. An additional 11.9% requested non-mobile phone support. For the actual response by Mobile Crisis providers, 61.0% received a Mobile response, 19.1% received a Deferred Mobile response, and 19.4% received a non-mobile response.

Figure 18. Responses across all Mobile Crisis episodes.



Most episodes received a response that was consistent with the request of the caller (80.7%), with an additional 5.5% receiving a more enhanced response than what was originally requested. A small number of callers (2.5%) requested a Mobile and received a Deferred Mobile, while 10.0% requested a Mobile or Deferred Mobile response and received a non-mobile response. Of these responses that changed to non-mobile, 92.6% were because the family later declined a mobile response or was unable to be reached. An additional 3.8% involved the original third-party caller cancelling the request.

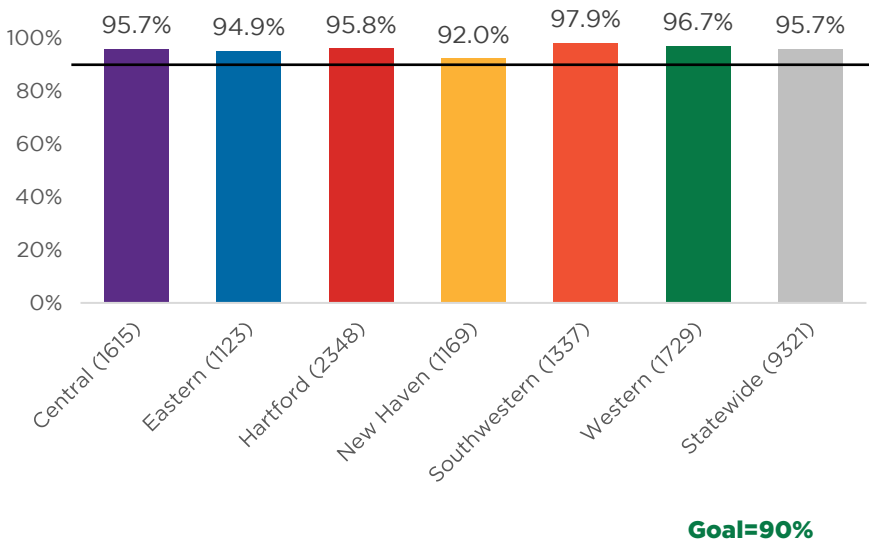
Table 5. Non-mobile reason by provider (when original request was for face-to-face response).

	Central (257)	Eastern (125)	Hartford (289)	New Haven (223)	Southwestern (51)	Western (169)	Statewide (1114)
MCIS Decision	1.9%	4.8%	2.4%	4.9%	13.7%	2.4%	**3.6%**
Family Declined Mobile	73.2%	79.2%	76.8%	70.4%	74.5%	72.8%	**74.2%**
Family Not Available	20.6%	12.8%	17.3%	22.9%	9.8%	17.8%	**18.4%**
Third Party Canceled	4.3%	3.2%	3.5%	1.8%	2.0%	7.1%	**3.8%**

Did mobility rates vary by provider or region?

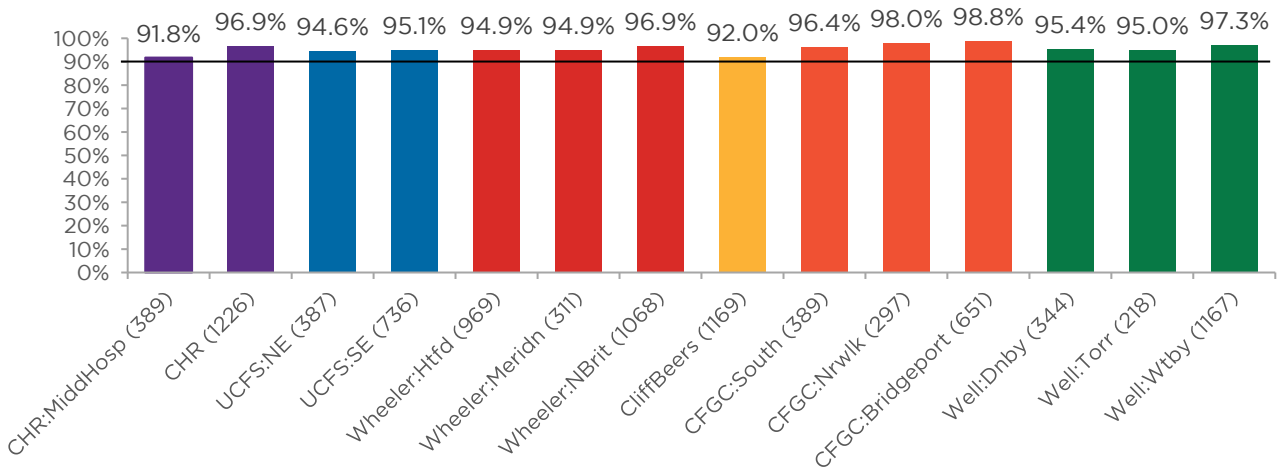
All six regions exceeded the benchmark, with performance ranging from 92.0% (New Haven) to 97.9% (Southwestern). Among individual providers, all 14 exceeded the 90% benchmark, with performance ranging from 91.8% (CHR: Middlesex) to 98.8% (CFGC: Bridgeport). **Most mobile responses took place in homes (49.6%) or schools (41.5%)**. A small percentage took place in a hospital emergency department (6.9%) or other community location (2.0%).

Figure 19. Mobility rate by region.



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

Figure 20. Mobility rate by provider.



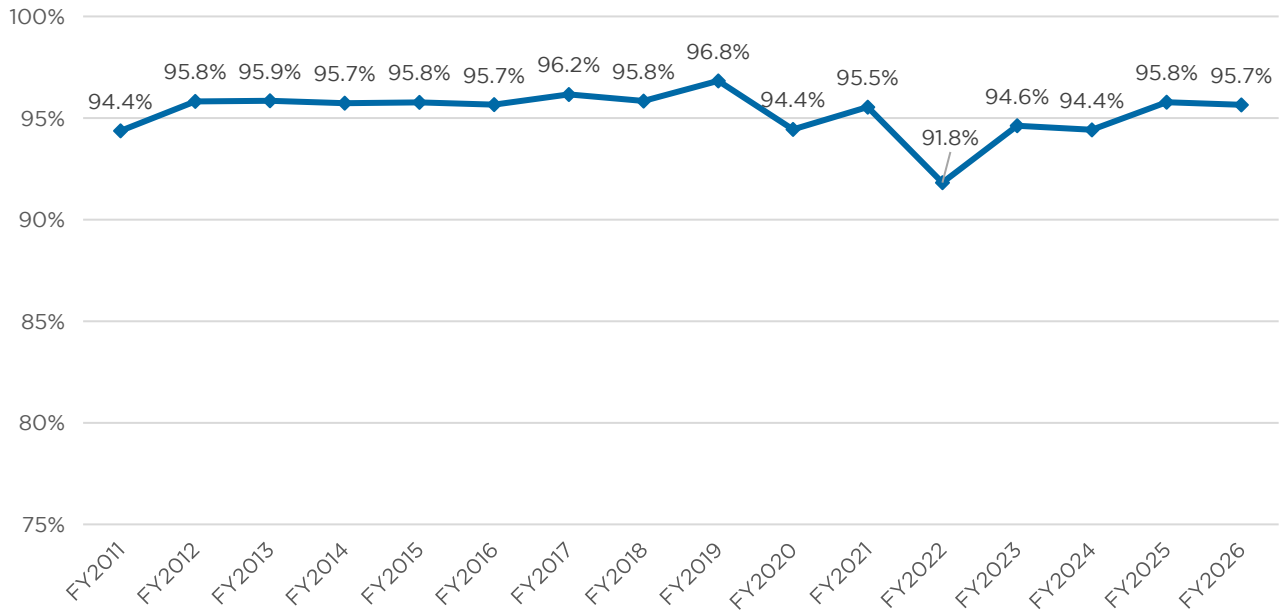
Note: Counts of 211-recommended mobile episodes are in parentheses.

Goal=90%

How have mobility rates changed over time?

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

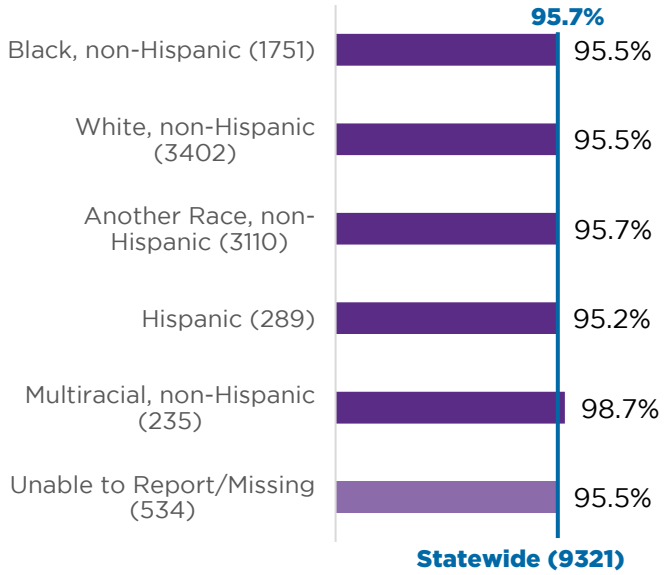
Figure 21. Statewide mobility rate over time.



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. In FY2026, there were no statistically significant differences in mobility rate across racial and ethnic groups.

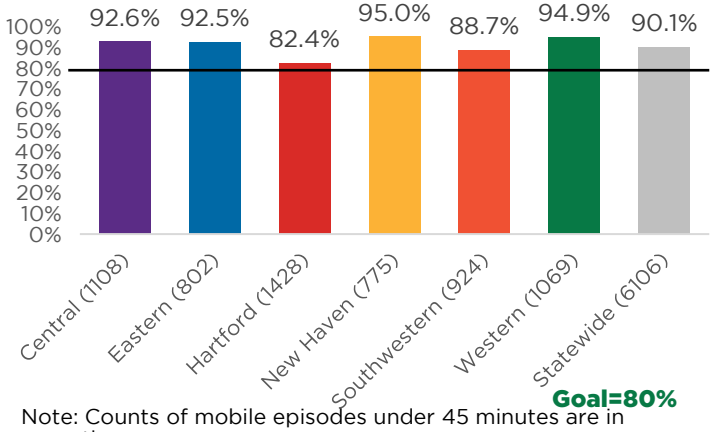
Figure 22. Mobile rate by race and ethnicity.



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

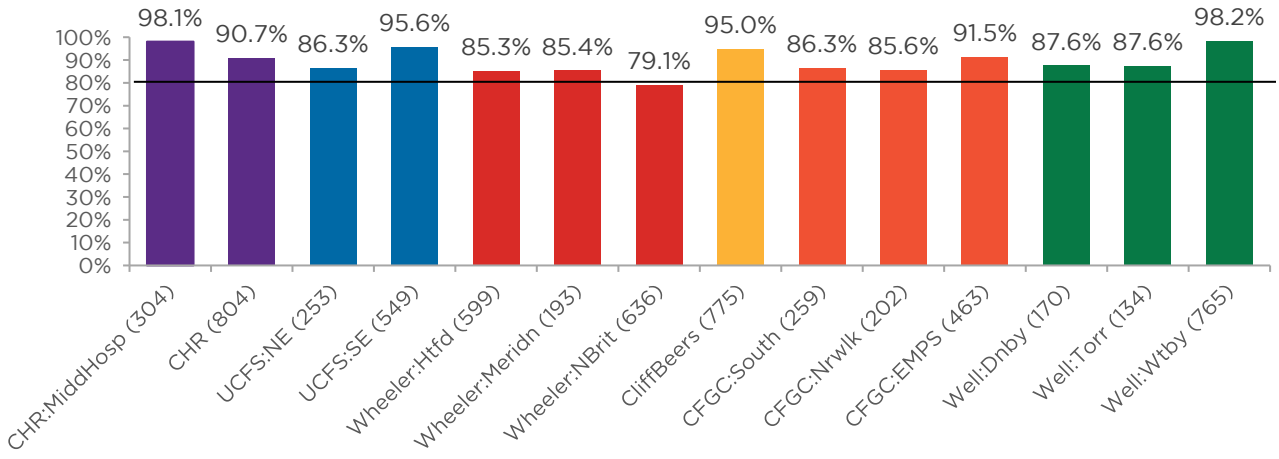
The median response time in FY2026 was 29 minutes, the same as FY2025. Of the 6,779 episodes that received an immediate Mobile response, **90.1% received a response within 45 minutes**, exceeding the 80% benchmark and slightly higher than FY2025 (89.1%). **All six regions exceeded the benchmark**, with performance ranging from 82.4% (Hartford) to 95.0% (New Haven). Thirteen of the fourteen individual providers met or exceeded the 80% benchmark, with performance ranging from 79.1% (Wheeler: New Britain) to 98.2% (Wellmore: Waterbury). The median response time for deferred mobile episodes was 4.3 hours.

Figure 23. Response time under 45 minutes by region.



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

Figure 24. Response time under 45 minutes by provider.

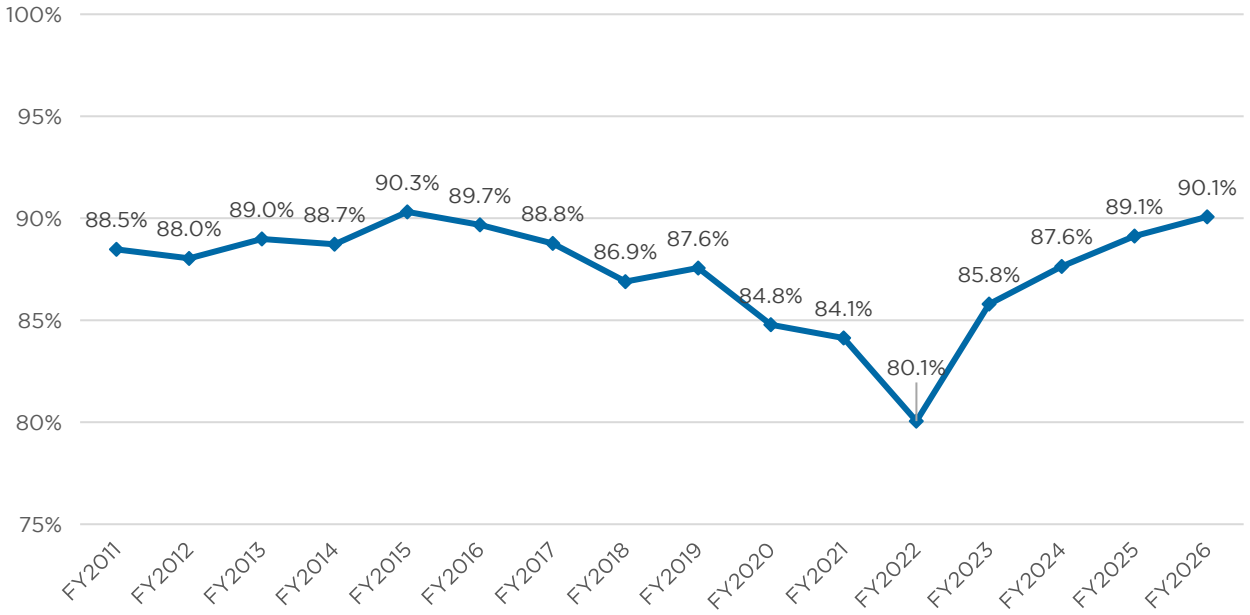


Note: Counts of mobile episodes under 45 minutes are in parentheses

How has response time changed over time?

The rate of responses under 45 minutes has consistently exceeded the 80% benchmark across the state. While still exceeding the benchmark, 45-minute response rate was at its lowest in FY2022 when Mobile Crisis was facing significant workforce shortages. Since hiring more staff, **the percentage of responses provided in 45 minutes or less has increased over the last two years, with FY2026 having the highest rate in ten years**.

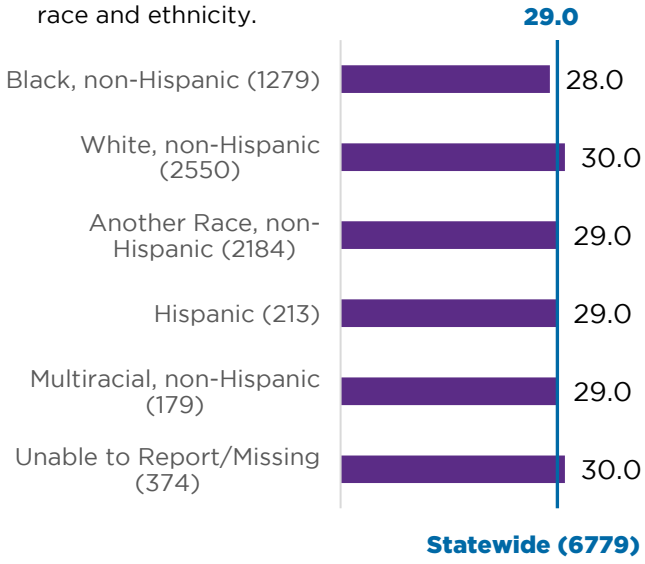
Figure 25. Statewide response time under 45 minutes over time.



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.

Figure 26. Median response time (minutes) by race and ethnicity.



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

There are a number of different Mobile Crisis intervention types, which were restructured and updated with new titles and definitions in FY2026 Q2. The definitions continued to be tweaked throughout FY2026, which may have resulted in inconsistencies in the data while the PIC worked with the providers to ensure everyone was on the same page. Going into FY2027, the quality of this data should be much better. Because of these changes, any comparisons to this data in previous years should be interpreted with caution. The first three intervention 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 child 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 efforts should be made to transition to "Extended Support"
- **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.

Table 6. Crisis response type by region.

	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Face-to-Face: Evaluation Only*	1.7%	3.9%	10.9%	15.8%	11.4%	3.7%	**7.9%**
Face-to-Face: Connect to Care**	32.9%	63.0%	29.2%	37.0%	41.8%	46.8%	**39.7%**
Face-to-Face: Extended Support***	41.5%	8.6%	33.5%	12.2%	16.7%	23.2%	**25.0%**
Crisis Response: Phone Only	21.5%	21.0%	22.4%	29.3%	14.6%	16.6%	**21.0%**
Face-to-Face: Consultation Only	2.4%	3.3%	3.5%	5.7%	15.4%	9.7%	**6.2%**

*Option was not added to PIE until November 2, 2025
**Includes some episodes from the beginning FY2026 previously classified as "Face-to-Face"
***Includes some episodes from the beginning of FY2026 previously classified as "Face-to-Face: Plus Stabilization Follow-Up"; this type was called "treatment and connection to care" in some FY26 quarterly reports, but has ultimately been named "extended support"

Across 11,323 episodes discharged in FY2026, 21.0% were handled over the phone. An additional 6.2% involved a face-to-face response, but did not include interaction with the child and were limited to consultation with family and other referrers (commonly school staff). The remaining **72.6% (8,225) involved**

a face-to-face assessment with the child. Of these episodes, 10.9% were Evaluation Only, though this was not a distinct category in PIE until November of this year. Over half (54.7%) of episodes with a face-to-face assessment were a traditional Connect to Care episode, while 34.4% were Extended Support episodes, including additional face-to-face contact with the child.

What activities are taking place during the extended support phase?

Beginning in November 2025, we began collecting data on what activities are taking place during the extended support phase. Preliminary data for episodes that were discharged during quarters 3 and 4, after this data collection was implemented, are displayed below. While face-to-face contact with the child is the most common activity (71.9%), it is expected to be much higher as that is a requirement of extended support episodes. The discrepancy is likely due to data entry issues as the details of this data collection continued to be ironed out. Other common elements include phone calls (69.7%) and face-to-face contact (56.9%) with caregivers, supporting families in accessing resources (48.6%), and reviewing and updating safety plans (43.4%). Work done in the second half of FY2026 to provide clear guidelines for these and other data elements is expected to result in higher data quality in FY2027.

Table 7. Activities during extended support phase.

Activity	Cases Reported	%
Face-to-face contact with child	848	71.9%
Phone call with caregiver	823	69.7%
Face-to-face contact with caregiver	671	56.9%
Supporting families in accessing resources, making phone calls, documentation, etc.	574	48.6%
Reviewing/updating crisis/safety plans	512	43.4%
Phone call with provider	328	27.8%
Family education	296	25.1%
Attending/coordinating meetinggs with families, schools, other providers	218	18.5%
Phone call with child	110	9.3%
Psychiatric consultation	32	2.7%
Total Extended Support Episodes (Discharged FY26 Q3-Q4).	1180	

How long are youth and families involved with Mobile Crisis?

Statewide, the median length of service for discharged episodes was 4 days for Evaluation Only episodes, 10 days for Connect to Care episodes, and 21 days for Extended Support episodes. 43.7% of Evaluation Only episodes exceeded five days, 37.4% of Connect to Care episodes exceeded 14 days, and **5.2% of Extended Support episodes exceeded 45 days, slightly exceeding the statewide benchmark of less than 5%**.

Table 8. Length of service for discharged episodes.

		Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Face-to-Face: Evaluation Only*	**n**	35	53	317	244	176	70	**895**
	Median (Days)	3	1	1	12	2	2	**4**
	Exceeding 5 days	37.1%	22.6%	27.4%	73.8%	40.3%	40.0%	**43.7%**
Face-to-Face: Connect to Care**	**n**	673	867	847	571	644	897	**4499**
	Median	18	6	7	17	20	8	**10**
	Exceeding 14 days	63.6%	9.3%	19.8%	59.5%	59.5%	31.5%	**37.4%**
Face-to-Face: Extended Support***	**n**	848	119	972	189	258	445	**2831**
	Median	24	22	18	22	35	14	**21**
	Exceeding 45 days	6.8%	2.5%	1.0%	14.3%	9.7%	5.4%	**5.2%**

*Option was not added to PIE until November 2, 2025
**Includes some episodes from the beginning FY2026 previously classified as “Face-to-Face”
***Includes some episodes from the beginning of FY2026 previously classified as “Face-to-Face: Plus Stabilization Follow-Up”; this type was called “treatment and connection to care” in some FY26 quarterly reports, but has ultimately been named “extended support”

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. 95.5% 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. It is also likely that many Evaluation Only 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 9. Length of service for open episodes (as of 6/30/26).

		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%**

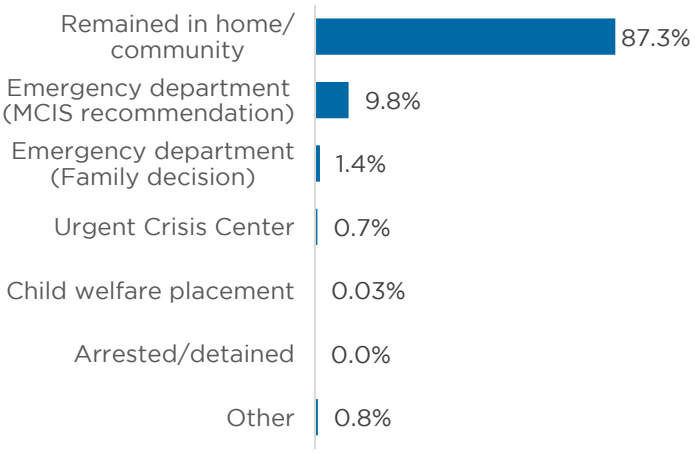
How often did families access a higher level of care during the episode?

Mobile Crisis also collects data on how often children utilize a higher level of care during the episode. In FY2026, 5.1% of families reported visiting the ED during their Mobile Crisis episode. No utilization of the ED during the episode was reported by 18.8% of families, while 76.1% 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 (578), 8.1% received a referral to the ED from Mobile Crisis. Admission to an inpatient psychiatric hospital during the episode was reported by 2.0% of children. No inpatient utilization was reported by 21.9% of families, while 76.1% were missing data. Of the children who did have an inpatient admission during their Mobile Crisis episode (227), 55.5% received a referral to inpatient from Mobile Crisis.

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 November 2025, 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 10.9% of episodes discharged during FY26 Q3 or Q4 that involved a face-to-face assessment. Of those that had data, **87.3% of children remained in their home/community following the initial assessment.**

Figure 27. Initial assessment outcome.



Are children meeting treatment goals?

Across all epsiodes, treatment goals were met 86.4% of the time. This varies between regions, ranging from 77.0% (Southwestern) to 98.5% (Western). During episodes that had a face-to-face assessment with the child, the statewide rate increased to 94.6% and was above 90% across all regions. This is another data element that required updated definitions during FY2026, which likely explains some of the variation across regions.

Table 10. Rate of episodes where treatment goals were met by region and episode type.

	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
FTF w/ Child	97.5%	94.7%	91.1%	95.7%	90.2%	99.1%	**94.6%**
Other Episodes	55.4%	69.7%	51.7%	73.0%	46.3%	97.0%	**64.6%**
All Episodes	87.4%	88.6%	80.7%	87.8%	77.0%	98.5%	**86.4%**

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 FY2026, collection rates[3] of worker Ohio scales were similar to FY2025. The collection rate of parent intake scales decreased slightly, while the collection rate of parent discharge scales increased. 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 New Haven region had the highest collection rates of parent Ohio scales at discharge.

Figure 28. Ohio scale collection rates over time.

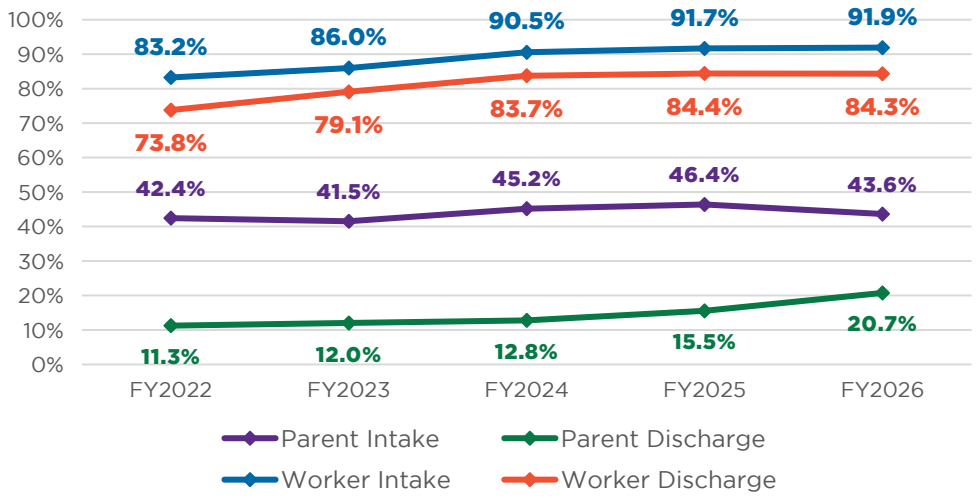


Figure 29. Ohio scale collection at **intake** by region.

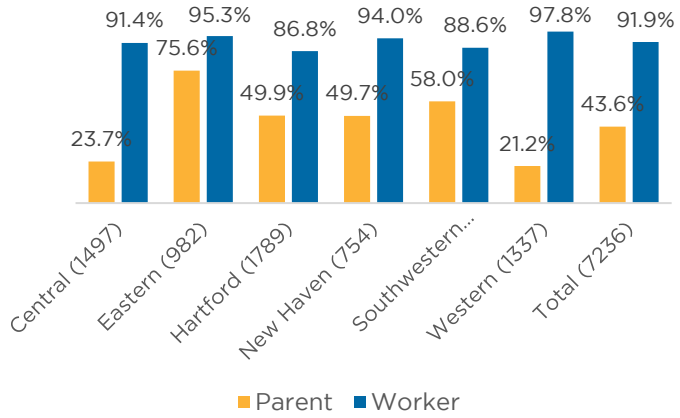
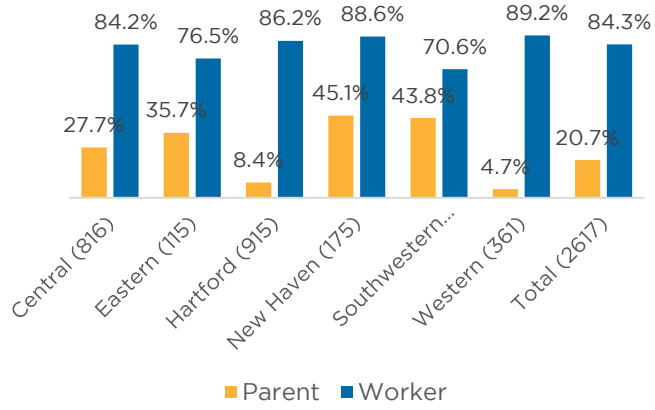


Figure 30. Ohio scale collection at **discharge** by region.



Number of Ohio scales expected to be collected are in parentheses.

[3] The percentages of completed Ohio Scales are only reflective of episodes where Ohio Scales are expected to be collected; Ohios should be collected at intake for Connect to Care and Extended Support episodes, and at discharge for Extended Support episodes lasting longer than 5 days.

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 FY2025, rates of improvement[4] from intake to discharge decreased across all Ohio scales. Rates of improvement vary across regions, with the Western region generally seeing the highest rate of improvement. There was no consistent variation in improvement by race and ethnicity.

Figure 31. Any improvement on Ohio Scales Reliable Change Index.

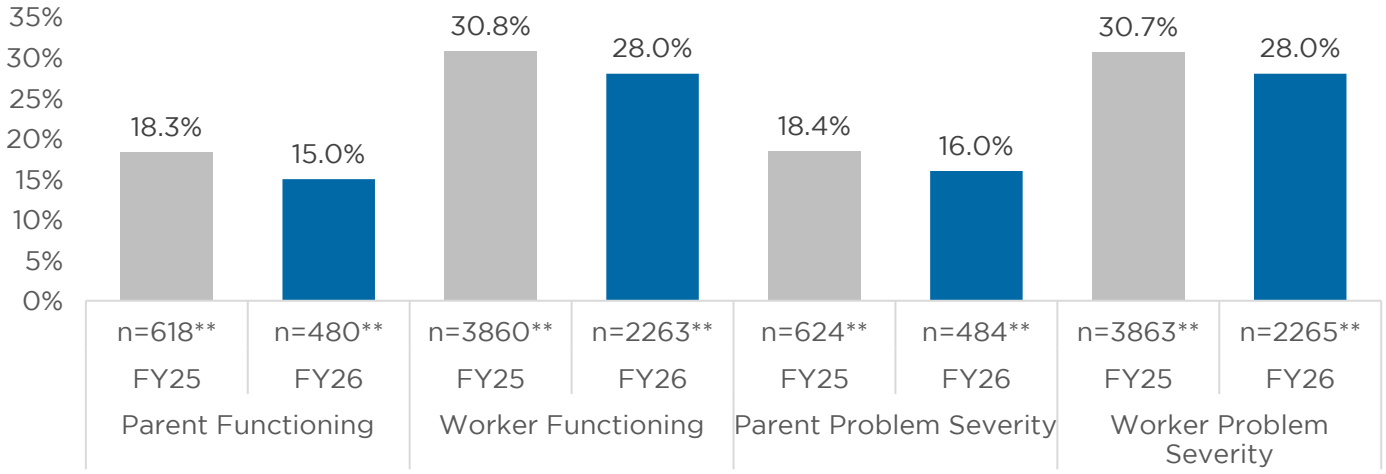


Table 11. Any improvement on Ohio Scales Reliable Change Index by region.

	Central	Eastern	Hartford	New Haven	Southwestern	Western
Parent-Completed Functioning Scale	2.8%	31.6%	6.3%	0.0%	19.4%	30.4%
	n=185	n=35**	n=68	n=79	n=94**	n=19**
Worker-Completed Functioning Scale	7.3%	25.5%	8.0%	11.0%	15.6%	49.0%
	n=700	n=85**	n=762**	n=156*	n=179**	n=381**
Parent-Completed Problem Severity Scale	2.8%	15.8%	9.7%	0.0%	23.3%	52.2%
	n=185†	n=35**	n=68*	n=81	n=96**	n=19**
Worker-Completed Problem Severity Scale	5.4%	22.6%	9.3%	15.8%	18.5%	45.1%
	n=700	n=85**	n=761**	n=156	n=181**	n=382**

[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. 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.

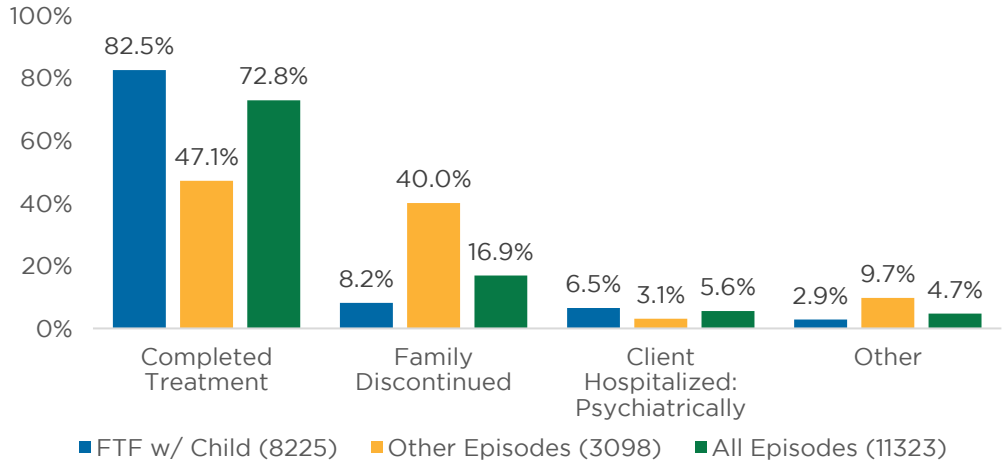
Table 12. Any improvement on Ohio Scales Reliable Change Index by race and ethnicity.

	Black, non-Hispanic	White, non-Hispanic	Another Race, non-Hispanic	Hispanic	Multiracial, non-Hispanic	Unable to Report/Missing
Parent-Completed Functioning Scale	9.5%	18.0%	22.2%	0.0%	9.1%	11.1%
	n=74	n=183**	n=11	n=171**	n=14	n=27
Worker-Completed Functioning Scale	17.8%	20.9%	22.7%	17.5%	13.0%	22.1%
	n=427**	n=813**	n=46	n=771**	n=57	n=149**
Parent-Completed Problem Severity Scale	10.8%	22.3%	21.4%	7.1%	8.3%	25.9%
	n=74*	n=184**	n=12	n=173**	n=14	n=27
Worker-Completed Problem Severity Scale	19.0%	23.2%	25.5%	14.0%	15.2%	24.8%
	n=427**	n=813**	n=46†	n=773**	n=57	n=149**

Why were youth discharged?

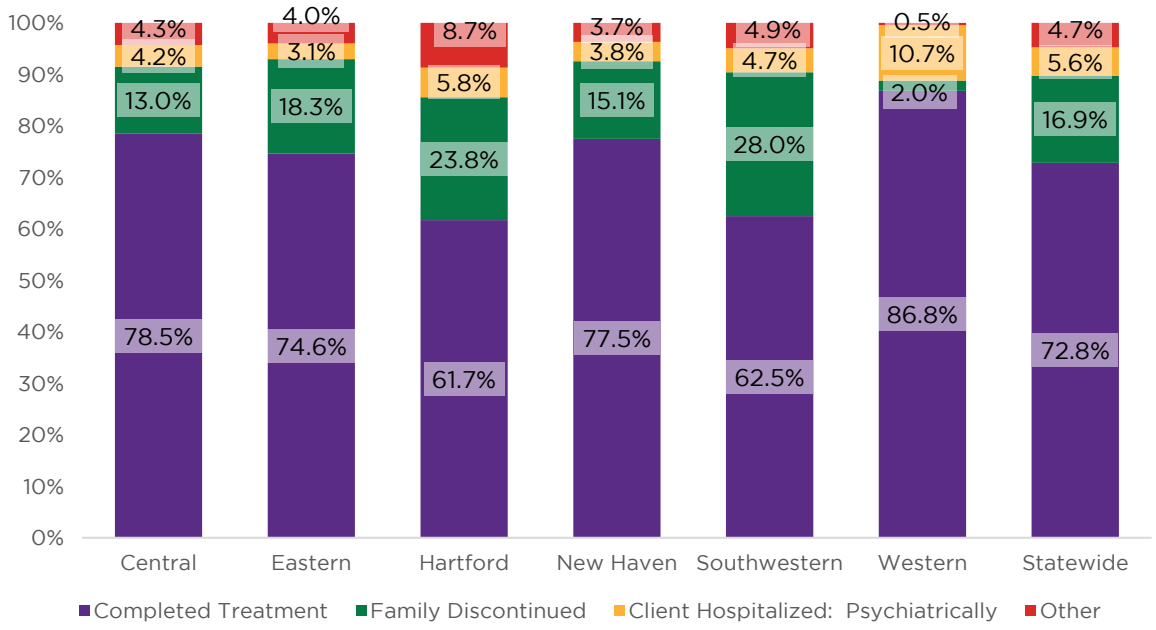
Statewide, **the majority of youth (72.8%) were discharged for completing their treatment with Mobile Crisis.** The rate of treatment completion was higher for episodes that involved a face-to-face assessment with the child (82.5%). For Mobile Crisis, completing treatment generally means that the clinician 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 16.9% of the time for all episodes, and only 8.2% of the time for episodes involving 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 needs or preferences of the child or family.

Figure 32. Reason for discharge by intervention type.



Reason for discharge does show variation across regions. Treatment completion ranged from 61.7% (Hartford) to 86.8% (Western). The rate of families discontinuing services ranged from 2.0% (Western) to 28.0% (Southwestern). Inconsistent data definitions may explain some of the variation between regions. During FY2026, the PIC worked with providers and DCF to develop clear guidelines for defining treatment completion. This should lead to improved data quality in FY2027.

Figure 33. 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 – both Black and Hispanic children have lower rates of treatment completion when compared to White youth. Black youth also have a higher rate of discontinuing services than White youth. However, while differences were statistically significant the effect size was negligible (p<.001; C=.074) 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 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=.132).

Figure 34. Families completing treatment by race and ethnicity.

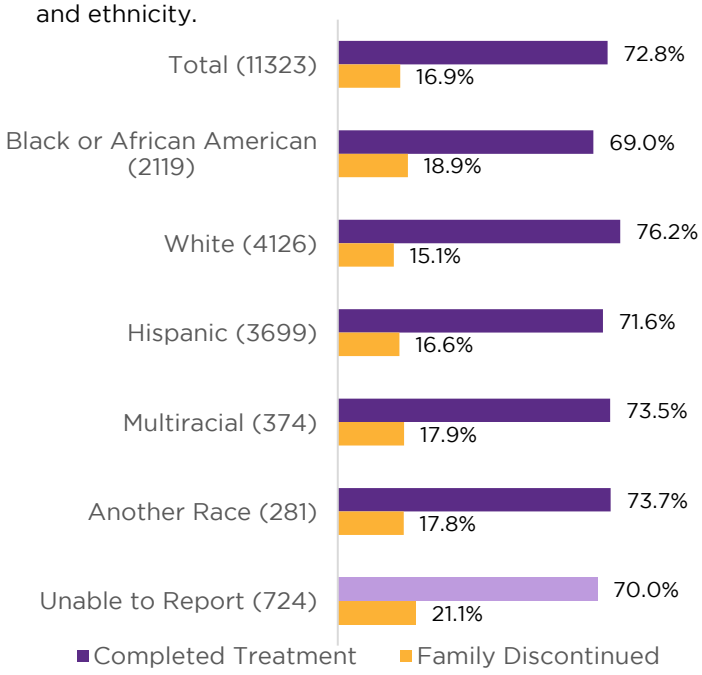
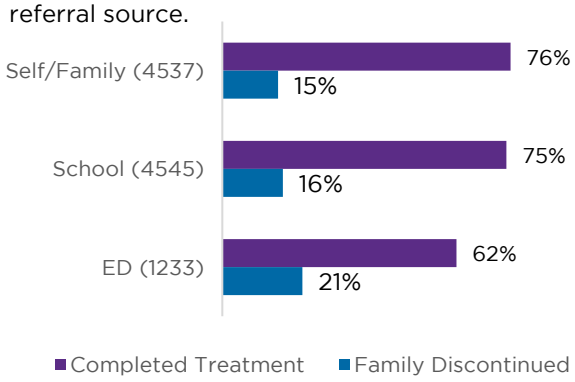


Figure 35. Families completing treatment by referral source.



What other services are youth being referred to?

Statewide, **the most common referrals made upon discharge from Mobile Crisis were back to an existing provider (42.2%) and to outpatient services (40.1%)**. Mobile Crisis referrals to the ED were rare, occurring for only 5.1% of children, ranging from 3.4% (Hartford region) to 10.4% (Southwestern region). Children can receive referrals to more than one service – 34.8% 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-eight percent of children who were referred back to an existing provider also received at least one additional referral. A small portion of children (12.0%) did not receive any referrals at discharge. Roughly half (52.6%) of these children did not complete their treatment with Mobile Crisis. Of the children who received a face-to-face assessment and completed treatment, 94.5% 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 815 episodes of care where at least one desired referral was unavailable. Cumulatively, there were 928 referrals reported as unavailable. The most common unavailable referrals were Outpatient Services (36.5%), Intensive In-Home Services (25.5%), Other: Community-Based (9.3%), and Intensive Outpatient Program (8.4%).

Table 13. Services referred to by region.

	Central	Eastern	Hartford	New Haven	Southwestern	Western	Statewide
Referred Back to Existing Provider	17.7%	39.1%	48.3%	52.6%	35.5%	58.3%	**42.2%**
Outpatient Services	48.1%	39.7%	36.6%	29.6%	41.1%	44.8%	**40.1%**
Intensive In-Home Services	15.0%	11.8%	8.8%	5.0%	5.7%	11.3%	**9.8%**
Intensive Outpatient Program	9.9%	7.6%	4.3%	3.2%	4.1%	4.1%	**5.5%**
Emergency Department	4.3%	4.9%	3.4%	6.1%	10.4%	3.5%	**5.1%**
Inpatient Hospital	3.5%	1.4%	4.5%	2.7%	2.1%	12.2%	**4.7%**
Other: Community-Based	7.2%	4.5%	4.7%	2.7%	3.6%	2.6%	**4.3%**
Psychiatric provider for medication	1.6%	3.6%	5.3%	3.8%	2.7%	0.2%	**3.0%**
Partial Hospital Program	3.9%	11.9%	1.0%	0.2%	0.1%	0.3%	**2.5%**
Care Coordination	3.2%	2.4%	2.7%	1.3%	1.5%	0.7%	**2.1%**
Extended Day Treatment	0.7%	0.0%	2.0%	0.8%	0.3%	0.4%	**0.9%**
Residential Treatment	0.5%	0.3%	0.4%	0.1%	0.3%	0.6%	**0.4%**
Other: Out-of-Home	0.3%	0.2%	0.5%	0.0%	0.3%	0.2%	**0.3%**
UCC	0.1%	0.4%	0.6%	0.0%	0.1%	0.3%	**0.3%**
SAC	0.0%	0.0%	0.3%	0.5%	0.0%	0.1%	**0.2%**
Group Home	0.0%	0.1%	0.1%	0.0%	0.1%	0.5%	**0.1%**
No Referral	7.2%	16.4%	13.7%	12.6%	16.7%	7.2%	**12.0%**

Were children linked to needed services?

The referral data above captures referrals that were made but not whether the child and family were actually linked to and engaged with these services. While there is currently no way to know to what extent families engaged in recommended services, we did recently start to ask whether the child and family were linked to any services before their discharge from Mobile Crisis. Of the 7,939 children who received one or more referrals from Mobile Crisis, 67.5% of them were linked to at least one of these referrals before discharge. This rate increases to 73.1% for children who completed treatment with Mobile Crisis.

Clinicians are also asked to report what their "first choice" referral for the child was and whether the child was linked to that service. The goal of this data is to explore whether children are able to be connected to the services that are most appropriate for their needs or if there are barriers to accessing certain services. The table below displays this data for the top three community-based referrals when a valid first choice was identified (n= 6,706). Outpatient services was the first choice for over half of cases (54.3%), which is in line with it being a top referral made at discharge. The majority of children and families were successfully linked to outpatient services (70.1%). Only 2.5% of youth were not linked to outpatient because of a waitlist – there were other reasons that they didn't get connected. Notably, intensive-in home rates were the first choice for 13.1% of cases, but had the lowest linkage rate (53.5%). 21.2% of these cases were not linked due to a waitlist, indicating that there may be a need for increased capacity for in-home services.

Table 14. First choice referrals and connection to care.

	n	% of Total First Choice Referrals	Linked	Not Linked - Waitlist	Not Linked – other reason
Outpatient Services	3640	54.3%	70.1%	2.5%	20.0%
Intensive In-Home Services	879	13.1%	53.5%	21.2%	17.0%
Intensive Outpatient Program	397	5.9%	64.5%	4.0%	24.2%

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 FY2026, 277 clients/families and 287 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 4.76 and 4.71. Among other referrers (e.g. schools, hospitals, DCF, etc.), the average ratings of 2-1-1 and Mobile Crisis were 4.89 and 4.74, respectively. The survey also askes respondents to rate there overall satisfaction with the Mobile Crisis response on a scale of 1 to 10. Clients/families gave an average rating of 9.00 and other referrers gave an average rating of 9.15. Qualitative comments varied from very satisfied to dissatisfied.

Table 15. Satisfaction with Mobile Crisis services.

2-1-1 Items*	Clients (n=277)	Referrers (n=287)
The 2-1-1 staff answered my call in a timely manner	4.69	4.94
The 2-1-1 staff was courteous	4.86	4.97
The 2-1-1 staff was knowledgeable	4.76	4.81
My phone call was quickly transferred to the MCIS provider	4.72	4.83
Sub-Total Mean: 2-1-1	**4.76**	**4.89**
Mobile Crisis Items*		
Mobile Crisis responded to the crisis in a timely manner	4.76	4.76
The Mobile Crisis staff was respectful	4.79	4.71
The Mobile Crisis staff was knowledgeable	4.78	4.78
The Mobile Crisis staff spoke to me in a way that I understood	4.78	4.84
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)	4.58	X
The services or resources my child and/or family received were right for us	4.57	X
The child/family I referred to Mobile Crisis was connected with appropriate services or resources upon discharge from Mobile Crisis	X	4.61
Sub-Total Mean: Mobile Crisis	**4.71**	**4.74**
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*	**9.00**	**9.15**

*** 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 response time was great, and I appreciated how well the team worked together.
- I believe the visit and conversation with a mobile therapist helped my child calm down and understand his mistakes and accountability.
- The only issue was that we had to follow up multiple times for a list of resources we have been promised during the visit.
- The support was excellent. She listened carefully and helped my child feel calm and supported again.
- Filling out the questionnaires and forms takes up a lot of time when teenager just needs help.
- They are always a great support! Life saving in moments of despair or personal loss.
- The clinician was knowledgeable, empathetic and cordial- in the way she spoke and relayed information. She was also very culturally sensitive to my needs and helped me make a plan that had me take my child to the ER quietly the next day.
- 45 minutes is too long for a child that is in crisis
- The team was grounded due to weather. Spoke to [a clinician] who was AMAZING! She got us a referral for additional service which no one else had been able to do. I only wish she was available as our families counselor because she was great!

Referrer Comments:

- The mobile crisis clinician was amazing, thank you for being there when we needed help.
- While the clinician was supportive, the response time was longer than ideal given the urgency of the situation
- Excellent teamwork and communication. Your staff made a challenging situation much more manageable.
- On behalf of the police department, thank you for the support and collaboration on this case.
- The support provided helped move the situation in a positive direction.
- 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.
- Based on this experience, I have confidence in referring future students to this program.

Another way that satisfaction data is collected is through the Ohio satisfaction scales. Of the 585 responding parents and guardians, 77% feel somewhat to extremely capable of dealing with their child's problems upon discharge from Mobile Crisis. Of the 549 responding parents and guardians, 91% felt that their ideas were included in their child's treatment plan either "a great deal", "moderately", or "quite a bit". Of the 532 responding parents and guardians, 89% felt somewhat to extremely satisfied with the services their child received.

Figure 36. Upon discharge, how capable of dealing with the child's problems does the parent/guardian

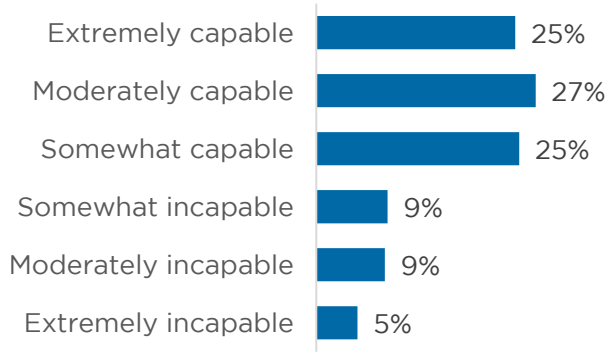


Figure 37. How does the parent/guardian rate the extent to which the child's treatment plan included their ideas about their child's treatment needs?

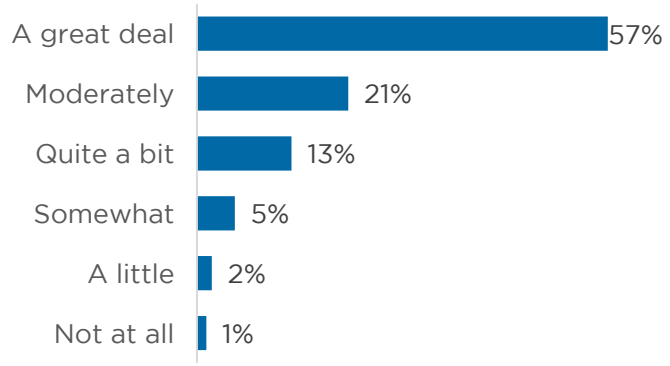
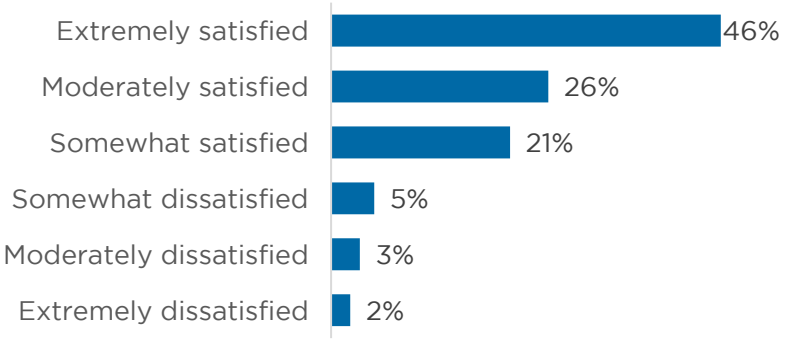


Figure 38. How satisfied is the parent/guardian with the mental health services the child has received?



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%. The training with the lowest completion rate is the *Columbia Suicide Severity Rating Scale* (40%). This is a training that is not offered directly by the PIC – instead, it is taken online and the certificate is provided to the Clearinghouse to get credit for completion. It is likely that many staff who are missing credit for this training have completed the training but are missing documentation.

Table 16. 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%

^Available in an online asynchronous format.
*These trainings were offered for the first time in FY2025.
**These trainings became available at the end of FY26 Q1.
***This was offered for the first time in FY26 Q1, and only offered once this year.

In FY2024, the PIC began to track training attendance more closely and work with providers to increase training completion rates. Beginning in FY2025, MCIS full-time staff are required to complete the six core trainings within their first year of employment.Part-time or per-diem staff will complete the 6 core trainings

by 18 months of employment. The remaining required trainings must be completed by the end of year 2 for full-time staff and by 2.5 years for part-time or per-diem staff. Each subsequent year, staff will attend a minimum of 2 trainings per year. We 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.

Of the 95 full-time staff who have been with Mobile Crisis at least a year, 45% have completed all six core trainings. Of the 77 full-time staff who have been with Mobile Crisis at least 2 years, 52% have completed all six core trainings and 38% have completed all 12 required trainings. Training completion rates across all metrics have improved since FY2025. The Eastern region has the highest training completion rates across all metrics.

Table 17. Trainings completed 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%**
Statewide FY2025	224	121	32%	103	37%	22%

Evaluation forms for trainings offered in FY2026 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 FY2027. Five of the six core trainings and two of the additional required trainings were offered between two and 4 times in FY2026, with the remaining five required trainings being available asynchronously. See Appendix A for training offering details. The shift to a greater number of asynchronous trainings has allowed more staff to be trained at a time and pace that is adaptable to the unpredictable nature of crisis work.

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

- 26 live (online or in person) training modules were held in FY2026, with a total attendance of 301.
- There were 407 attendees across all Mobile Crisis trainings in FY2026, representing 142 unique individuals that attended at least one training this fiscal year (both live and asynchronous trainings).
- There have been 490 trainings (live – online or in person) in the seventeen years of Mobile Crisis PIC implementation, and 824 Mobile Crisis staff members have completed one or more trainings during that time (both live and asynchronous trainings).

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 FY2026, aside from the DDS training we offer, we had Dr. Peter Tolisano provided a new psychopharmacology training.

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.

How did providers educate the community about Mobile Crisis?

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

In FY2025 Q3, the PIC began incentivizing community-based outreaches (not school staff 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 FY2026, providers conducted 153 formal outreaches to the community, compared to 188 in FY2026. Performance ranged from 7 outreaches (New Haven) to 40 outreaches (Eastern).

Table 18. 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**

How does Mobile Crisis support the community during a loss?

Mobile Crisis is often called upon to support school communities following the untimely death of a student or teacher. Mobile Crisis is typically notified by DCF or the Connecticut State Department of Education (CSDE) and will work alongside Regional Crisis Teams (RCTs) out of the CT Center for School Safety and Crisis Preparation and the Regional Suicide Advisory Boards (RSABs) to reach out to the school and offer support. Mobile Crisis may provide a grief response to the school, sending clinicians to be available for anyone in the school who may need support. Though this could lead to Mobile Crisis opening a case with individual students when a need is identified, the community-level response is not captured in PIE. In quarter 3 of FY2026, DCF and CHDI asked providers to start tracking these responses and submitting data on a quarterly basis in order to capture this important work that Mobile Crisis is doing in addition to their individual crisis response work. While many providers were able to share data for the full year, this was not the case for all and the following data may be incomplete.

In FY2026, Mobile Crisis providers reported receiving notification for 54 untimely deaths in their community. Of these, 19 school communities requested that Mobile Crisis come to the school for a grief response. For each of these responses, Mobile Crisis teams sent between 1 and 4 clinicians to the school for one to two days.

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

In FY2026, 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 following the end of each quarter of FY2026, occurring in November 2025, February 2026, May 2026, and August 2026. The PIC continues to develop and update routine performance improvement plans 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 FY2026 include increasing community-based outreaches and awareness of MCIS services with those who are not frequent users of Mobile Crisis; increasing attendance at PIC trainings; improving collection rates of Ohio scales at intake and discharge; and recruitment, hiring, and training of new staff.

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 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: CHDI was able to publish a public-facing, interactive data dashboard 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 dashboard includes the ability to filter by time period, region, and provider site, and to see key metrics broken down by demographic groups. The dashboard is updated on a monthly basis and currently includes data going back to FY2019. The PIC continues to work on making additions to this dashboard as well as considering additional dashboards that would add value to the body of public-facing Mobile Crisis data.

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 just completed a pilot of 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 data definitions and identifying additional data elements to collect, as well as creating and distributing improved data documentation to ensure consistent data collection and entry across providers.

CHDI staff alongside colleagues from DCF and the Innovations Institute at the UConn School of Social Work published an article providing an overview of best practices for Mobile Response and Stabilization Services (MRSS). The article also highlights practices and data from Mobile Crisis in Connecticut as an exemplary program, showing the success of quality improvement efforts that have strengthened the service over time.

> Theriault, K. M., Vanderploeg, J. J., Quinn, S.E., Randall, K. G., Bonadio, F.T., & Cortez, Y. (2026). Mobile Response and Stabilization Services. *Child and Adolescent Psychiatric Clinics of North America.* https://doi.org/10.1016/j.chc.2026.03.007

PIC staff also participated in the Training Institutes, a national conference held in July 2025 by the Innovations Institute at the University of Connecticut School of Social work. We gave three presentations related to the work of Mobile Crisis in Connecticut:

- Quality Improvement and Consultation: Applications in Evidence-Based Practices and Crisis Services

- Using Data to Implement Quality Youth Crisis Systems
- School Utilization of Mobile Crisis in Connecticut (as part of 'Using Data in Schools" data points presentation)

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. PIC staff also participated in the TCB Services Workgroup focused on pulling together data across the crisis continuum and informing conversations about how Mobile Crisis fits into the overall crisis continuum.

Additionally, CHDI continued consultation to the state of Louisiana through a contract with the Louisiana State University Center for Evidence to Practice. Louisiana has now more directly into child and adolescent MRSS services and CHDI helped to contribute to their development of the state's infrastructure for training, data collection, performance measurement, and quality improvement. Work during FY2026 included conducting provider focus groups, providing TA around workforce development and program operations, and conducting a review of tools and assessments that may be useful for Mobile Crisis programs.

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.

Untimely Death/Suicide Postvention Response: Whenever there is a death by suicide, or an untimely death, 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) 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 response protocol. In FY2026, a meeting was held between all partners to discuss whether the protocol was working after it had been in place for a year.

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 we had two keynote speakers. Yanique Grant-Buchanan, LCSW gave a presentation titled "Holding Space Without Losing Yourself: Ethical Self-Care, Countertransference, and Wellness in Mobile Crisis Practice: An Interactive Session on Balance, Boundaries, and Professional Sustainability." The second Keynote speaker, Mathew Dicks, gave a presentation titled "Stories that Heal: The Power of Storytelling in Crisis Work." The main 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 FY2027

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.

Explore and Strengthen Extended Support Phase

3. CHDI will utilize standardized and enhanced data elements to analyze trends in episodes involving extended support from Mobile Crisis.
4. CHDI will work with providers and DCF to determine what is occurring during this extended support phase and what practices are most successful.
5. CHDI will work with providers and DCF to provide training and/or make recommendations around effective practices.

Enhance Analysis of Outcome Data

6. Utilize clarified definitions and new data elements to conduct more comprehensive analysis of Mobile Crisis outcomes.
7. Explore the use of outcome measures instead of or in addition to the Ohio Scales to provide data on improvement for all children served by Mobile Crisis. Currently, the Ohio Scales are only expected to be collected at discharge for children who engage in the extended support phase (22.5% of episodes in FY2026). Of this group, while most have completed worker Ohio Scales at discharge (84.3%), much fewer have completed parent Ohio Scales (20.6%) This leaves the majority of children served by Mobile Crisis without an outcome measure.

Workforce

8. CHDI will continue to work with MCIS trainers to enhance and improve training content through an equitable lens.
9. CHDI will continue to monitor training completion by MCIS staff in accordance with the updated training standards and determine whether asynchronous options increase training rates.
10. CHDI will use training attendance and completion data to assess whether training expectations align with training offerings.
11. CHDI will conduct a survey and work with providers and DCF to identify additional training needs, including the development of a training for community grief responses.

System Development

12. CHDI will leverage its role as the Performance Improvement Center for Mobile Crisis, 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.
13. CHDI will work with providers, DCF, and other stakeholders to promote strong relationships with UCCs and EDs, particularly EDs who are not common referrers to Mobile Crisis.
14. CHDI will continue to advocate for Mobile Crisis as a key element of the crisis continuum.

Appendix A: Changes to Data Collection and Definitions

Table A1. Previous crisis response types and definitions.

Crisis Response: Phone Only	Indicates cases in which contact with the client and family was limited to the initial MCIS call without further face-to-face contact
Crisis Response: Face-to-Face	Indicates cases in which there is face-to-face contact with the client and family, but the interval between Episode Start Date and Episode End Date is not longer than five days
Crisis Response Plus Stabilization Follow-Up	Indicates cases in which there is face-to-face contact with the client and family, and the interval between Episode Start Date and Episode End Date is longer than five days. It is expected that total length of service in these cases will not be longer than 45 days.
Telehealth	*No definition in the data system*
Face-to-face: Consultation Only	*No definition in the data system*

Table A2. Updated crisis response types and definitions.

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: Evaluation Only *(This is a new response type, describing cases that would previously have been included in the "Crisis Response: Face-to-Face" category.)*	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 *(This is a revision of previous "Crisis Response: Face-to-Face" cases. When combining data from before and after the revisions, these cases will be combined in a single category.)*	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 efforts should be made to transition the episode to an "Extended Support" episode. Note that 14 days is a guideline, but the length of time an episode is open does not determine the episode type. If there is no additional face-to-face contact with the child, the episode remains a Connect to Care episode regardless of time open. It is possible that a single in-person follow-up may occur early in the episode that is primarily focused on completing paperwork rather than meaningful clinical work – if this was the only in-person follow-up, the episode would still be classified as "Connect to Care".
Face to Face: Extended Support *(This is a revision of previous "plus stabilization follow-up" cases. This response type was briefly named "Treatment and Connection to Care" in Quarter 2 and 3 reports for FY26 before ultimately selecting the name "Extende Support". When*	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 weekly in person.

combining data from before and after the revisions, these cases will be combined in a single category.)	
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 parents decline 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.

Table A3. Additional data definitions.

<table>
<tr><td>Reason for Discharge: Completed Treatment</td><td>Similar to the crisis assessment and safety plan, the discharge plan should be family-driven and youth-guided, use natural and informal supports, and be culturally/linguistically competent. Clinicians will refer the child and their family to an appropriate level of care. Mobile Crisis will provide crisis stabilization services for up to 45 days or until referral and linkage to an appropriate level of care is achieved.

Selecting "completed treatment" should be based on the crisis response type (eval only, connect to care, extended support) and should reflect whether or not the family completed the recommended activities associated with that phase of care.</td></tr>
<tr><td>Met Treatment Goals</td><td>For programs that do not utilize comprehensive treatment plans and goals, “yes” should be selected for ‘met treatment goals’ when the clients have received the intended benefits of the program. For MCIS, the key elements of each episode type are laid out in the table below. More activities can and likely will occur during any of these episode types – these elements are the ones considered essential to meeting the treatment goals

A case can still meet treatment goals if you determine that they need to go to the ED for further evaluation. While a goal of Mobile Crisis is to divert from the ED and higher levels of care whenever possible, if at any point during the assessment the clinician has determined that the ED is in the best interest of the child, treatment goals have still been met.

<table>
<tr><th></th><th>Eval Only</th><th>Connect to Care</th><th>Extended Support</th></tr>
<tr><td>Initial Assessment</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Safety Planning</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Linkage to services and supports**</td><td></td><td>X</td><td>X</td></tr>
<tr><td>Re-assessment/ updating safety plans</td><td></td><td></td><td>X</td></tr>
<tr><td>Additional face-to-face contact (child)</td><td></td><td></td><td>X</td></tr>
</table>
**Not every child/family will need a referral to formal services. Linkage here includes connecting back with an existing provider, connecting to new services, and connecting to natural/informal supports. Episodes may close before the child has started services, but treatment goals are still met as long as the formal referral was made and discussed with the family. Families may also decline services – treatment goals can still be met in this case as long as the clinician had a conversation with families around specific services and supports that may be helpful.

For episodes with a response of "Phone Only" - if the request came in as a non-mobile, select 'yes' for Met Treatment Goals. If the request came in as 'mobile' or 'deferred mobile'</td></tr>
</table>

	but was handled over the phone, select 'no'. Because there is no assessment/treatment occurring with the child, these responses will be excluded from most analyses For episodes with a response of "FTF: Consultation Only" - as long as in-person consultation was provided to the caller as indicated by this response type, select 'yes' for Met Treatment goals. Because there is no assessment/treatment occurring with the child, these responses will be excluded from most analyses

Table A4. New data elements.

At the end of the initial assessment, where did the child go?	• Remained in home/the community • Urgent Crisis Center • Emergency department (MCIS recommendation) • Emergency department (Family/referrer decision) • Arrested/detained • Child welfare placement • Other
Was a full assessment* of the child completed? (for Eval Only episodes)	
Why did engagement end at the Evaluation Only phase?	• Services of supports are already in place • Family declined further engagement with MCIS • Other
Why did engagement end at the Connect to Care phase?	• Child successfully connected to care • Child not linked to care and family discontinued services and/or declined engagement in MCIS Extended Support phase
How did engagement end at the Extended Support phase?	• Child successfully linked to care • Child not linked to care and family declined further engagement with MCIS
What activities took place during the Extended Support phase (select all that apply)	• Face-to-face contact with child (required for this episode type) • Face-to-face contact with caregiver • Phone call with child • Phone call with caregiver • Phone call with provider • Psychiatric consultation • Attending/coordinating meetings with families, schools, other providers • Supporting families in accessing resources, making phone calls, documentation, etc. • Family education • Reviewing/updating crisis/safety plans • Other (please specify)

Appendix B: FY2026 PIC Training Offerings

Table B1. FY2026 PIC training offerings.

Training	Requirement	Total Live Offerings	Available Asynchronously
Crisis Assessment, Planning and Intervention	Core	4	
Emergency Certificate	Core	3	
Assessing Violence Risk in Children and Adolescents	Core	4	
Traumatic Stress and Trauma-Informed Care	Core	2	
21st Century Culturally Responsive Mental Health Care	Core	3	
Columbia Suicide Severity Rating Scale	Core		X
A-SBIRT (Adolescent Screening, Brief Intervention, and Referral to Treatment)	Required		X
Autism, Families, and Severe Behavior	Required		X
Overview of Developmental Disabilities	Required		X
Disaster Behavioral Health Response Network	Required	3	
Problem Sexual Behavior	Required	2	
School Refusal	Required		X
Autism Spectrum Disorders: An Overview of Characteristics, Misconceptions, and Community Resources (advanced course)	Recommended	2	
Clinical and Behavioral Effectiveness with Developmental Disabilities: Demystifying Conceptualization & Advancing Positive Behavior Support (advanced course)	Recommended	2	
Question, Persuade, and Refer (QPR)	Recommended		
Effective Family Engagement	Recommended		X
Race and Mental Health (2 Parts)	Recommended		X
Psychopharmacology	Recommended	1	