

Oregon Mobile Crisis Intervention Services

2024 ANNUAL REPORT

Prepared by the Data, Evaluation and Technical Assistance (DAETA) Team at Oregon
Health & Science University



Report to the Oregon Health Authority for Contract 164956

May 2025

Suggested Citation: Data, Evaluation and Technical Assistance (DAETA) Team. *Oregon Mobile Crisis Intervention Services 2024 Annual Report*. Oregon Health & Science University. May 15, 2025.

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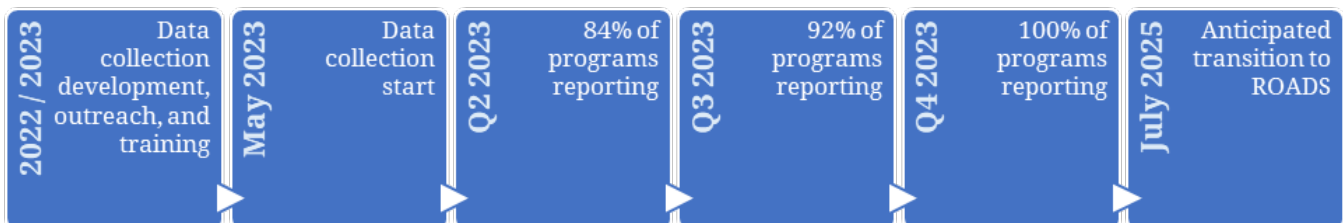
Introduction

In 2022, the Oregon Health Authority (OHA) contracted with the Data, Evaluation, and Technical Assistance (DAETA) team at Oregon Health & Science University (OHSU) to develop and implement a comprehensive data collection system for the Mobile Crisis Intervention Services (MCIS) program in Oregon.

Together with OHA, and in consultation with national experts, the Oregon Association of Community Mental Health Programs (AOCMHP), and individual MCIS programs, the DAETA team developed a list of data points that track MCIS key performance indicators. Programs submit quarterly encounter-level data to the DAETA team, which is then used by the team to generate aggregate reports. Statewide and program-level reports are distributed to programs and OHA on a quarterly and annual basis. Programs began collecting data in May 2023 and the first quarterly reports were prepared in Q2 2023 (Figure 1).

This project was anticipated to last one year while OHA's Measures and Outcomes Tracking System (MOTS) was decommissioned and the Resilience Outcomes Analysis and Data Submission (ROADS) system was launched. The ROADS launch was delayed and is now expected to occur in July 2025.

Figure 1: Timeline of MCIS Data Collection



The data collection rollout faced numerous challenges in the beginning stages of implementation. However, ongoing communication and collaboration among the DAETA team, OHA and CMHPs have enabled significant improvement in 2024 and as a result, more robust data collection and analysis is highlighted throughout this report.

Challenges experienced by CMHPs have included miscommunication regarding data requirements, inconsistent use of the data dictionary (and subsequent data validation issues), and difficulties obtaining important data in crisis situations. Programs have voiced concerns regarding the administrative burden that data collection has created for their team, and in

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particular small teams without data personnel have at times struggled to submit complete data in the appropriate format. While these challenges have led to some data quality issues, these are not unexpected for the beginning stages of a statewide data collection process. The DAETA team has provided individual technical assistance to programs to address data quality issues, and significant improvements were noted in 2024.

Over the past year, ensuring high-quality data collection has been a priority area for the DAETA team, as well as our partners at OHA and in the community. We look forward to further collaboration to use data to inform clinical and systems improvements, as we work together to build a stronger behavioral health crisis system for all Oregonians.

The challenges outlined above should be considered when interpreting trends in this report.

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Statewide Data Summary

MCIS is a statewide program providing in-person intervention for individuals experiencing a behavioral health crisis. The services are implemented by the community mental health programs (CMHPs) across the state. Many counties have subcontracted with outside agencies to provide MCIS services. There are 38 total programs collectively serving the state. The following section summarizes the statewide MCIS dispatch data submitted to the OHSU DAETA Team in 2024.

In this report, we focus on understanding the dispatch details and demographics of individuals served across the state. We also look more closely at the possible associations between selected MCIS variables using various statistical tests.

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How many Oregonians were served?

In 2024 there were **25,720 MICS dispatches across the state, with 16,414 unique individuals served**. There were more dispatches in Q2 2024 compared to Q2 2023 (Figure 2). There were fewer dispatches in Q3 and Q4 2024 compared to 2023. The total dispatches per quarter remained consistent across 2024 with slight declines toward the end of the year (Figure 3).

Figure 2. Total Dispatches by Quarter

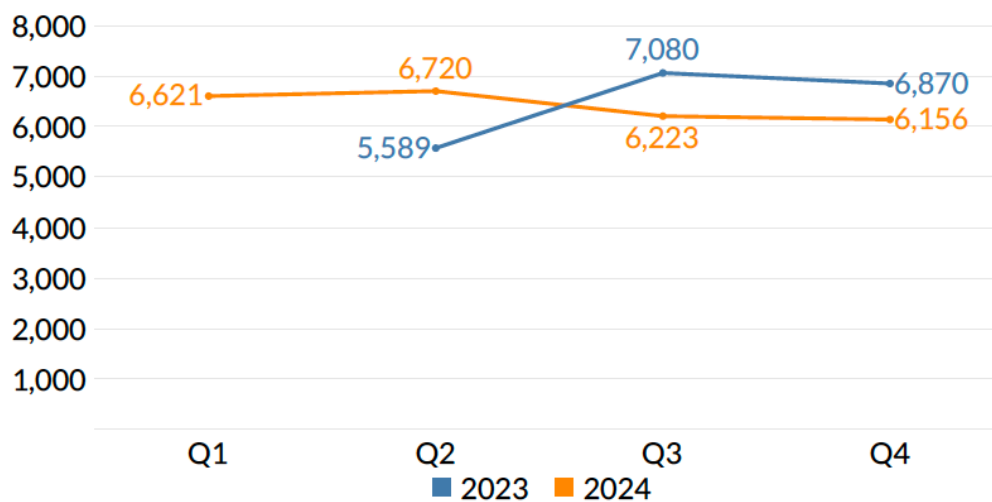
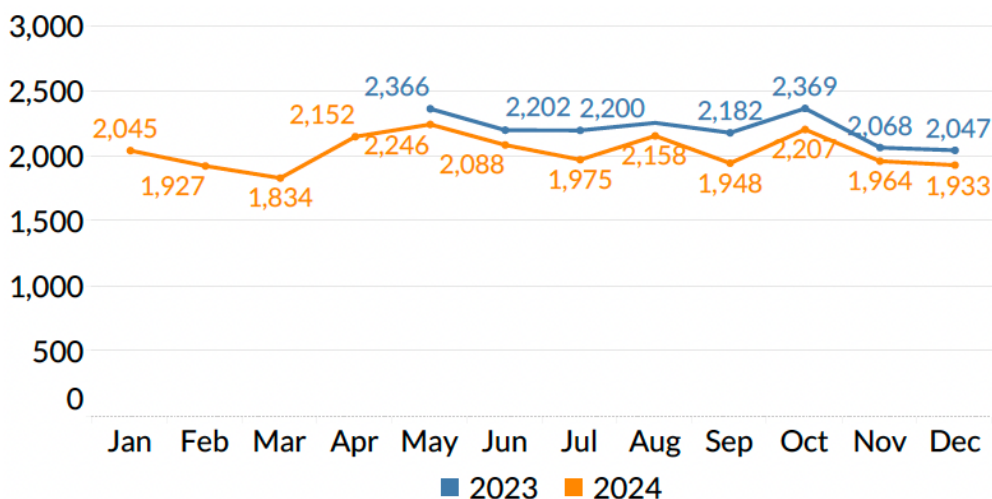


Figure 3. Total Dispatches by Month



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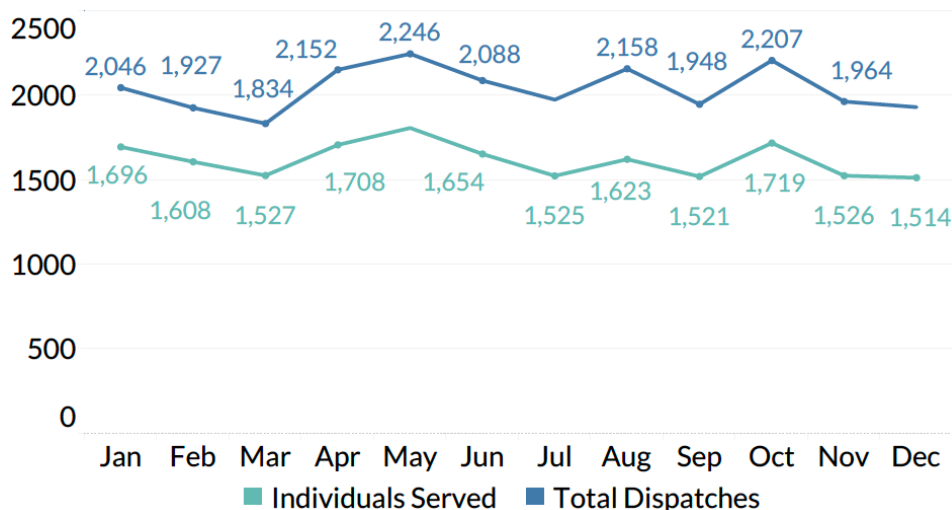
While most dispatches in 2024 were to unique individuals, **36% were repeat dispatches to an individual who had previously received a MCIS dispatch**. This is an increase of 3% from 2023 (Table 1). Across 2024, the number of individuals served remained consistent with the total dispatches in any given month (Figure 4).

Table 1. Total Dispatches and Individuals Served by Year and Quarter

| | | Total Dispatches | Individuals Served | % Repeat |
|--------------------|--------------|------------------|--------------------|------------|
| 2023 | Q2 | 5,589 | 4,007 | 28% |
| | Q3 | 7,080 | 5,037 | 29% |
| | Q4 | 6,870 | 5,083 | 26% |
| | Total | 19,539 | 13,038 | 33% |
| 2024 | Q1 | 6,621 | 4,931 | 26% |
| | Q2 | 6,720 | 4,860 | 28% |
| | Q3 | 6,223 | 4,303 | 31% |
| | Q4 | 6,156 | 4,353 | 29% |
| | Total | 25,720 | 16,414 | 36% |
| Grand Total | | 45,259 | 27,723 | 39% |

**The percentage of repeat dispatches is calculated individually within each quarter, across quarters for each year, and across all quarters and years for the grand total.*

Figure 4. 2024 Total Dispatches and Individuals Served



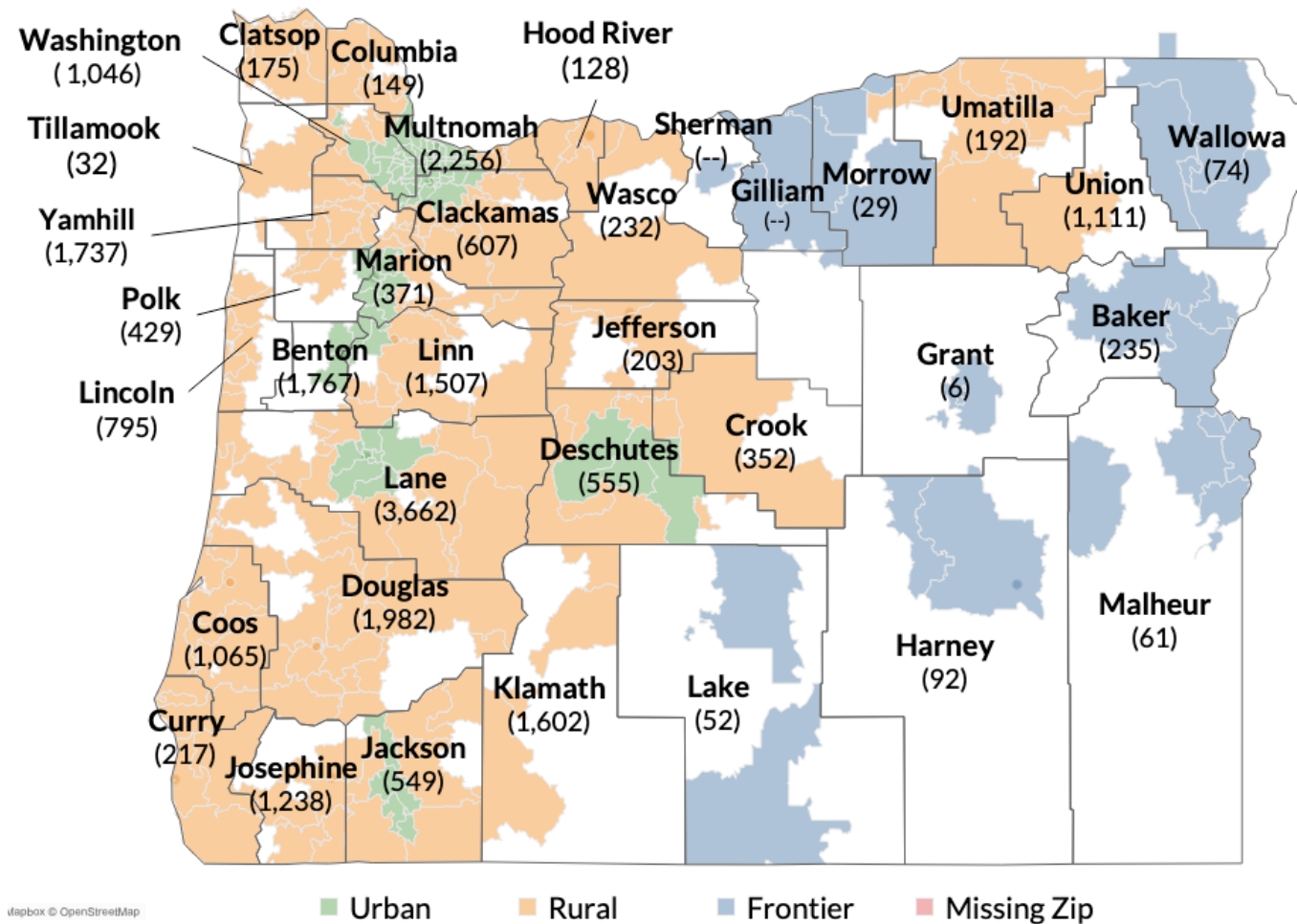
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Where did dispatches occur?

In 2024, the greatest number of dispatches occurred in Lane County, Multnomah County, and Douglas County (Figure 5). Urban dispatches accounted for 41% of total statewide dispatches. Dispatches to rural areas made up 52% of total dispatches and frontier areas made up 2% of dispatches. An additional 5% of dispatches had missing zip code information.

Figure 5. 2024 Statewide Distribution of MCIS Dispatches



Note: map data reflects the distribution of dispatches across the state by zip codes associated with each county. The information provided does not reflect who is responding to the dispatch.

(--) data suppressed for confidentiality, $n < 5$

small numbers ($5 \leq n < 12$) may be statistically unreliable; interpret with caution

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The statewide dispatch utilization rate was 57.9 dispatches per 10,000 people. By county, the utilization rate varied greatly (Figures 6 and 7). Union, Klamath, Benton, and Douglas County had the most dispatches per 10,000 people. Union County was an outlier with 424 dispatches per 10,000 people. Grant, Wheeler, Marion, Sherman, and Tillamook had the fewest dispatches per 10,000 people.

Figure 6. 2024 Dispatches per 10,000 People

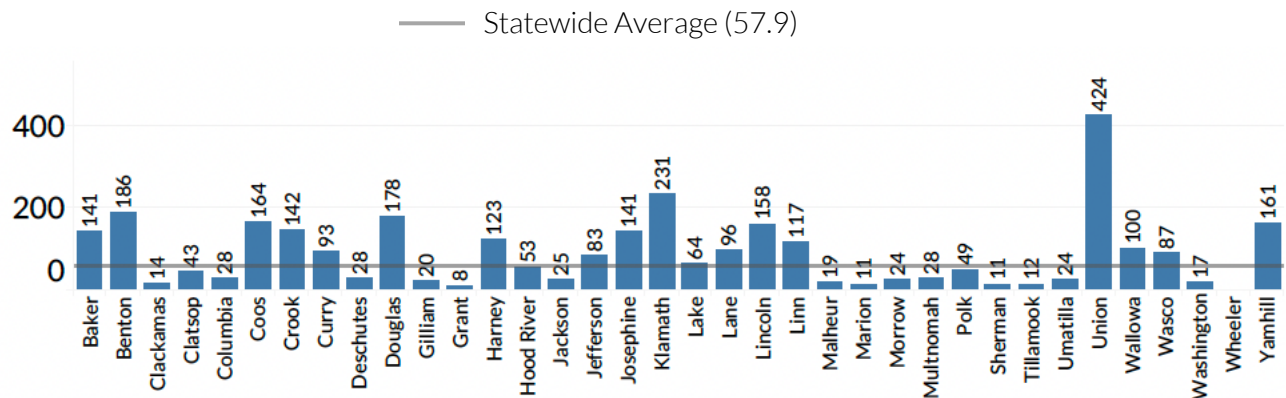
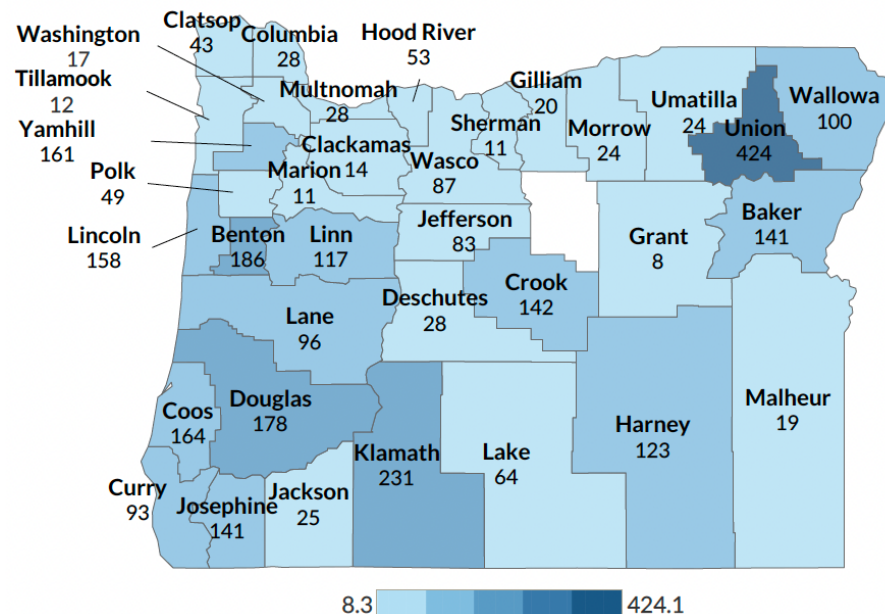


Figure 7. 2024 Dispatches per 10,000 People by Oregon County



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When did dispatches occur?

Most dispatches occurred between 8 am and 8 pm (82%) with the busiest times between 1 pm and 4 pm (30%). Each weekday consistently made up 15-16% of dispatches with slightly higher dispatch volumes from Wednesday through Friday. Fewer dispatches occurred on the weekends.

Figure 8. 2024 Dispatches by Hour and Day of the Week

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | |
|-------|--------|--------|---------|-----------|----------|--------|----------|--------|
| 12 AM | 125 | 94 | 75 | 86 | 90 | 100 | 93 | 663 |
| 1 AM | 36 | 40 | 34 | 46 | 48 | 53 | 62 | 319 |
| 2 AM | 30 | 20 | 32 | 16 | 29 | 50 | 39 | 216 |
| 3 AM | 34 | 29 | 35 | 19 | 23 | 37 | 40 | 217 |
| 4 AM | 20 | 20 | 14 | 21 | 22 | 26 | 23 | 146 |
| 5 AM | 32 | 20 | 32 | 35 | 33 | 38 | 37 | 227 |
| 6 AM | 33 | 29 | 25 | 29 | 33 | 34 | 38 | 221 |
| 7 AM | 57 | 59 | 88 | 50 | 61 | 57 | 64 | 436 |
| 8 AM | 173 | 179 | 207 | 207 | 199 | 196 | 177 | 1,338 |
| 9 AM | 132 | 293 | 257 | 235 | 227 | 264 | 160 | 1,568 |
| 10 AM | 163 | 285 | 284 | 277 | 304 | 281 | 204 | 1,798 |
| 11 AM | 141 | 267 | 249 | 300 | 307 | 244 | 161 | 1,669 |
| 12 PM | 155 | 241 | 259 | 248 | 241 | 232 | 188 | 1,564 |
| 1 PM | 162 | 276 | 289 | 308 | 280 | 309 | 165 | 1,789 |
| 2 PM | 164 | 312 | 344 | 321 | 321 | 342 | 213 | 2,017 |
| 3 PM | 181 | 316 | 297 | 333 | 352 | 291 | 182 | 1,952 |
| 4 PM | 150 | 241 | 261 | 307 | 284 | 235 | 149 | 1,627 |
| 5 PM | 147 | 279 | 232 | 279 | 228 | 247 | 160 | 1,572 |
| 6 PM | 139 | 183 | 196 | 185 | 202 | 173 | 155 | 1,233 |
| 7 PM | 128 | 167 | 152 | 152 | 168 | 163 | 160 | 1,090 |
| 8 PM | 120 | 157 | 128 | 155 | 149 | 167 | 129 | 1,005 |
| 9 PM | 101 | 133 | 118 | 137 | 121 | 148 | 102 | 860 |
| 10 PM | 100 | 73 | 100 | 113 | 106 | 89 | 95 | 676 |
| 11 PM | 48 | 75 | 58 | 79 | 75 | 55 | 53 | 443 |
| | 2,571 | 3,788 | 3,766 | 3,938 | 3,903 | 3,831 | 2,849 | 24,646 |

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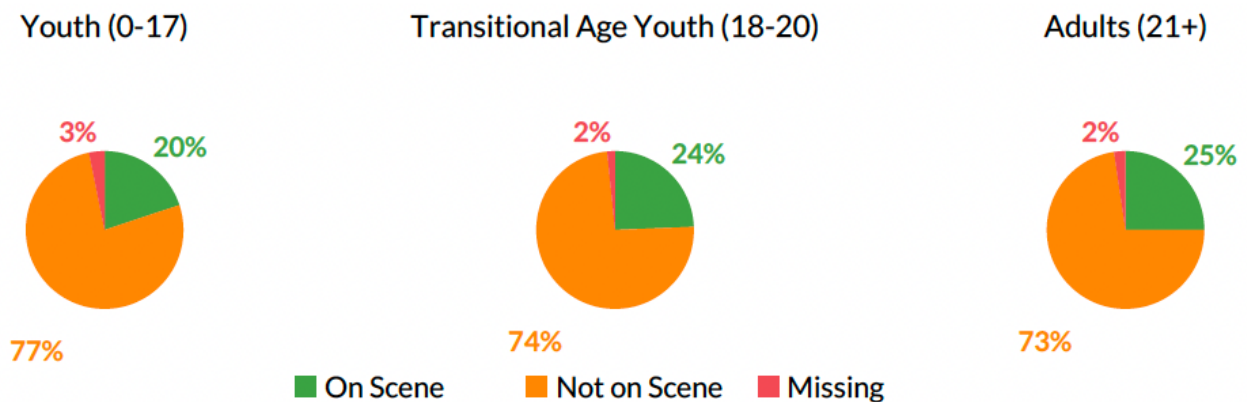
Who responded and how quickly?

For a majority of encounters, two MCIS staff were dispatched and one of them was usually a QMHP per the Oregon Administrative Rules (OARs). Emergency medical services were on scene for 6% of dispatches and law enforcement was on scene approximately a quarter of the time. The overnight and early morning dispatches were more likely to have QMHPs and/or QMHAs responding, whereas peers were more likely to be on the response team during the day.

| | |
|-----|--|
| 62% | of encounters had two MCIS responders dispatched |
| 73% | had at least one MCIS QMHP dispatched |
| 6% | had emergency medical services on scene |
| 22% | had law enforcement on scene |

Law enforcement was on scene for transitional age youth (18-20) and adults (21+) more often than youth (0-17) (Figure 9). Law enforcement was commonly on scene when there was harm or risk of harm to individuals or property, especially for transitional age youth (Table 2). For transitional age youth (18-20), agitation or disruptive behavior was also related to higher rates of law enforcement involvement.

Figure 9. Law Enforcement on Scene by Age Group



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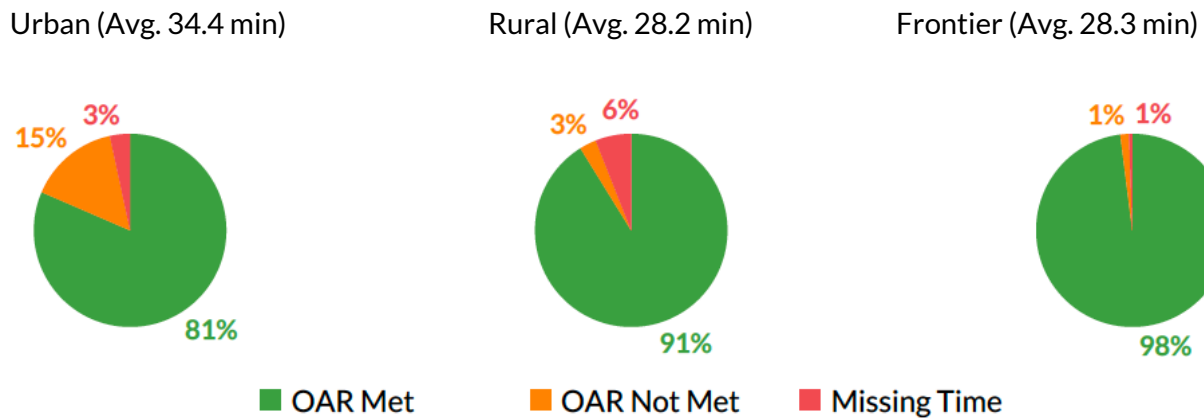
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Table 2. Top Reasons for Dispatch When Law Enforcement is on Scene

| Reason for Dispatch | Percent of Dispatches with Law Enforcement on Scene | | |
|-------------------------------------|---|--------------------------------|--------------|
| | Youth (0-17) | Transitional Age Youth (18-20) | Adults (21+) |
| Agitation or Disruptive Behavior | 27% | 46% | 37% |
| Concerns About Treatment Engagement | 34% | 16% | 22% |
| Disorganized Behavior | 23% | 31% | 34% |
| Harm/Risk of Harm to Others | 32% | 61% | 49% |
| Harm/Risk of Harm to Property | 30% | 65% | 51% |
| Paranoia | 23% | 31% | 32% |

Statewide dispatches met the required OAR response times 88% of the time; requirements and adherence to the OARs varied by rurality (Figure 10). The average response time statewide was 30.2 minutes, though there was great variability across all dispatches.

Figure 10. Response Time by Rurality



Note: OARs require that teams respond to dispatches in urban areas within 60 minutes, rural areas within 120 minutes, and frontier areas within 180 minutes.

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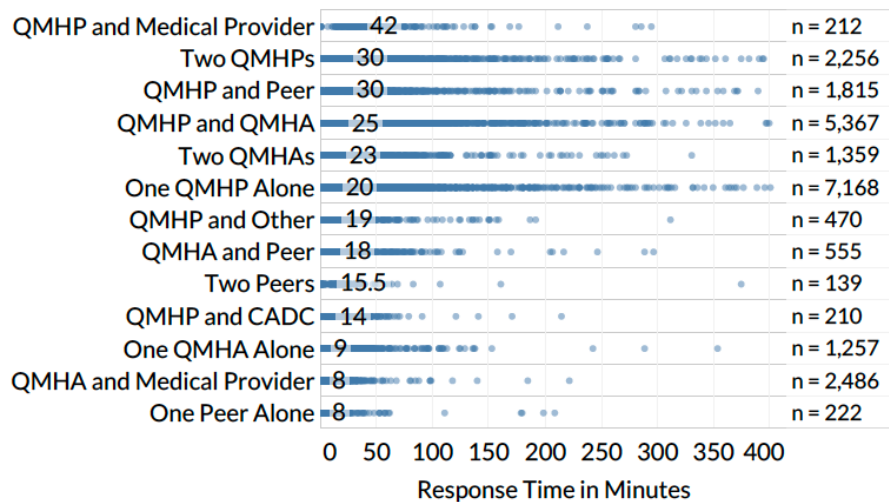
In urban areas, the dispatch time requirements were more commonly met for institutional responses than responses to the community/public setting (Table 3). In rural areas, the opposite trend was observed with dispatch time requirements more commonly met for community responses compared to institutional responses. Notably, frontier areas had the greatest proportion of dispatches with the response time met across dispatch locations.

Table 3. OAR Response Time Requirement Met by Dispatch Location

| | Community Response (Residence/School/Public Setting) | | | Institutional Response (Jail/Hospital/Clinic) | | | Other Setting | | |
|--------------|--|----------------|-----------------|--|----------------|-----------------|---------------|----------------|-----------------|
| | OAR Met | OAR Not Met | Missing Time | OAR Met | OAR Not Met | Missing Time | OAR Met | OAR Not Met | Missing Time |
| Urban | 80% | 17% | 3% | 88% | 11% | 1% | 89% | 9% | 2% |
| Rural | 95% | 2% | 3% | 92% | 4% | 3% | 97% | 1% | 1% |
| Frontier | 97% | 2% | 1% | 99% | 1% | | 100% | | |
| Total | 87% | 10% | 3% | 91% | 6% | 2% | 95% | 4% | 1% |

Response time differed among the various responder teams (Figure 11). Responder teams composed of a QMHA and a Medical Provider had the fastest average response time. Peers had the fastest average response time for solo teams. Note that these averages do not reflect the large range of response times across every responder team composition, as indicated by the points in the figure.

Figure 11. Median Response Time by Responder Pair



Each • represents the response time of an individual dispatch
 Chart includes most common responder pairs with >100 dispatches in 2024

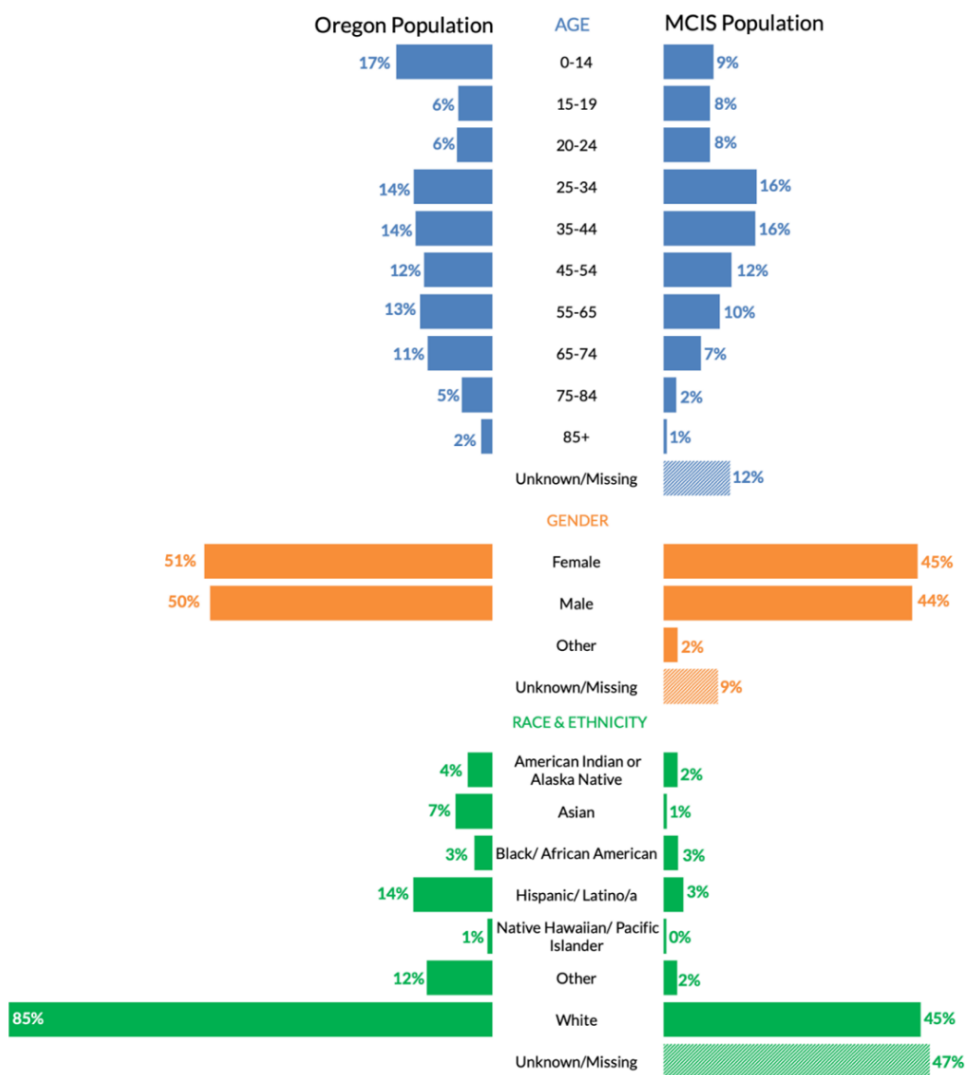
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Who was served?

The majority of dispatches served individuals between the ages of 15 and 44, an overrepresentation compared to the Oregon population (Figure 12). MCIS served a similar number of females and males with proportions relatively consistent with the Oregon population. **The most common race/ethnicity of individuals served was White.** Equity of services across race/ethnicity is difficult to determine due to the large amount of unknown and missing data.

Figure 12. Demographic Comparison of the Oregon Population and Individuals Served by MCIS



Note: Oregon Population data is from the U.S Census Bureau, 2020 census profile of general population and housing characteristics. Please interpret comparisons to 2024 MCIS data with caution.

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Across all demographics, data collection has improved from 2023 with less missing and unknown data; however, programs continue to report that this information is difficult to collect in a crisis situation. Large amounts of missing data limit the ability to characterize the population served and assess equity:

| | | |
|--|---|---|
| Sexual Orientation <ul style="list-style-type: none"> • 14% straight • 2% LGBTQIA+ • <1% other • 84% missing or unknown | Primary Insurance <ul style="list-style-type: none"> • 40% Medicaid • 8% Medicare • 7% commercial insurance • 34% missing or unknown | Known/Suspected IDD <ul style="list-style-type: none"> • 6% of individuals had a known or suspected I/DD • 45% data missing or 'unable to determine' |
| DHS Involvement (age 0-17) <ul style="list-style-type: none"> • 5% of children were in DHS custody at time of dispatch • 28% missing or unknown | Military Status <ul style="list-style-type: none"> • 3% current or former military/ national guard • 43% missing or unknown | Living Situation <ul style="list-style-type: none"> • 52% private residence • 15% transient/homeless • 7% other • 26% missing or unknown |

Who requested dispatches and to where?

Dispatches were most requested by the county crisis line (29%) (Table 4). This category includes calls coming from community members (6%), friends or family members (13%), and the clients themselves (10%). Emergency departments and hospitals called to request dispatches 22% of the time and law enforcement requested dispatches 19% of the time. This varied by region (Table 3) with urban areas having friend/family as the top caller. In rural areas, law enforcement was the top caller. Finally, ED/hospital was the top caller in frontier regions.

Table 4. Caller Requesting Dispatch by Rurality

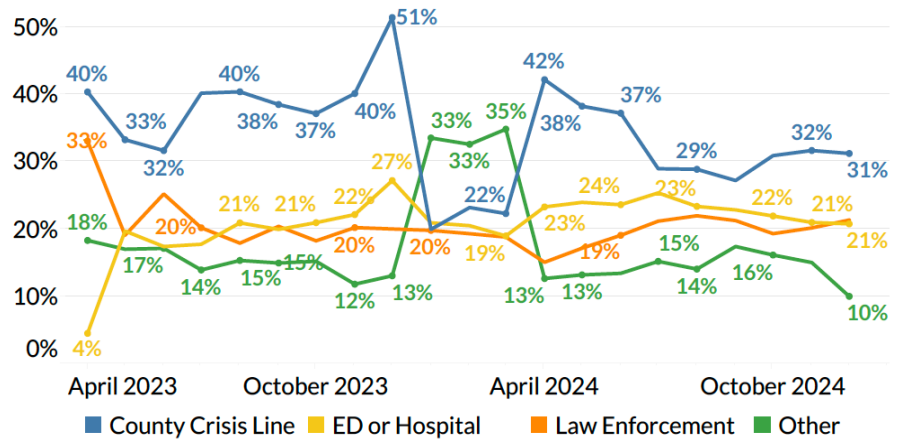
| Caller | Urban | Rural | Frontier | Missing Zip | Grand Total |
|-------------------|-------|-------|----------|-------------|-------------|
| 911 Dispatcher | 3% | 3% | 5% | 1% | 3% |
| 988 Dispatcher | 1% | 1% | 1% | 1% | 1% |
| Community Member | 12% | 2% | 5% | 2% | 6% |
| ED or Hospital | 18% | 27% | 26% | 2% | 22% |
| EMS Personnel | 0% | 2% | 0% | 0% | 1% |
| Friend/Family | 23% | 6% | 12% | 7% | 13% |
| Identified Client | 14% | 8% | 11% | 3% | 10% |
| Law Enforcement | 8% | 29% | 17% | 3% | 19% |
| Other | 21% | 12% | 22% | 67% | 18% |
| Missing | 0% | 10% | | 14% | 6% |

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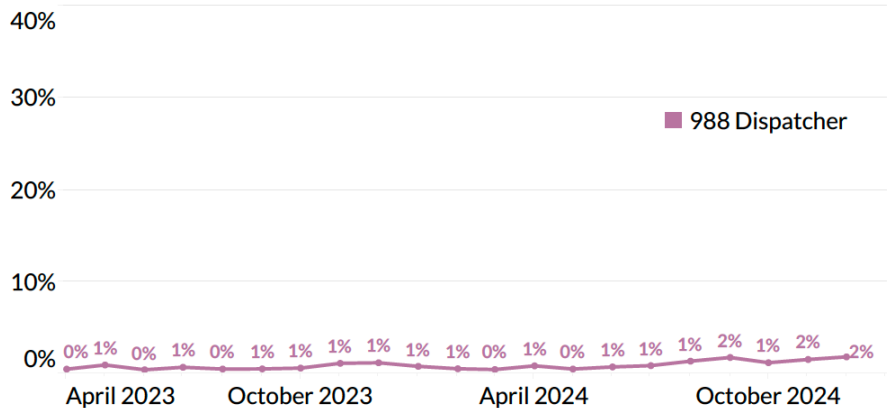
Among the top four caller types requesting dispatch, there have been some notable changes (Figure 13). Law enforcement and ED/ hospital have remained relatively consistent between 20-30%. At the same time there was a notable decrease in county crisis line calls in early 2024, there was a large increase in calls reported to be within the category of “other”.

Figure 13. Caller Requesting Dispatch Over Time



Calls coming from a 988 dispatcher make up a very small proportion of the total dispatches each month. However, a slight increase of about 1% has occurred since MCIS data tracking began in April 2023 (Figure 14).

Figure 14. 988 Caller Requesting Dispatch Over Time



Data from 988 Call Centers

988 call centers reported 74,089 total contacts through chat, phone and text in 2024. Data from CMHPs estimate that a very small percentage (< 1%) of these calls resulted in a documented MCIS dispatch. It is unknown how many individuals requested an MCIS dispatch through 988 and did not receive one.

988 data and MCIS data are tracked in separate databases and it is difficult to track individuals as they move through the crisis system. Both systems have large amounts of missing data. For example, 988 caller location and age are missing from over half of records, which limits the ability to assess need and utilization across the state.

Better coordination and validation between data efforts is needed to fully understand how the crisis system is functioning (please see *Recommendations* section).

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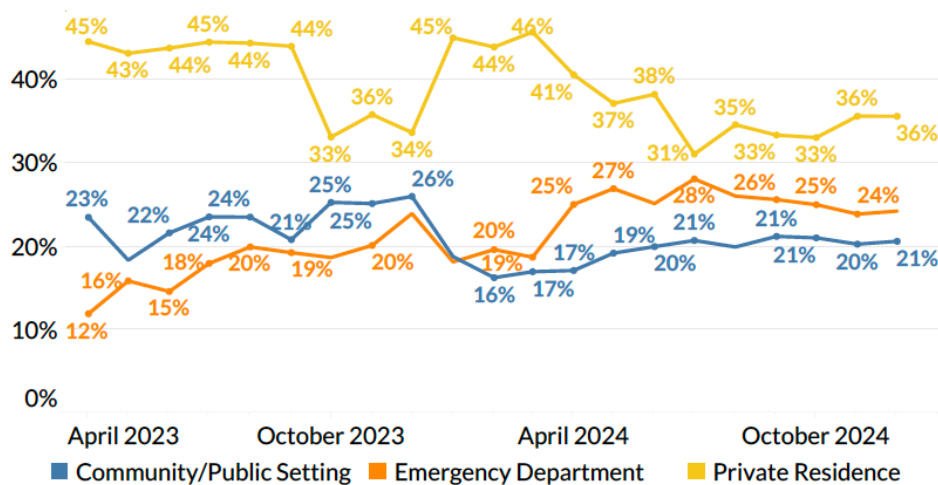
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In 2024, most dispatches were to private residences, emergency departments or community or public settings. Dispatches to emergency departments slightly increased from 2023 (19% to 24%). The distribution of dispatch locations varied by Oregon region (Table 5). Private residences were by far the most common dispatch location in urban areas. In rural areas, emergency departments were the most common dispatch location. Frontier areas included both emergency departments and private residences as common dispatch locations.

Table 5. Dispatch Location by Rurality

| Dispatch Location | Urban | Rural | Frontier | Missing Zip | Grand Total |
|--------------------------|-------|-------|----------|-------------|-------------|
| Community/Public Setting | 18% | 20% | 15% | 11% | 19% |
| Emergency Department | 15% | 33% | 26% | 1% | 24% |
| Jail | 3% | 7% | 3% | 0% | 5% |
| Medical Hospital | 1% | 2% | 6% | 2% | 2% |
| Outpatient Clinic | 1% | 1% | 8% | | 1% |
| Private Residence | 56% | 20% | 26% | 68% | 37% |
| Reservation | | 0% | | | 0% |
| School | 1% | 2% | 10% | 0% | 2% |
| Other | 6% | 10% | 5% | 4% | 8% |
| Missing | 0% | 4% | 1% | 15% | 3% |

Figure 15. Dispatch Location Over Time



Of the top three most common dispatch locations, the proportion of dispatches to private residences and community settings have slightly declined, while dispatches to emergency departments have slightly increased (Figure 15).

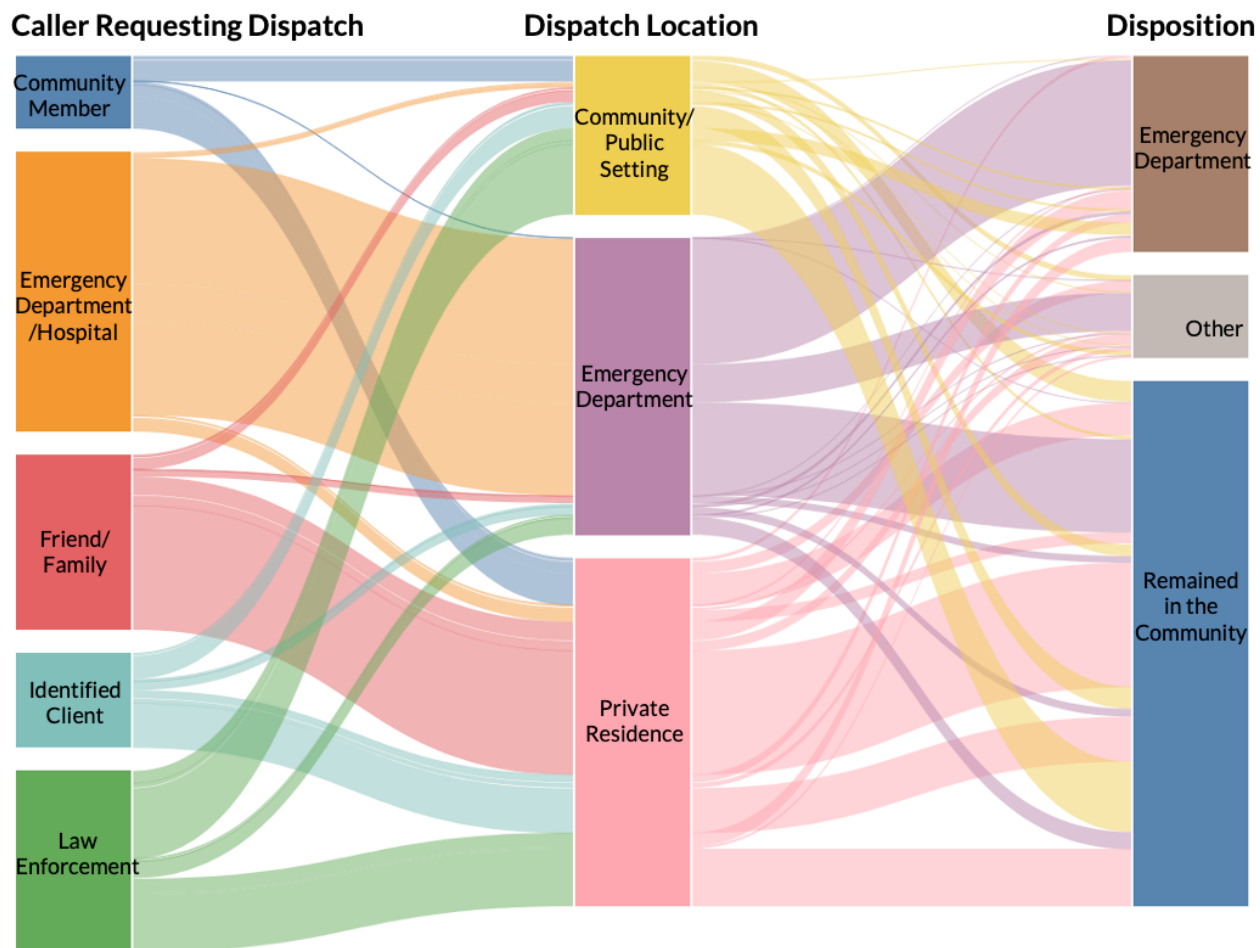
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The Sankey diagram below (Figure 16) shows how the caller requesting dispatch, dispatch location, and disposition are related. This diagram provides a visual representation of the flow and volume of MCIS encounters. The following can be observed:

- Most dispatches to an ED are requested by the ED/hospital. Around half of ED dispatches result in the individual remaining in the emergency department.
- Dispatches requested by friends or family members are typically to a private residence, and a large number result in the individual remaining in the community.
- Law enforcement dispatches are roughly split between community/public settings and private residences with varying outcome dispositions.

Figure 16. Sankey Diagram of Caller Requesting Dispatch, Dispatch Location and Disposition



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Institution-Based Crisis Response:

Dispatches to Jails and Hospitals

Some MCIS programs report that they are the primary mental health responders within their local jails or hospitals. This is more common in rural and frontier areas that have fewer mental health professionals and resources to fully staff these institutional settings. While outside of the typical mobile crisis model, these programs are filling a gap in their community by partnering with law enforcement and hospital personnel.

To better understand how these dispatches may differ from the typical community-based response model, a statistical analysis comparing individuals who were served at hospitals and jails to all other dispatch locations was conducted with the 2024 data. The results found:

- **Demographics were not associated with dispatch location.** No significant demographic differences were observed between dispatches to hospitals/emergency departments (ED) and jails compared to other community-based dispatch locations.
- **The reason for dispatch was associated with dispatch location.** Jail and hospital/ED dispatches received more cases related to *Substance Use* and *Adult Interpersonal Conflict or Violence (not in protected category)* compared to community-based dispatches. This suggests that law enforcement and hospital personnel are requesting MCIS assistance with individuals with substance use and/or interpersonal conflict or violence.
- **The number of responders and the responder type was associated with dispatch location.** Community dispatches more commonly had two-responder teams than jail and hospital/ED dispatches. QMHPs were the primary responder to jail and hospital/ED dispatches, while QMHPs and QMHAs were the primary responder team to the community. This suggests that the one-responder model is often utilized when the team is dispatched to facilities where the environment is more controlled.
- **Access to follow-up services may be associated with dispatch location.** Facility-based dispatches had more responses to "Yes: within 72 hours" and fewer responses to "Yes: after 72 hours" regarding follow-up services provided when compared to community-based dispatches. In other words, facility-based dispatches provided more follow-up services within 72 hours than community-based dispatches.

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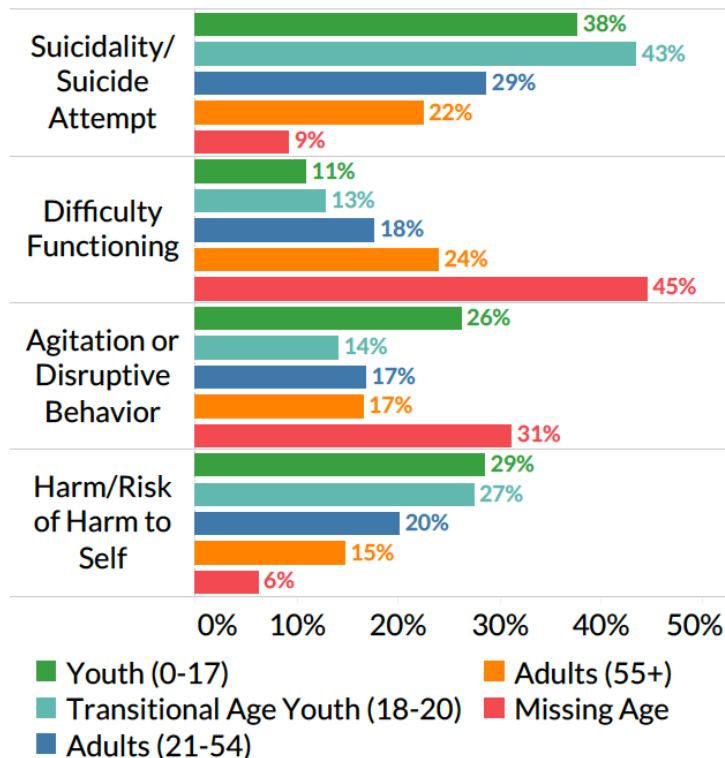
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Why was a dispatch requested?

Across all ages and quarters, the most common dispatch reasons were suicidality or suicide attempts (27%), difficulty functioning (21%), agitation or disruptive behavior (20%), and harm/risk of harm to self (19%). Dispatches for suicidality rose from 20% in 2023, and those for difficulty functioning increased from 14%. Notably, the proportion of dispatches with missing information declined from 12% in 2023 to 4% in 2024. Trends within age groups were also apparent (Figure 17):

- Youth 0-17 and transitional age youth 18-20 more commonly needed dispatches for suicidality and harm/risk of harm to self
- Adults 21-54 and 55+ more commonly had dispatches related to difficulty functioning
- Youth 18-20 were more likely to require a dispatch due to harm/risk of harm to property or concerns about treatment engagement
- Adults 55+ were more likely to need a dispatch due to adult interpersonal conflict or violence (non-protected category)

Figure 17. Reason for Dispatch by Age



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Repeat Dispatches

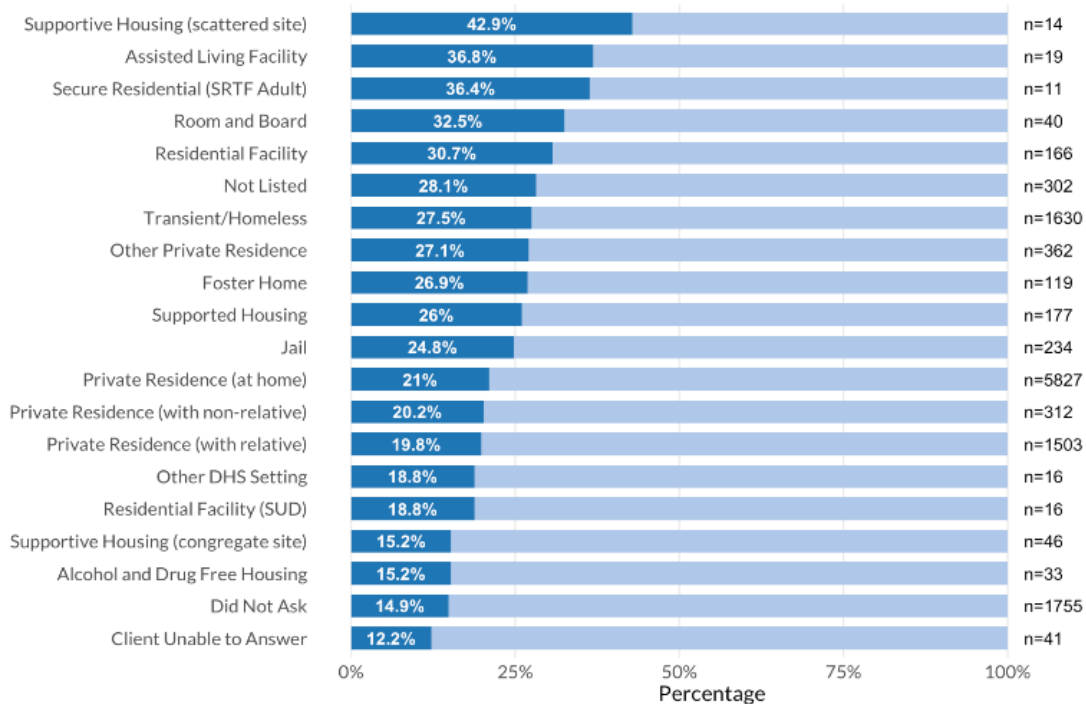
An analysis of individuals who had multiple dispatches in 2024 found that where the identified client lived was associated with whether or not they had a repeat dispatch (Figure 18).

Dispatches to individuals who live in scattered-site supportive housing had the highest percentage of repeat dispatches. Scattered site supportive housing is different from congregate supportive housing in that housing units are spread throughout a community instead of being concentrated in one area tailored to the specific needs of a population being housed. Both models help individuals achieve housing stability and access critical services; it is unclear why there is a discrepancy in MCIS utilization between the scattered-site and congregate-site models.

Assisted living facilities and adult secure residential treatment facilities had the next highest percentage of individuals with repeat dispatches. Both of these types of facilities are staffed with licensed medical and/or behavioral health professionals; we recommend that OHA explore some of the root causes behind repeat dispatches occurring at these facilities.

Lastly, individuals who were reported to be experiencing homelessness were more likely to have a repeat dispatch than individuals living in a private residence.

Figure 18. Percent of Individuals with Repeat Dispatches by Living Situation



Note: small numbers ($5 \leq n < 12$) may be statistically unreliable; interpret with caution

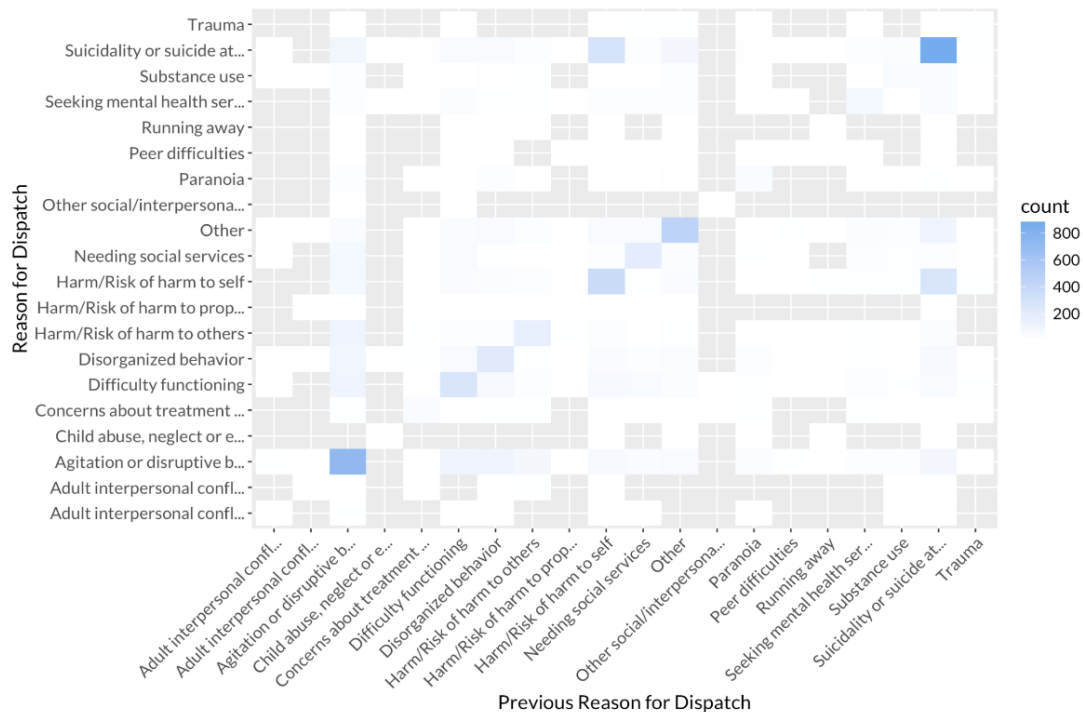
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The reason for dispatch was often the same across individuals with multiple dispatches. (Figure 19). For example, individuals presenting with agitation or disruptive behavior were likely to have the same reason for dispatch for subsequent dispatches. This was also true for individuals who presented with suicidality or suicide attempt, disorganized behavior, difficulty functioning, and harm/risk of harm to self or others. These specific reasons for dispatch are also among the most frequent reason for dispatch overall. Additionally, those who were initially dispatched to for harm/risk of harm to self were more likely to have the same presenting issue at subsequent dispatches. The large amount of grey and white boxes in the figure indicates that different reasons for dispatch for subsequent dispatches were rare or nonexistent. Taken together, these results show that individuals who have repeated use of MCIS often seek the service for the same reason.

Figure 19. Reason for Dispatch for Multiple Encounters

(gray boxes indicate no data)



Small differences were observed in those with single versus repeat dispatches across disposition. For instance, repeat dispatches were slightly more likely to end in the ED (19%) compared to single dispatches (18%). Additionally, repeat dispatches were less likely to remain in the community (63%) compared to single dispatches (67%). For youth aged 0-20, no notable differences were observed between single and repeat dispatches in whether or not they were referred to and/or enrolled in Stabilization Services. Overall, this suggests that specific services should be targeted for improvement to reduce the incidence of repeat dispatches, such as those that address suicidality and suicide attempts.

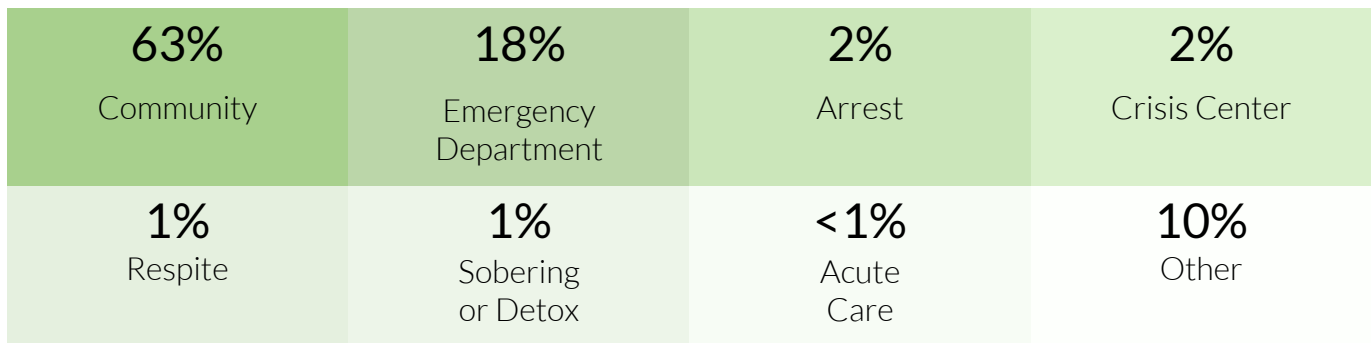
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How were dispatches resolved?

A majority of dispatches ended with the individual remaining in the community (Figure 20). This has remained consistent across quarters and years. It is important to note that while discharging to the community is the most frequent disposition, it is unknown how many of these individuals are connected to longer-term supports that will support their well-being after experiencing a crisis. Programs anecdotally report that some individuals remain in the community because they are not able to access facility-based services that would be beneficial; however, we do not currently collect data on connection to services after MCIS encounter.

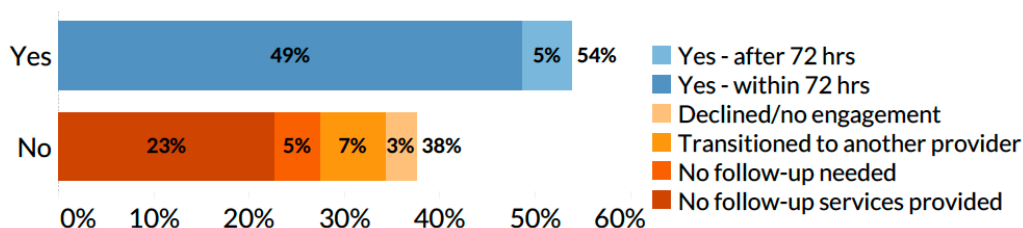
Figure 20. Disposition of MCIS Dispatches in 2024



Note: 3% of dispatches had missing disposition data

In 2024, Director's Custody holds were utilized in 3% of dispatches, hospital holds were utilized in 2% of dispatches, and police custody holds were utilized in 2% of dispatches. The OARs require that MCIS teams “must attempt to follow-up with the individual and families within 72 hours after the initial contact”. In 2024, follow-up services were provided by the Mobile Crisis Team within 72 hours 49% of the time (Figure 21), which is an increase from 38% in 2023. Follow-up services were more likely to be reported for youth 0-17 years old, whereas adults aged 55+ were least likely to receive follow-up services.

Figure 21. Follow-up status after MCIS encounter



Note: missing data accounted for an additional 9% of dispatches

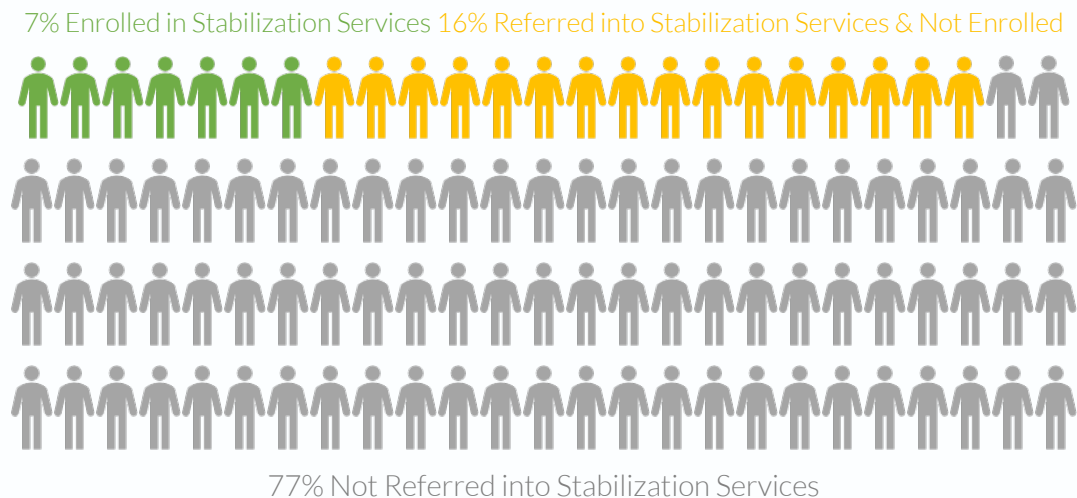
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Youth 20 and Under: Referral to Stabilization Services

Stabilization Services is a short-term crisis stabilization program available to youth 20 and under who receive a MCIS dispatch (note: Stabilization Services can also be accessed through other settings, please see the *Stabilization Services 2024 Annual Report* for more information about this program). As of the end of 2024, 14 CMHPs were providing Stabilization Services (see Appendix B, Table 1). Of those teams, not all youth who received a MCIS dispatch were referred and enrolled into Stabilization Services. **In 2024, 7% of youth who received a MCIS dispatch were reported to be enrolled into Stabilization Services.**

Figure 22. Percentage of MCIS Youth Referred and Enrolled Into Stabilization Services



Data from a subset of 1,968 MCIS youth included for study who received a MCIS dispatch during 2023 and 2024 was analyzed to determine differences between those enrolled into Stabilization Services compared to youth who were neither referred nor enrolled. The goal of this statistical analysis was to assess inequities in access and guide program development. A full description of the methodology and statistical results can be found in **Appendix B**.

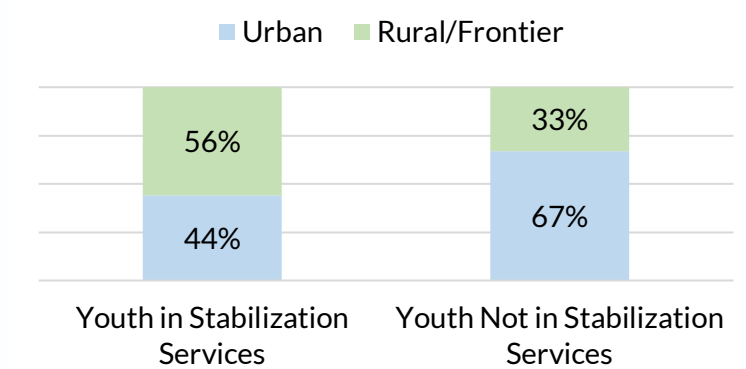
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Several key takeaways emerged from this analysis:

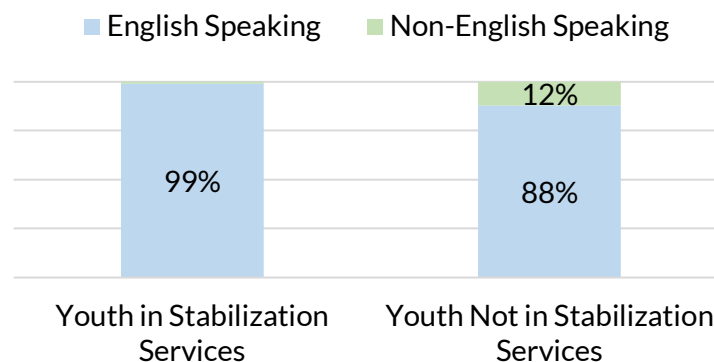
There are differing levels of program access across Oregon regions (Figure 23). Youth from rural and frontier regions are overrepresented whereas youth from urban areas are underrepresented in Stabilization Services. This may indicate that rural and frontier regions have more program capacity than urban areas.

Figure 23. Stabilization Services Enrollment: Urban versus Rural/Frontier Geography



Language barriers may be associated with Stabilization Services enrollment (Figure 24). Almost all youth enrolled in Stabilization Services spoke English, compared to 88% of youth not enrolled. This may indicate that the Stabilization Services are not equitably serving youth who do not speak English.

Figure 24. Stabilization Services Enrollment: English versus Non-English Speaking

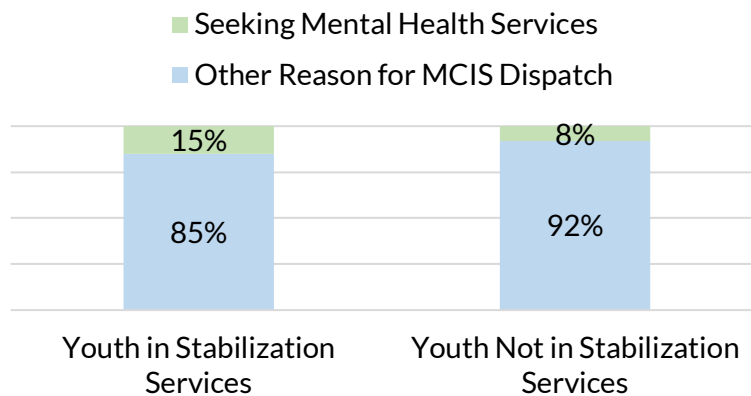


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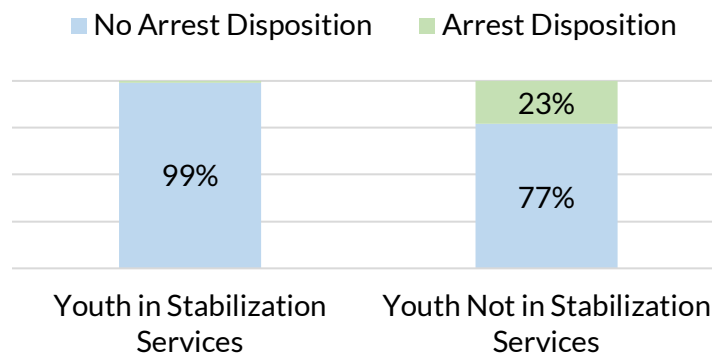
Seeking mental health services is predictive of enrollment (Figure 25). Youth enrolled in Stabilization Services were more likely to request a MCIS dispatch because they were seeking mental health services than youth who weren't enrolled. This suggests that Stabilization Services are effectively being offered to youth who are seeking services.

Figure 25. Stabilization Services Enrollment: Reason for MCIS Dispatch



Arrest dispositions appear to be an informal exclusion criterion (Figure 26). Youth who were arrested at the conclusion of their MCIS dispatch are less likely to be enrolled into Stabilization Services than youth who are not arrested. This may indicate that youth with arrest dispositions are being served through other avenues, or that due to their disposition (removal from the community), they are not receiving community-based care.

Figure 26. Stabilization Services Enrollment: Arrest versus No Arrest MCIS Disposition



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Summary

A statewide effort to enhance the crisis continuum of care in Oregon was supported by systemic changes in 2022 and 2023: a new federal mandate and subsequent partnership with 988 (Lines for Life), more directive and comprehensive mobile crisis Oregon Administrative Rules (OARs), and the development and launch of a crisis stabilization program for youth in Oregon (Stabilization Services).

In 2023, Mobile Crisis Intervention Services teams were required to both adapt to the new program standards outlined in OARs and set up workflows to collect and submit the key performance indicators required by the OHSU DAETA team and OHA. Data collection and reporting by the DAETA Team continued throughout 2024. This report demonstrates areas of success as well as challenges in both program implementation and data collection.

The DAETA team's primary role is to collect accurate and timely data about MCIS dispatches across the state. There have been ongoing challenges with inaccurate, unusable, or incomplete data being submitted; however, data quality improved during 2024. Improvements were fostered through staff trainings and technical assistance provided by the DAETA team. The following observations should be considered with those challenges in mind.

2024 Data Summary

- There were over 25,000 MCIS dispatches (to over 16,000 unique individuals) across the state in 2024. This reflects the efforts of 38 community agencies.
- The 2024 statewide per capita utilization rate was 57.9 dispatches per 10,000 people, but that varied greatly by program.
- Demographic information remains challenging to collect. This limits evaluation of whether services are provided equitably across the state; however, improvements in data collection were noted in 2024.
- There were several important differences observed between the three major geographic designations in Oregon (urban, rural, and frontier), including response time and partnerships with law enforcement and medical personnel/facilities. Urban areas responded more to requests from friends/family members and were less likely to meet OAR response time requirements. Law enforcement was the top caller in rural areas and adherence to response time requirements was high. Finally, frontier regions were most likely to respond to requests from EDs/hospitals and they were most likely to meet response time requirements.
- Suicidality and suicide attempts remain the most common reason for requesting dispatches, and individuals with repeat dispatches often presented with the same needs as their previous dispatches.

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- The availability of Stabilization Services continues to be limited statewide, with around 7% of youth receiving a MCIS dispatch being enrolled into the program. It is not known what percentage of youth receiving an MCIS dispatch have requested, but were not be able to obtain, Stabilization Services.
- Despite the volume of data collected across the crisis continuum, there are still many unknowns, including:
 - The relationship between 988/county crisis lines and MCIS dispatch, including how many individuals request an in-person response and do not receive one
 - The post-dispatch outcomes, including connection to services and longer-term health and well-being
 - Individuals' satisfaction with MCIS services

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Accomplishments

The OHSU DAETA worked closely with OHA and CMHPs throughout 2024 to maintain a system for data collection, evaluation, and reporting of MCIS data. The team also provided technical assistance to community-based programs and led workforce development and support initiatives. Highlights of the team's work are included below.

Data Collection and Outcomes Monitoring

- The team met regularly with the OHA Crisis Team, Business Information Systems Team, and Compass Team to manage statewide data collection.
- The team communicated regularly with CMHPs regarding data collection, data quality, training and technical assistance.
- The team created quarterly statewide and individual program data reports to support programs and OHA with ongoing quality monitoring efforts.

Program Development

- The team presented at AOCMHP meetings and OHA-run Learning Collaboratives to engage providers around data and built rapport with the on-the-ground teams.
- The team sought out consultation and learning by participating in various workgroups and learning collaboratives. Lessons learned from these opportunities were incorporated into current reporting mechanisms.

2025 Goals

In 2025, the DAETA team aims to complete the following work:

- The team will work with OHA to support the rollout of ROADS and to identify processes to transfer ROADS data to OHSU for analysis and reporting.
- The team will continue to collaborate with OHA and CMHPs to identify programs struggling with data collection and develop strategies to improve data quality.
- The team will launch an interactive dashboard to show critical data points that OHA can access and manipulate in live time.
- The team will launch a pilot with Cascadia Behavioral Health to assess the longer-term outcomes of MCIS, which will include a phone survey of individuals who received a dispatch.
- The team will integrate data sources, including 988 call center data, to better understand utilization of crisis services across the state.

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Recommendations

The OHSU DAETA team recommends that OHA take the following actions:

1. OHA in partnership with OHSU should review reports prepared by the DAETA team and engage in an inquiry and feedback process with each program. The process should include providing feedback and seeking to understand:
 - a. Program strengths and challenges
 - b. Data submission adherence and timeliness
 - c. Discrepancies between the data submitted by MCIS teams and Stabilization Services teams
 - d. Other data quality issues, such as high “other” or “unknown” response rates and large amounts of missing data
2. OHA in partnership with OHSU should establish measurable goals relating to access, quality, and outcomes that each program strives to reach to ensure services across the state are adequate and equitable.
3. OHA in partnership with OHSU should continue to work with programs to address barriers to quality data entry and submission. In particular, most demographics are either not reported or are reported with large proportions of missing or unknown data. Since this data is essential for evaluating the equity of mobile crisis services, OHA should set measurable goals for data quality and work with programs to meet benchmark standards.
4. OHA in partnership with OHSU should investigate high rates of “Other” responses on various data points. We recommend that the team explores whether these are true instances of circumstances that are outside of the developed field options or whether they are a data entry error. This will highlight either (or both) data field update needs or training needs.
5. OHA in partnership with OHSU should establish a workgroup to identify which calls to 988 requesting MCIS response result in an MCIS dispatch, and which calls result in another disposition (including police dispatch, resolution over phone despite request for in-person response, etc.).

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6. OHA in partnership with OHSU should establish a process to collect feedback from individuals regarding their experience with MCIS, expanding the Cascadia pilot to a process that allows for statewide initiative to understand the impact of this service.
7. OHA in partnership with OHSU should finalize a plan for the REDCap to ROADS transition, which should include developing:
 - a. A final timeline for the transition
 - b. A communication strategy to notify CMHPs of changing requirements
 - c. A plan to transfer 2023-2025 REDCap data to the ROADS system
 - d. A plan to transfer ROADS data to the DAETA team for ongoing analysis and report generation

Early planning will help improve user experience, limit confusion, and allow for more seamless transition.

Mobile Crisis Intervention Services (MCIS) 2024 Annual Report

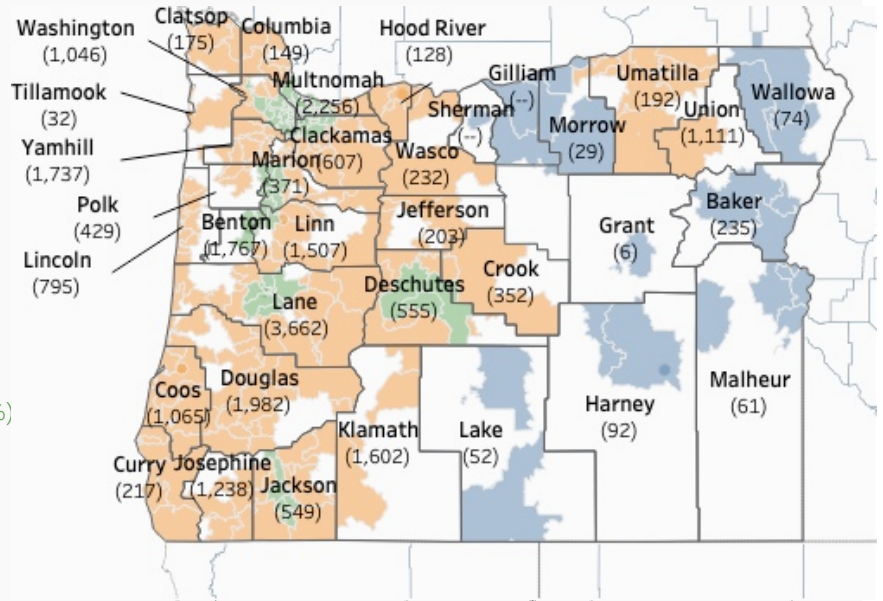
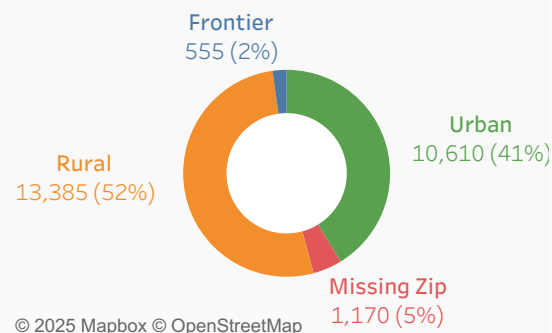
Total Dispatches: 25,720

The first section of this report represents dispatches across the state during 2024; historical data can be accessed at the end of the report. Throughout the report, responses displayed as 'Unknown' refers to the program-reported responses of 'Not Listed,' 'Client Unable to Answer,' 'Client Declined to Answer' or 'Did Not Ask.' 'Missing' refers to fields in which data was not received from the programs.

This report was prepared by the OHSU DAETA Team, please email mobilecrisisinfo@ohsu.edu for more information.

Dispatches by Rurality, Zip Code, and County (n = 25,720)

Map data reflects the distribution of dispatches across the state by zip codes associated with each county. The information provided does not reflect what agency responded to the dispatch.



Dispatch Location by Rurality and Response Time (n = 25,388)

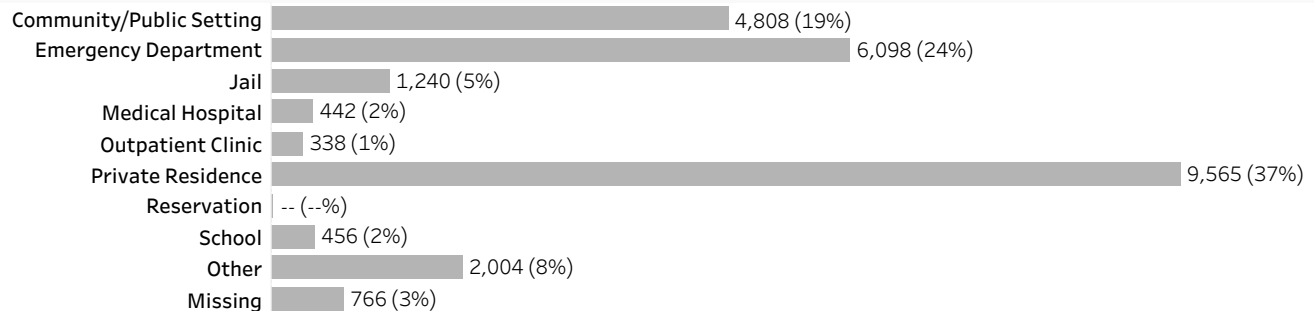
* OAR Met/Not Met: Oregon Administrative Rule requires that **Urban** dispatches are responded to within 60 minutes.

Rural dispatches are responded to within 120 minutes, and **Frontier** dispatches are responded to within 180 minutes.

* Dispatches canceled before arrival are not included in this chart.

| | Community Response (Residence/School/Public Setting) | | | Institutional Response (Jail/Hospital/Clinic) | | | Other Setting | | | Missing | | | Total by Rurality |
|----------------|--|----------------|-----------------|--|----------------|-----------------|----------------|----------------|-----------------|--------------|----------------|-----------------|----------------------|
| | OAR Met | OAR Not Met | Missing Time | OAR Met | OAR Not Met | Missing Time | OAR Met | OAR Not Met | Missing Time | OAR Met | OAR Not Met | Missing Time | |
| Urban | 6,151 (80%) | 1,305 (17%) | 228 (3%) | 1,841 (88%) | 229 (11%) | 14 (1%) | 549 (89%) | 58 (9%) | 12 (2%) | 6 (21%) | -- (--%) | 19 (66%) | 10,416 (100%) |
| Rural | 5,415 (95%) | 104 (2%) | 171 (3%) | 5,311 (92%) | 256 (4%) | 185 (3%) | 1,267 (97%) | 19 (1%) | 15 (1%) | 162 (29%) | | 393 (71%) | 13,298 (100%) |
| Frontier | 275 (97%) | 5 (2%) | -- (--%) | 233 (99%) | -- (--%) | | 27 (100%) | | | 6 (100%) | | | 552 (100%) |
| Missing Zip | | | 891 (100%) | | | 33 (100%) | | | 31 (100%) | | | 167 (100%) | 1,122 (100%) |
| Total | 11,841 (81%) | 1,414 (10%) | 1,293 (9%) | 7,385 (91%) | 488 (6%) | 232 (3%) | 1,843 (93%) | 77 (4%) | 58 (3%) | 174 (23%) | -- (--%) | 579 (76%) | 25,388 (100%) |

Dispatch Location (n= 25,720)



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small numbers (5 ≤ n < 12) may be statistically unreliable; interpret with caution

MCIS 2024 Annual Report (Total Dispatches: 25,720)

Reason For Dispatch (n = 25,720)

Multi-Select Question: up to 5 responses can be selected per dispatch; individuals may be represented in more than one category

Top 3 Most Common Reasons for Dispatch by Age Group

Youth (0-17): Suicidality/Suicide Attempt (37.7%), Harm/Risk of Harm to Self (28.5%), Agitation or Disruptive Behavior (26.2%)

Transitional Age Youth (18-20): Suicidality/Suicide Attempt (43.4%), Harm/Risk of Harm to Self (27.5%), Other Reason for Dispatch (14.2%)

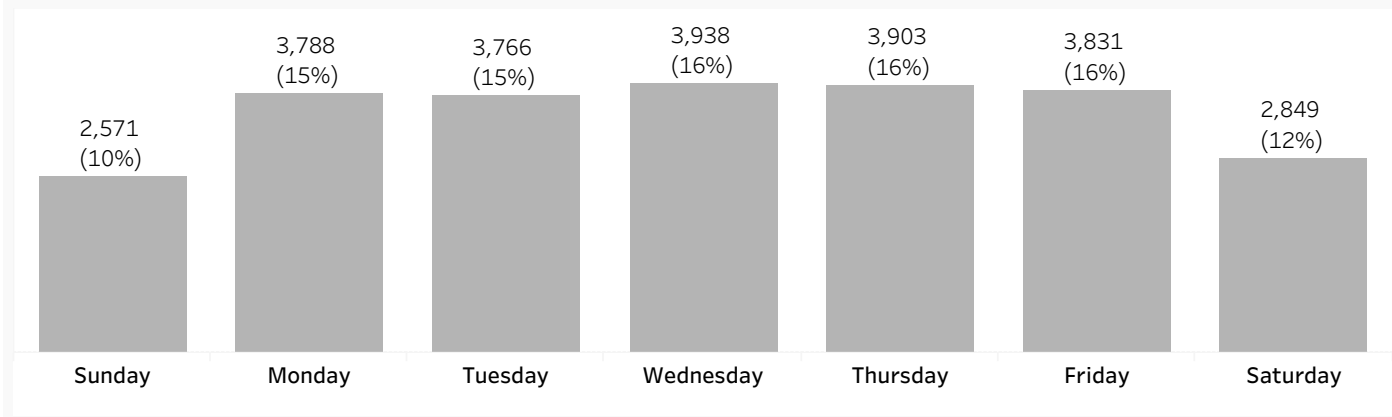
Adults (21+): Suicidality/Suicide Attempt (26.9%), Difficulty Functioning (19.3%), Harm/Risk of Harm to Self (18.7%)

| | Youth (0-17) | Transitional Age Youth (18-20) | Adults (21+) | Missing Age | Grand Total |
|---|------------------|--------------------------------|------------------|------------------|------------------|
| Adult Interpersonal Conflict or Violence (Protected Category) | 8 (0.2%) | 8 (0.7%) | 74 (0.4%) | -- (--%) | 94 (0.4%) |
| Adult Interpersonal Conflict or Violence (Not Protected Category) | -- (--%) | 17 (1.6%) | 95 (0.5%) | -- (--%) | 119 (0.5%) |
| Agitation or Disruptive Behavior | 952 (26.2%) | 150 (14.0%) | 3,020 (16.8%) | 936 (31.2%) | 5,058 (19.7%) |
| Child Abuse, Neglect or Exploitation | 39 (1.1%) | -- (--%) | 35 (0.2%) | -- (--%) | 79 (0.3%) |
| Concerns About Treatment Engagement | 47 (1.3%) | 31 (2.9%) | 647 (3.6%) | 24 (0.8%) | 749 (2.9%) |
| Difficulty Functioning | 394 (10.9%) | 137 (12.8%) | 3,486 (19.3%) | 1,337 (44.5%) | 5,354 (20.8%) |
| Disorganized Behavior | 132 (3.6%) | 96 (9.0%) | 2,888 (16.0%) | 90 (3.0%) | 3,206 (12.5%) |
| Harm/Risk of Harm to Others | 654 (18.0%) | 89 (8.3%) | 1,267 (7.0%) | 150 (5.0%) | 2,160 (8.4%) |
| Harm/Risk of Harm to Self | 1,035 (28.5%) | 294 (27.5%) | 3,367 (18.7%) | 186 (6.2%) | 4,882 (19.0%) |
| Harm/Risk of Harm to Property | 216 (6.0%) | 23 (2.1%) | 233 (1.3%) | 31 (1.0%) | 503 (2.0%) |
| Paranoia | 22 (0.6%) | 32 (3.0%) | 1,214 (6.7%) | 60 (2.0%) | 1,328 (5.2%) |
| Peer Difficulties | 100 (2.8%) | 29 (2.7%) | 239 (1.3%) | 23 (0.8%) | 391 (1.5%) |
| Running Away | 166 (4.6%) | 6 (0.6%) | 69 (0.4%) | 27 (0.9%) | 268 (1.0%) |
| Needing Social Services | 85 (2.3%) | 49 (4.6%) | 1,673 (9.3%) | 190 (6.3%) | 1,997 (7.8%) |
| Seeking Mental Health Services | 293 (8.1%) | 147 (13.7%) | 2,040 (11.3%) | 95 (3.2%) | 2,575 (10.0%) |
| Substance Use | 67 (1.8%) | 55 (5.1%) | 1,578 (8.8%) | 91 (3.0%) | 1,791 (7.0%) |
| Suicidality or Suicide Attempt | 1,367 (37.7%) | 465 (43.4%) | 4,856 (26.9%) | 277 (9.2%) | 6,965 (27.1%) |
| Trauma | 122 (3.4%) | 45 (4.2%) | 519 (2.9%) | 29 (1.0%) | 715 (2.8%) |
| Other Reason for Dispatch | 479 (13.2%) | 152 (14.2%) | 3,088 (17.1%) | 369 (12.3%) | 4,088 (15.9%) |
| Missing | 123 (3.4%) | 22 (2.1%) | 493 (2.7%) | 387 (12.9%) | 1,025 (4.0%) |

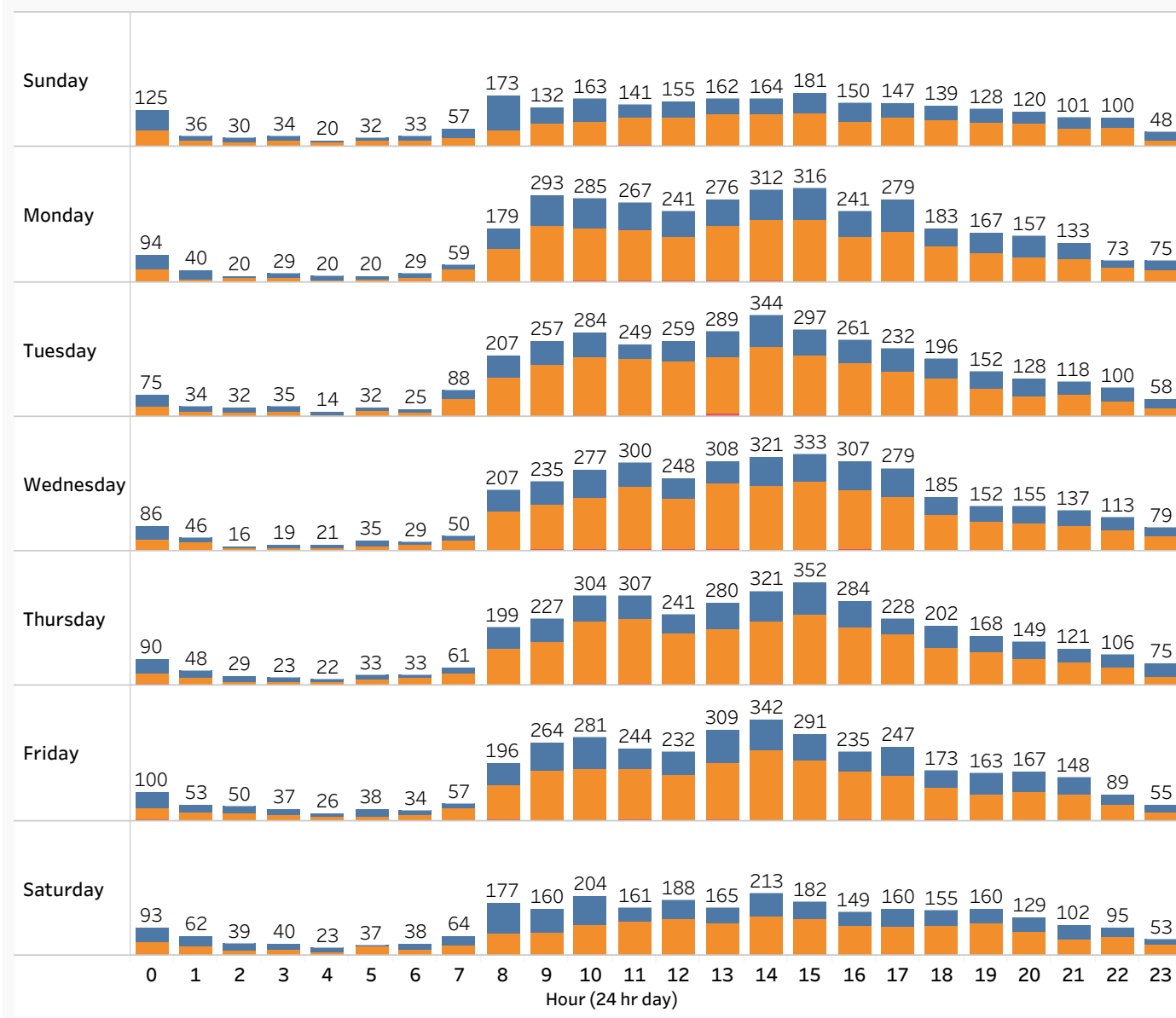
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small numbers (5 ≤ n < 12) may be statistically unreliable; interpret with caution

MCIS 2024 Annual Report (Total Dispatches: 25,720)

Total Dispatches by Day of the Week (n = 24,646)



Total Dispatches by Day and Hour (n = 24,646)



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small numbers (5 ≤ n < 12) may be statistically unreliable; interpret with caution

MCIS 2024 Annual Report (Total Dispatches: 25,720)

Responder Type (n= 25,720)

QMHA: Qualified Mental Health Associate

QMHP: Qualified Mental Health Professional

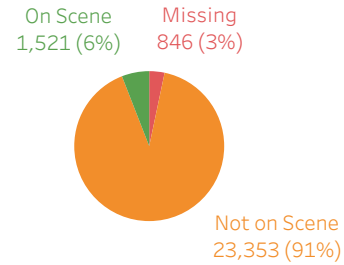
Other Responders: Certified Alcohol and Drug Counselor, Peer Support Specialist, Licensed Medical Provider

Number of MCIS Responders

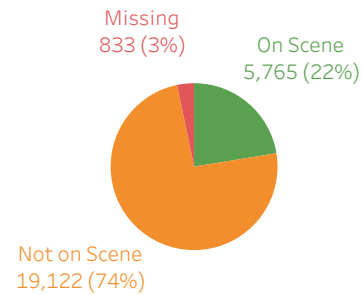
| | | |
|--------------|-------------|---------|
| 2 Responders | 1 Responder | Missing |
| 15,974 | 9,355 | 391 |
| (62%) | (36%) | (2%) |

| | |
|---------------------------|-------|
| One QMHP Alone | 7,609 |
| | (30%) |
| One QMHA Alone | 1,323 |
| | (5%) |
| Other Responder Alone | 423 |
| | (2%) |
| QMHP and QMHP/A | 8,201 |
| | (32%) |
| QMHA and Other Responder | 4,697 |
| | (18%) |
| QMHP and Other Responder | 2,892 |
| | (11%) |
| Two Other Responders | 163 |
| | (1%) |
| Peer and Other | 17 |
| | (0%) |
| Peer and CADC | -- |
| | (--%) |
| Missing | 391 |
| | (2%) |
| Peer and Medical Provider | -- |
| | (--%) |

Emergency Medical Services on Scene



Law Enforcement on Scene



Caller Requesting Dispatch (n= 25,720)

| | | |
|-----------------------|-------------------|-------------|
| County Crisis Line | 911 Dispatcher | 784 (3%) |
| | 988 Dispatcher | 269 (1%) |
| | ED or Hospital | 5,686 (22%) |
| | EMS Personnel | 245 (1%) |
| | Law Enforcement | 4,835 (19%) |
| | Other | 4,677 (18%) |
| | Missing | 1,574 (6%) |
| | Community Member | 1,605 (6%) |
| | Friend/ Family | 3,393 (13%) |
| | Identified Client | 2,652 (10%) |

Endpoint of Dispatch (n= 25,720)

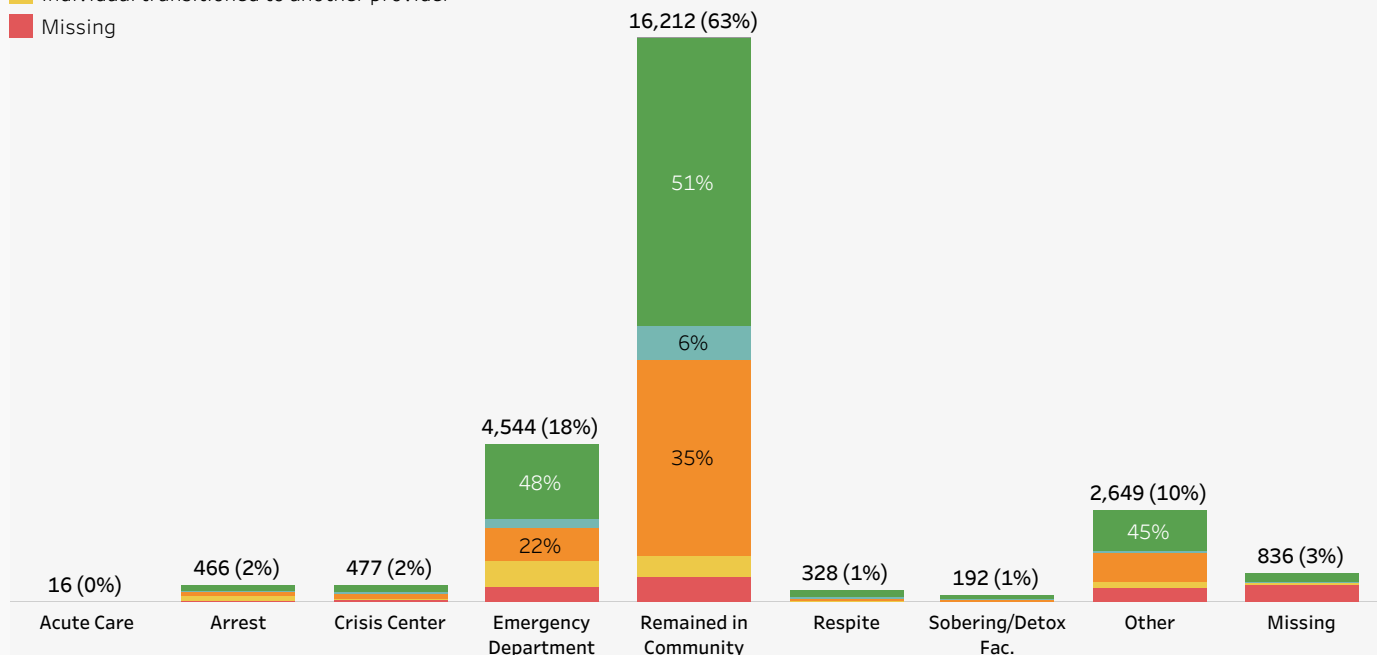
| | |
|---|--------------|
| Engaged Client | 19,969 (78%) |
| Client Declined to Engage | 1,070 (4%) |
| Unable to Locate Client | 1,207 (5%) |
| Did Not Make Contact Due to Safety Issues | 77 (0%) |
| Dispatch Cancelled Before Arrival | 332 (1%) |
| Other | 2,140 (8%) |
| Missing | 925 (4%) |

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small numbers (5 ≤ n < 12) may be statistically unreliable; interpret with caution

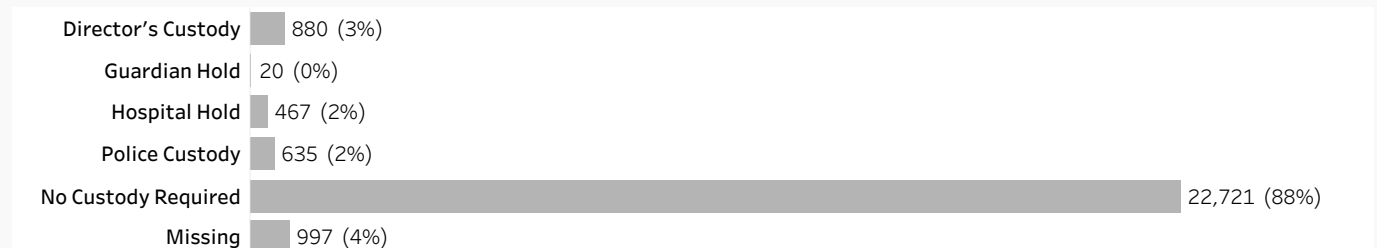
MCIS 2024 Annual Report (Total Dispatches: 25,720)

Disposition and Follow-Up Status (n= 25,720)

- Follow-up services provided by MCIS team within 72 hrs
- Follow-up services provided after 72 hrs
- No follow-up services provided by MCIS team
- Individual transitioned to another provider
- Missing



Custody Required (n= 25,720)



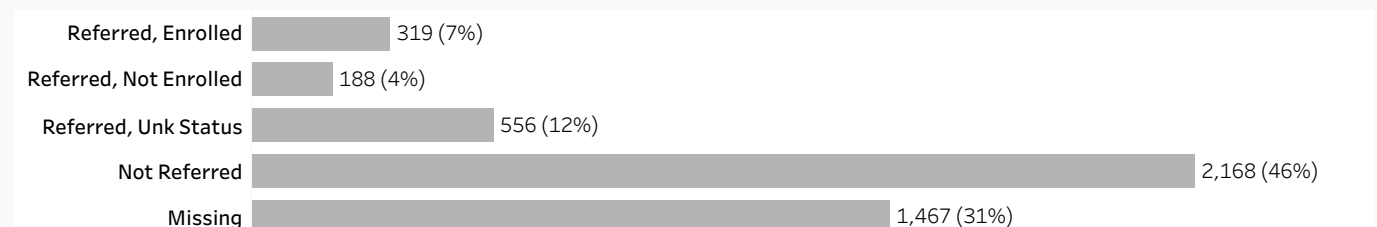
Abuse Reported (n= 25,720)

| | | |
|---------|--------|-----|
| Yes | 501 | 2% |
| No | 22,059 | 86% |
| Missing | 3,160 | 12% |

Language Need Met (n= 25,720)

| | | |
|---------|--------|-----|
| Yes | 17,037 | 66% |
| No | 147 | 1% |
| N/A | 8,058 | 31% |
| Missing | 478 | 2% |

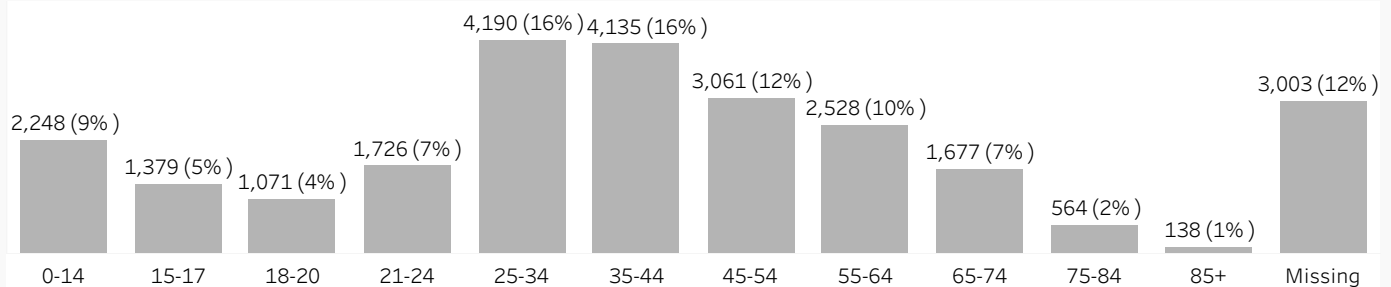
Stabilization Services Enrollment (ages 0-20, n= 4,698)



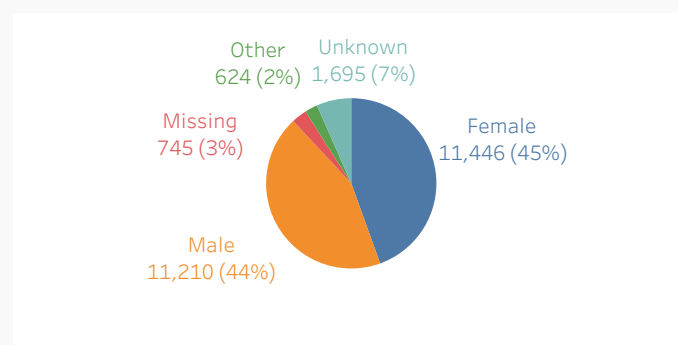
MCIS 2024 Annual Report (Total Dispatches: 25,720)

Demographic Information

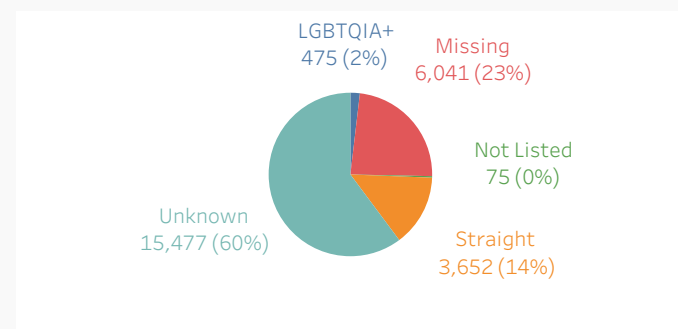
Age (n= 25,720)



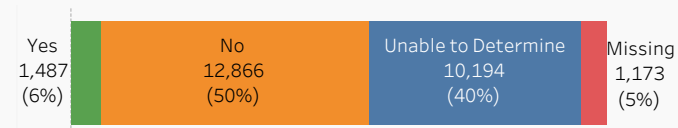
Gender (n= 25,720)



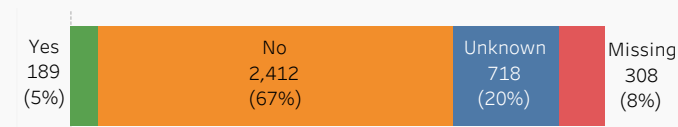
Sexual Orientation (n= 25,720)



Known or Suspected Intellectual or Developmental Disability (n= 25,720)



DHS Custody (ages 0-17, n= 3,627)



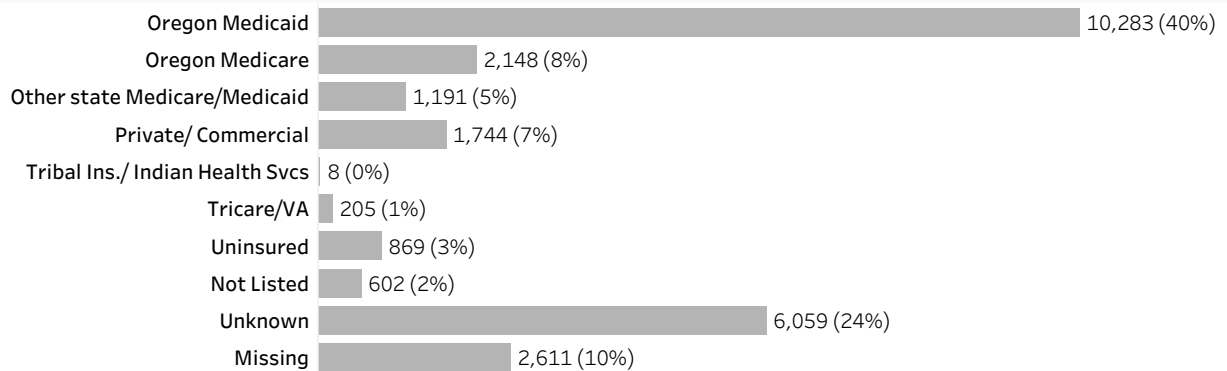
Race and Ethnicity (n = 25,720)

Multi-Select Question: up to 3 responses can be selected per dispatch; individuals may be represented in more than one category

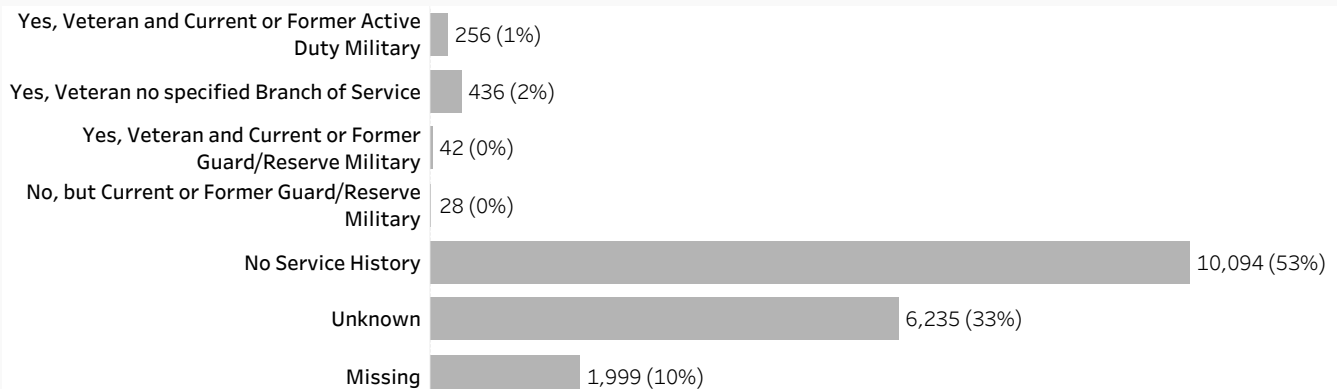
| | | |
|--|--------|-------|
| African American | 468 | (2%) |
| Afro-Caribbean | -- | (--%) |
| Alaska Native | 41 | (0%) |
| American Indian | 577 | (2%) |
| Asian Indian | 5 | (0%) |
| Cambodian | 0 | (0%) |
| Canadian Inuit, Metis or First Nation | 0 | (0%) |
| Central American | 18 | (0%) |
| Chamoru (Chamorro) | 0 | (0%) |
| Chinese | 12 | (0%) |
| Communities of Myanmar | -- | (--%) |
| Communities of the Micronesian Regions | 0 | (0%) |
| Eastern European | 87 | (0%) |
| Ethiopian | -- | (--%) |
| Filipino/a | 6 | (0%) |
| Hmong | 0 | (0%) |
| Indigenous Mexican, Central American | -- | (--%) |
| Japanese | 9 | (0%) |
| Korean | -- | (--%) |
| Laotian | 0 | (0%) |
| Marshallese | -- | (--%) |
| Mexican | 361 | (1%) |
| Middle Eastern | 11 | (0%) |
| Native Hawaiian | 35 | (0%) |
| North African | 0 | (0%) |
| Other African (Black) | 25 | (0%) |
| Other Asian | 93 | (0%) |
| Other Black | 155 | (1%) |
| Other Hispanic or Latino/a/x | 497 | (2%) |
| Other Pacific Islander | 83 | (0%) |
| Other Race and Ethnicity | 598 | (2%) |
| Other White | 11,123 | (43%) |
| Samoan | -- | (--%) |
| Slavic | 12 | (0%) |
| South American | 12 | (0%) |
| South Asian | -- | (--%) |
| Vietnamese | 5 | (0%) |
| Western European | 351 | (1%) |
| Client Unable to Answer | 165 | (1%) |
| Client Declined to Answer | 1,268 | (5%) |
| Did Not Ask | 8,747 | (34%) |
| Missing Race | 1,812 | (7%) |

MCIS 2024 Annual Report (Total Dispatches: 25,720)

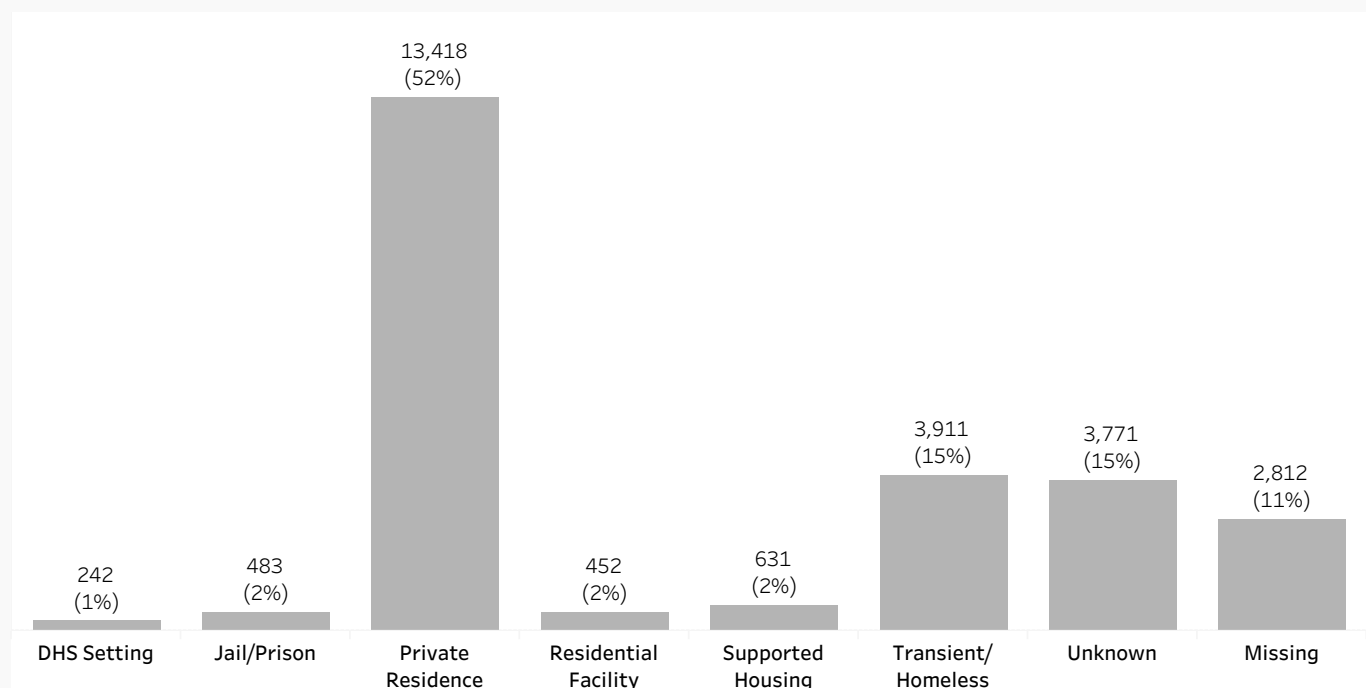
Primary Insurance (n= 25,720)



Military/Veteran Status (ages 18+, n= 19,090)



Current Living Arrangement (n= 25,720)



(--) data suppressed for confidentiality, n < 5
small numbers (5 ≤ n < 12) may be statistically unreliable; interpret with caution

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Appendix B: Analysis of Stabilization Services Enrollment

A statistical analysis exploring demographic and dispatch related factors for 226 MCIS youth enrolled into Stabilization Services compared to 1,742 MCIS youth who were neither referred nor enrolled into Stabilization Services between 2023-2024 is presented in this section. Since Stabilization Services did not have any children enrolled under 6 years old, this analysis focuses only on youth between ages of 6-20 years old. Future study should include those 0-5 years old, along with individuals who were referred into Stabilization Services but never enrolled into the program.

A total of 14 MCIS teams had Stabilization Services in place by the end of 2024; **Table 1** details the specific MCIS teams and their stabilization service, sorted by the date each stabilization service began data collection. Of those MCIS teams, 11 of the 14 had Stabilization Services in place for the entire 2024 calendar year.

Table 1. MCIS Teams and Stabilization Services teams sorted by data collection start date

| MCIS Team | Stabilization Service | Data Collection Start Date |
|--|--|----------------------------|
| Adapt (Douglas) | Adapt (Douglas) | 4/1/2023 |
| Benton County Health Department | Benton County Health Department | 4/1/2023 |
| Clackamas County Health, Housing & Human Services | Catholic Community Services | 4/1/2023 |
| Deschutes Behavioral Health | Youth Villages | 4/1/2023 |
| Multnomah County Behavioral Health Division | Catholic Community Services | 4/1/2023 |
| Washington County Health & Human Services | Catholic Community Services | 4/1/2023 |
| Adapt (Curry) | Adapt (Curry) | 10/1/2023 |
| Coos Health and Wellness | Coos Health and Wellness | 10/1/2023 |
| Linn County Mental Health | Linn County Mental Health | 10/1/2023 |
| Marion County Health Department | Marion County Health Department | 10/1/2023 |
| Lane County Behavioral Health Services (Riverview Center for Growth) | Lane County Behavioral Health Services (Riverview Center for Growth) | 1/1/2024 |
| New Directions NW, Inc. | New Directions NW, Inc. | 4/1/2024 |
| Lifeways, Inc. | Lifeways, Inc. | 7/1/2024 |
| Options for Southern Oregon | Options for Southern Oregon | 10/1/2024 |

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Overall Sample Characteristics

Table 2 describes demographic information for the subset of 1,968 youth included for analysis. Overall, most youth were between ages of 13-17 years old, White, English speaking, publicly insured, lived in private residences, and were from urban areas. The most common MCIS teams were Washington County Health & Human Services (~19%), Multnomah County Behavioral Health Division (~17%), and Adapt-Douglas (~13%).

Table 2. Count and percentage of demographic characteristics for the subset of 1,968 MCIS youth between 2023-2024

| Age Group (Years) | |
|------------------------|--------------|
| 6-12 | 453 (23.0%) |
| 13-17 | 1050 (53.4%) |
| 18-20 | 465 (23.6%) |
| Gender | |
| Female | 841 (42.7%) |
| Male | 858 (43.6%) |
| Other | 96 (4.9%) |
| Unknown | 173 (8.8%) |
| Sexual Orientation | |
| Not Straight | 54 (2.7%) |
| Straight | 168 (8.5%) |
| Unknown | 1746 (88.7%) |
| Primary Race/Ethnicity | |
| AIAN | 32 (1.6%) |
| Asian | 11 (0.6%) |
| Black | 85 (4.3%) |
| Hispanic | 120 (6.1%) |
| MENA | -- (--%) |
| NHPI | 22 (1.1%) |
| Other | 139 (7.1%) |
| Unknown | 871 (44.3%) |
| White | 686 (34.9%) |
| Client Language | |
| Other Language | 209 (10.6%) |
| English | 1691 (85.9%) |
| Unknown | 68 (3.5%) |

| Living Arrangement | |
|------------------------|--------------|
| Private Housing | 1609 (81.8%) |
| DHS Setting | 53 (2.7%) |
| Jail/Prison | 16 (0.8%) |
| Residential Facility | 35 (1.8%) |
| Supported Housing | 25 (1.3%) |
| Transient/Homeless | 49 (2.5%) |
| Unknown | 181 (9.2%) |
| DHS Involvement (Ever) | |
| Yes | 97 (4.9%) |
| No | 1439 (73.1%) |
| Unknown | 432 (22.0%) |
| IDD Status | |
| Yes/Suspected | 164 (8.3%) |
| No | 1230 (62.5%) |
| Unknown | 574 (29.2%) |
| Geographic Designation | |
| Urban | 1245 (63.3%) |
| Frontier | 40 (2.0%) |
| Rural | 662 (33.6%) |
| Unknown | 21 (1.1%) |
| Primary Insurance | |
| Private | 205 (10.4%) |
| Public | 850 (43.2%) |
| Uninsured | 14 (0.7%) |
| Other | 76 (3.9%) |
| Unknown | 823 (41.8%) |

(--) data suppressed for confidentiality, $n < 5$

Note: small numbers ($5 \leq n < 12$) may be statistically unreliable; interpret with caution

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Dispatch-Related Factors

Table 3 describes dispatch related information for the subset of 1,968 youth included for analysis. Overall, most youth had only a single MCIS encounter during the study period, with more youth being served during 2024 compared to 2023 (65% vs 35%, respectively). The most common dispatch requestors were from community crisis lines, with most dispositions allowing youth to remain in the community. Almost 93% of MCIS youth had a QMHP responder, with around every 1 in 3 dispatches with law enforcement on scene. The most common reasons for MCIS dispatches were for: suicidality (~37%), harm/risk of harm to self (~34%), agitation or disruptive behavior (~32%), and harm/risk of harm to others (~23%).

Table 3: Count and percentage of dispatch-related factors for the subset of 1,968 MCIS youth between 2023-2024

| Total MCIS Dispatches | | Abuse Reported | |
|--------------------------|-------------------|-------------------------------------|-------------|
| Average (SD) | 1.53 (1.87) | Yes | 145 (7.4%) |
| Median [Min, Max] | 1.00 [1.00, 29.0] | Custody Required | |
| Year | | Yes | 222 (11.3%) |
| 2023 | 689 (35.0%) | Dispatch Reasons | |
| 2024 | 1279 (65.0%) | Adult IPV (Protected) | 15 (0.8%) |
| Dispatch Requestor | | Adult IPV (Not Protected) | 13 (0.7%) |
| 988/911 | 114 (5.8%) | Agitation/disruptive behavior | 621 (31.6%) |
| County crisis line | 764 (38.8%) | Child abuse/neglect/ exploit | 25 (1.3%) |
| ED/hospital/EMS | 285 (14.5%) | Concerns about treatment engagement | 30 (1.5%) |
| Law enforcement | 444 (22.6%) | Difficult functioning | 186 (9.5%) |
| Other | 361 (18.3%) | Disorganized behavior | 108 (5.5%) |
| Responder Types | | Harm/risk of harm to others | 447 (22.7%) |
| Peer | 273 (13.9%) | Harm/risk of harm to property | 150 (7.6%) |
| QMHP | 1823 (92.6%) | Harm/risk of harm to Self | 661 (33.6%) |
| Law Enforcement on Scene | | Needing social services | 55 (2.8%) |
| Yes | 697 (35.4%) | Social/interpersonal | 132 (6.7%) |
| EMS on Scene | | Paranoia | 26 (1.3%) |
| Yes | 149 (7.6%) | Peer difficulties | 41 (2.1%) |
| Disposition | | Running away | 108 (5.5%) |
| Community | 1053 (53.5%) | Seeking services | 177 (9.0%) |
| Arrest | 402 (20.4%) | Substance use | 42 (2.1%) |
| ED or acute care | 355 (18.0%) | Suicidality or suicide attempt | 718 (36.5%) |
| Other | 158 (8.0%) | Trauma | 64 (3.3%) |

(--) data suppressed for confidentiality, $n < 5$

Note: small numbers ($5 \leq n < 12$) may be statistically unreliable; interpret with caution

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Factors Associated with Stabilization Services Enrollment

This section presents demographic and MCIS dispatch related factors for youth enrolled in Stabilization Services compared to youth who were not referred into Stabilization Services. These associations only account for differences by a single factor, without accounting for any potential confounders. Chi-square tests and Fisher's exact test in cases of sparse data were used to determine factors statistically associated with Stabilization Services enrollment (Table 4).

Demographic Factors

Compared to youth not enrolled or referred into Stabilization Services, youth in Stabilization Services were more likely to be:

- Between the ages of 13-17 years old
- Female
- Non-Hispanic White
- Speak English
- Have private insurance
- Come from rural or frontier geographic designations

On the other hand, youth in Stabilization Services were less likely to be:

- Between the ages of 18-20 years old
- Male
- Other (non-White) race/ethnicity
- Non-English speaking
- Come from urban geographic designations

Dispatch Related Factors

Compared to youth not enrolled or referred into Stabilization Services, youth in Stabilization Services were more likely to:

- Have dispatch requestors from the ED, hospital, EMS, or law enforcement
- Be seeking mental health services
- Have dispositions for remaining in community, or ED/acute care

On the other hand, youth in Stabilization Services were less likely to:

- Have community crisis line dispatch requestors
- Have dispositions for arrest
- Have a QMHP or Peer responder on scene
- Require custody
- Have dispatch reasons for harm/risk of harm to others or property

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Table 4: MCIS Youth Demographic and Dispatch Related Factors Associated with Stabilization Services enrollment: Chi-square test and Fisher's Exact test results (n=1,968)

| | Not Enrolled in Stabilization Services (N=1742) | Enrolled in Stabilization Services (N=226) |
|----------------------------------|--|---|
| Age Group (Years)** | | |
| 6-12 | 404 (23.2%) | 49 (21.7%) |
| 13-17 | 910 (52.2%) | 140 (61.9%) |
| 18-20 | 428 (24.6%) | 37 (16.4%) |
| Gender** | | |
| Female | 721 (41.4%) | 120 (53.1%) |
| Male | 776 (44.5%) | 82 (36.3%) |
| Other | 86 (4.9%) | 10 (4.4%) |
| Unknown | 159 (9.1%) | 14 (6.2%) |
| Sexual Orientation** | | |
| Not-Straight | 43 (2.5%) | 11 (4.9%) |
| Straight | 138 (7.9%) | 30 (13.3%) |
| Unknown | 1561 (89.6%) | 185 (81.9%) |
| Primary Race/Ethnicity*** | | |
| Other Race/Ethnicity | 458 (26.3%) | 26 (11.5%) |
| Unknown | 676 (38.8%) | 122 (54.0%) |
| Non-Hispanic White | 608 (34.9%) | 78 (34.5%) |
| Client Language*** | | |
| Other | 208 (11.9%) | -- (--%) |
| English | 1473 (84.6%) | 218 (96.5%) |
| Unknown | 61 (3.5%) | 7 (3.1%) |
| Primary Insurance*** | | |
| Other | 80 (4.6%) | 10 (4.4%) |
| Private | 161 (9.2%) | 44 (19.5%) |
| Public | 748 (42.9%) | 102 (45.1%) |
| Unknown | 753 (43.2%) | 70 (31.0%) |
| Geographic Designation*** | | |
| Rural/Frontier | 574 (33.0%) | 128 (56.6%) |
| Unknown | 20 (1.1%) | -- (--%) |
| Urban | 1148 (65.9%) | 97 (42.9%) |
| Dispatch Requestor*** | | |
| 988/911 | 110 (6.3%) | -- (--%) |
| ED/Hospital/EMS | 223 (12.8%) | 62 (27.4%) |
| Law Enforcement | 359 (20.6%) | 85 (37.6%) |
| Community Crisis Line | 711 (40.8%) | 53 (23.5%) |
| Other | 339 (19.5%) | 22 (9.7%) |
| Disposition*** | | |
| Arrest | 399 (22.9%) | -- (--%) |

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| | | |
|---|--------------|-------------|
| Community | 915 (52.5%) | 138 (61.1%) |
| ED/Acute Care | 295 (16.9%) | 60 (26.5%) |
| Other | 133 (7.6%) | 25 (11.1%) |
| Peer on Scene** | | |
| Yes | 258 (14.8%) | 15 (6.6%) |
| No | 1484 (85.2%) | 211 (93.4%) |
| QMHP on Scene*** | | |
| Yes | 1635 (93.9%) | 188 (83.2%) |
| No | 107 (6.1%) | 38 (16.8%) |
| Custody Required** | | |
| Yes | 207 (11.9%) | 15 (6.6%) |
| No | 1535 (88.1%) | 211 (93.4%) |
| Harm/Risk of harm to Others* | | |
| Yes | 409 (23.5%) | 38 (16.8%) |
| No | 1333 (76.5%) | 188 (83.2%) |
| Harm/Risk of harm to Property* | | |
| Yes | 143 (8.2%) | 7 (3.1%) |
| No | 1599 (91.8%) | 219 (96.9%) |
| Seeking Mental Health Services** | | |
| Yes | 144 (8.3%) | 33 (14.6%) |
| No | 1598 (91.7%) | 193 (85.4%) |

* $p < .05$ ** $p < .01$ *** $p < .001$ (Two-Sided Test)

(--) data suppressed for confidentiality, $n < 5$

Note: small numbers ($5 \leq n < 12$) may be statistically unreliable; interpret with caution