

UC HEALTH MOBILE CRISIS TEAM

HAMILTON COUNTY, OH

Quarter 1 2026

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OPERATIONAL SUMMARY

The Mobile Crisis Team (MCT) saw a 22% **increase in** encounters in Q1 2026 (n=1851) from Q1 2025 (n=1521).

STAFFING HIGHLIGHTS

Structure

The Mobile Crisis Team at UC Health has operated 24 hours a day, 7 days a week since April 2023. Its leadership structure includes a full-time manager, a clinical supervisor, and the director of social services, all of whom provide support for both clinical and operational needs.

The clinical team is composed of clinicians who triage calls, respond to community-based crises, and conduct follow-up with patient referrals to help individuals access care and treatment. Peer specialists co-respond to crises and provide follow-up support after Mobile Crisis interventions, helping community members stabilize and reduce the likelihood of future crises.

To further strengthen this work, a Peer Support Specialist Team Supervisor role was added, using existing peer and clinician FTEs. This addition provides more focused guidance and support, enabling peer specialists to be more effective in their community-based roles.

Current Staffing

Shift/Position	Dedicated FTE	Open FTE
Leadership	3.0	0
Program Coordinator	1.0	0
Triage (1st & 2nd Shift)	2.0	0
Weekday Clinician	9.5	0.8
Weekend Clinician	2.5	0.2
Overnight Clinician	3.0	0.25
Peer Support Specialist	4.0	0.5
Total FTE	**25.0**	**1.45**

COMMUNITY MEMBERS SERVED

All data below provides information on all consumers of MCT services in Hamilton County from January-March 2026.

Total Number of Consumers	Quarter 1 Count
Total Served	1851
Unique Individuals Served	1156

By the end of Q1 2026, the Mobile Crisis Team saw a **22% increase** in total population served compared to the end of Q1 2025 (n=1521).

Age	Quarter 1 Count	Quarter 1 Percentage
0-17	118	6.4%
18-34	535	29%
35-54	562	30.4%
55 & Older	466	25.2%
Age Unknown	170	9%

Nearly a third (65.8%) of Mobile Crisis Team patients are between the ages of 18 and 54. 6.4% of patients are children and adolescents aged 0-17, and MCT's 55+ population has increased to over 1 in 4 patients seen (25.2%)

Gender	Quarter 1 Count	Quarter 1 Percentage
Female	935	50%
Male	863	47%
Unknown	53	3%

Referral Path to MCT	Quarter 1 Count	Quarter 1 Percentage
Police/Radio	794	43%
Family/Self/Community Member	753	41%
Behavioral Health/Medical Provider	186	10%
Other	118	6%

From Q1 2025, police/radio referrals decreased by *8%.* Simultaneously, referrals from outside agency providers, family, and "other" have increased, indicating increasing knowledge of MCT's services and that community referrals are now more commonplace and better utilized.

Race	Quarter 1 Count	Quarter 1 Percentage
African American	778	42%
Caucasian	791	43%
Other	77	4%

Unknown	205	11%

Primary Diagnosis	Quarter 1 Count	Quarter 1 Percentage
Schizophrenia Spectrum and Other Psychotic Disorders (*includes schizoaffective and psychosis)	467	25%
Bipolar I & II	278	15%
Depressive Disorders	188	10%
Substance Use Disorder	71	5%
Other	872	44%
Unknown	18	1%

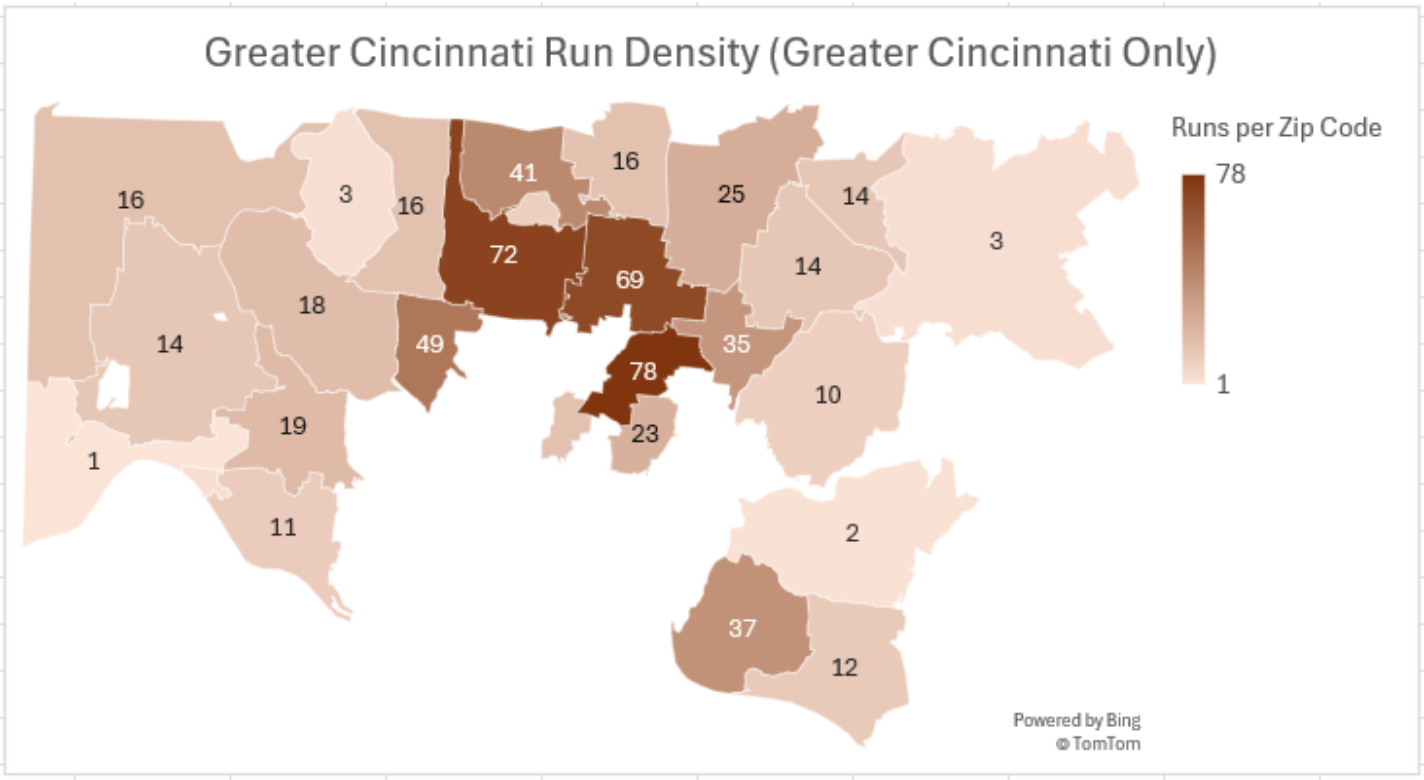
Several barriers to accurate diagnosis and documentation in the community have been identified and addressed. As a result, “unknown” diagnoses represented only 1% of all documented cases this quarter.

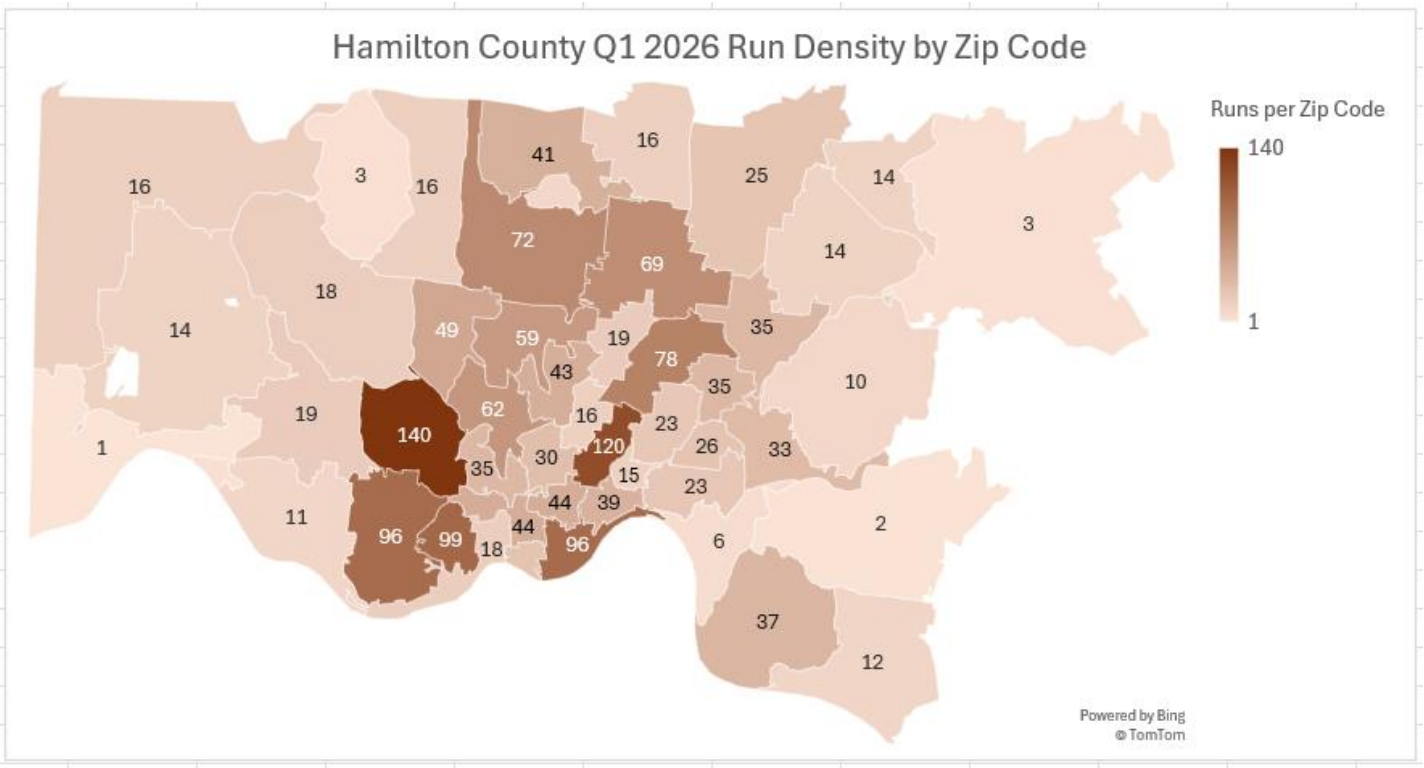
Although “Other” remains a sizable diagnostic category in this report, the Mobile Crisis Team (MCT) is now collecting more detailed and specific data that aligns more closely with current DSM-5 diagnostic criteria. This more granular information is available upon request; however, for consistency with historical reporting, the categories presented here have not been modified.
It is also important to note that the “Other” category includes neurocognitive disorders such as Alzheimer’s disease and other forms of dementia. When considered alongside the fact that nearly one-quarter of MCT responses involve adults aged 55 and older, this helps explain why a significant proportion of cases fall within the “Other” category.

GEOGRAPHIC RESPONSE AREAS

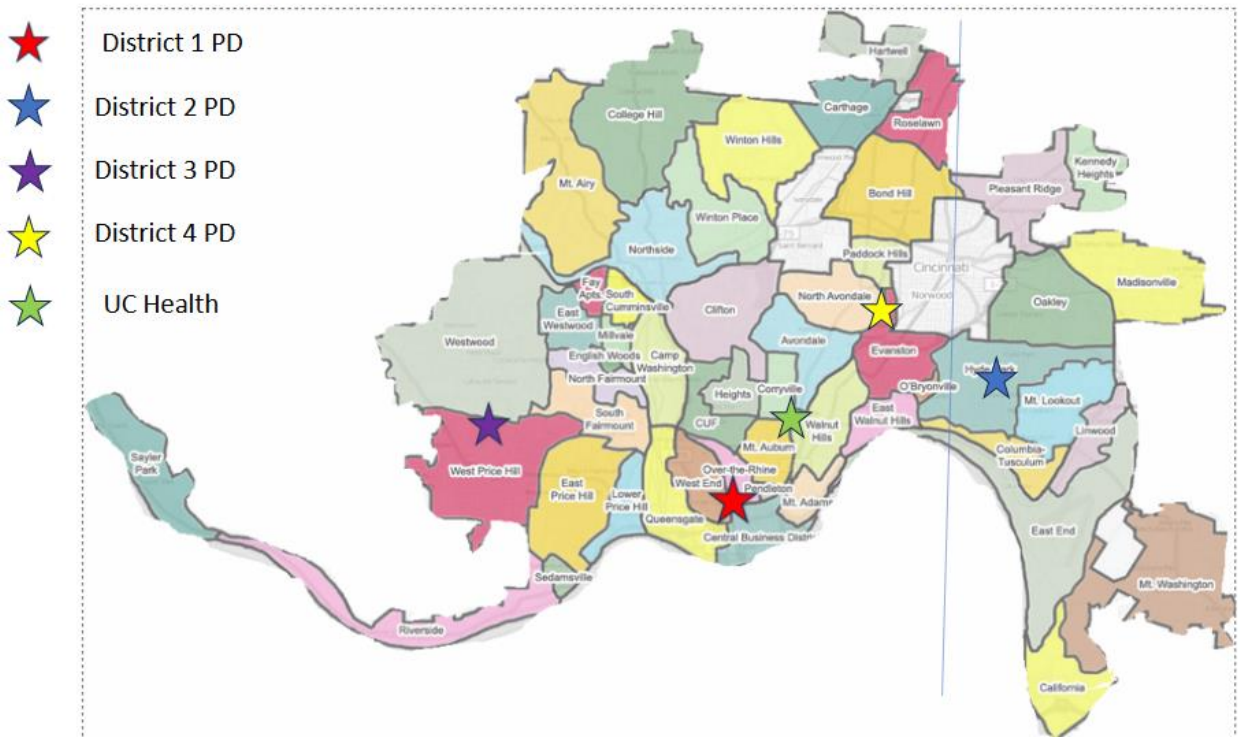
Outside City of Cincinnati

The first image, is County excluding Cincinnati, and it illustrates the zip codes and response volumes outside the City of Cincinnati in Hamilton County for Q1 2026. This area has been a key focus in recent years through ARPA funding, and the Mobile Crisis Team (MCT) has successfully expanded both its response capacity and integration within county communities.


Greater Cincinnati Run Density (Greater Cincinnati Only)
Runs per Zip Code
78
1
16
3
16
41
16
25
14
3
72
69
14
18
49
35
14
78
10
19
23
1
11
2
37
12
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Hamilton County Q1 2026 Run Density by Zip Code
Runs per Zip Code
140
1
16
3
16
41
16
25
14
3
72
69
14
18
49
59
19
35
14
43
78
35
10
19
62
16
23
140
120
26
33
1
35
30
15
23
44
39
11
96
99
44
18
96
6
2
37
12
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City of Cincinnati MCT Satellite Stations



By ZIP Code

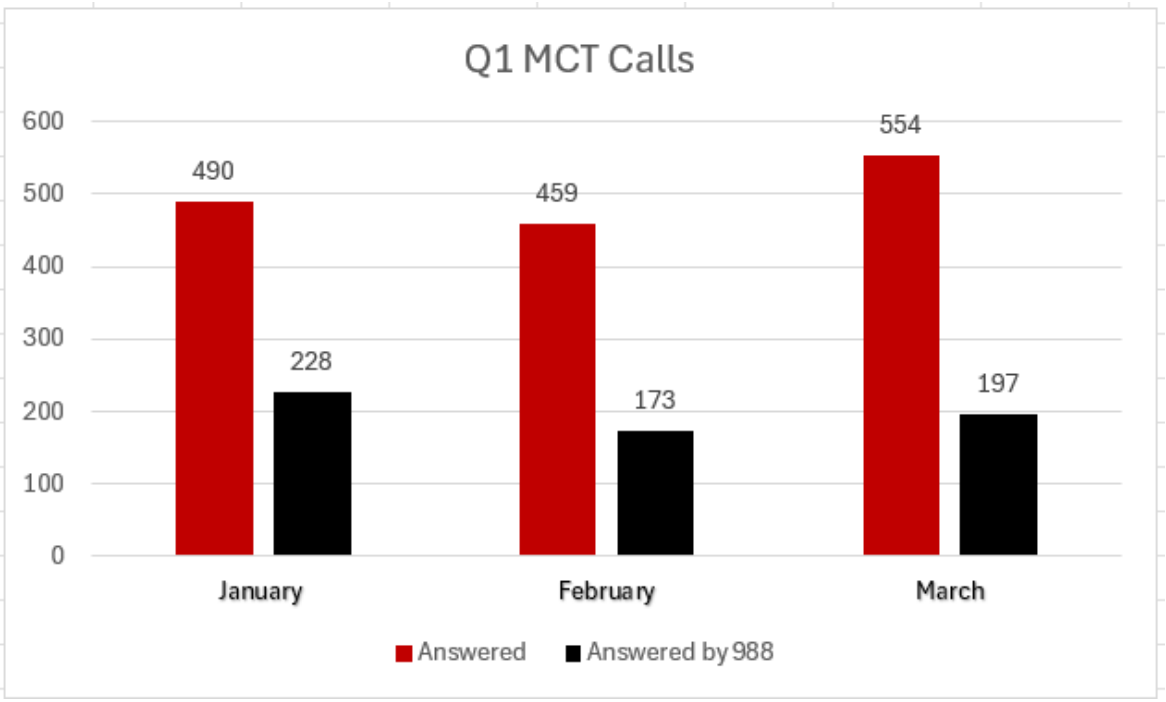
Zip Code	Count	Region
45202	96	Over-the-Rhine
45203	26	Cheviot
45204	18	Price Hill
45205	99	East/Lower Price Hill
45206	39	East Walnut Hills
45207	15	Sayler Park
45208	23	Hyde Park
45209	26	Oakley
45211	140	Westwood
45213	35	Pleasant Ridge
45214	44	East Price Hill
45216	19	Carthage
45219	44	Clifton
45220	30	Cumminsville
45223	62	Northside
45224	59	College Hill
45225	35	South Fairmount
45226	6	Hyde Park
45227	33	Mariemont
45229	120	Avondale
45232	43	Winton Place
45238	96	Price Hill
45001	3	County
45002	14	County
45030	16	County
45052	1	County

Zip Code	Count	Region
45140	3	County
45212	23	County
45215	69	County
45217	16	County
45218	10	County
45230	37	County
45231	72	County
45233	11	County
45236	35	County
45237	78	County
45239	49	County
45240	41	County
45241	25	County
45242	14	County
45243	10	County
45244	2	County
45246	16	County
45247	18	County
45248	19	County
45249	14	County
45251	16	County
45252	3	County
45255	12	County
Unknown	87	

COUNT DOES NOT EQUAL TOTAL RUNS DUE TO COMMUNITY RESPONSES WHERE PATIENT DID NOT HAVE HAMILTON CO. RESIDENTIAL ADDRESS/TRIAGES CALLS OUT TO OTHER COUNTIES.

CALL CENTER

The visuals below summarize the phone data for Q1 2026 for the Mobile Crisis Team. Calls are answered by either MCT Clinicians, Peer Specialist or routed to 988 if no MCT staff person is available to answer.



The average speed of answer in Q1 was 0:09 and the average length of a triage call was 5:53.

The data shows a 68.5% phone call answer rate by MCT staff for Q1.

MCT RESPONSE AND INTERVENTION

MCT Response Type	Quarter 1 Count	Percentage Count
Phone Consultation	590	32%
Onsite Response	1261	68%
Total	1851	100%

A phone consultation can be defined as a call coming into the main Mobile Crisis phone number that is answered by an MCT worker. During this call, it is determined that an on-site response is either not warranted/appropriate, or the call is de-escalated via phone.

An on-site response is defined as either an MCT Clinician and/or peer specialist (alone or in a pair) or MCT paired with law enforcement or a partner agency responding in person to a mental health crisis.

Shift Responding	Quarter 1 Count	Daily Run Percentage
Day (1st shift)	773	42%
Evening (2nd shift)	837	45%
Overnight (3rd shift)	241	13%

Phone Consultations have increased by 115% since Q1 2025 (n=275) and on-site responses have slightly increased (1.2%) from Q1 2025. This is likely a result of secured staffing and integration with 9-11 countywide, plus an overall increase in interventions.

92% of the time, MCT responds to on-site assessments within 0-60 minutes. Greater response times include requests to schedule later or at times that work for the patient or referent, or times when MCT is understaffed. MCT is still far exceeding the national benchmark for response times **(SAMHSA).**

MCT Response Time	Quarter 1 Count	Quarter 1 Percentage
0-60 Minutes	1154	92%
1-2 Hours	42	3%
2-4 Hours	15	1%
4+ Hours	50	4%
Consult Only	590	32% of total interventions*

Consult-Only refers to each phone encounter the clinicians have with a patient or referent in which the caller is triaged to either have a clinician response ASAP or delayed per need reported by the caller, or if the issue is more appropriate for 9-11 due to the medical emergency. During the Consult Only, de-escalation is provided if needed, and if the caller is better served on a non-crisis line, this may be a referral placed by the clinician. *Consult-Only numbers are not included in "response time %".*

Geographic Region	Quarter 1 Count	Quarter 1 Percentage
District I	201	11%
District II	220	12%
District III	466	25%
District IV	287	15%
Outside of Cincinnati (In HamCo)	584	32%
Outside of Hamilton County	33	2%
Unknown	57	3%

MCT Interventions	Quarter 1 Count	Quarter 1 Percentage
SOB/Hospitalization	311	17%
Assessment/No SOB	432	23%
Consult Only	590	32%
Attempted Intervention	518	28%

District	SOB/ Hospitalization	Assessment/No SOB	Consult Only	Attempted Intervention
D1	50	50	39	63
D2	42	50	58	74
D3	64	86	146	160
D4	58	69	85	81
County	97	167	182	140

*** COUNT DOES NOT EQUAL TOTAL DUE TO COMMUNITY RESPONSES WHERE PATIENT DID NOT HAVE HAMILTON CO. RESIDENTIAL ADDRESS/TRIAGES CALLS OUT TO OTHER COUNTIES.**

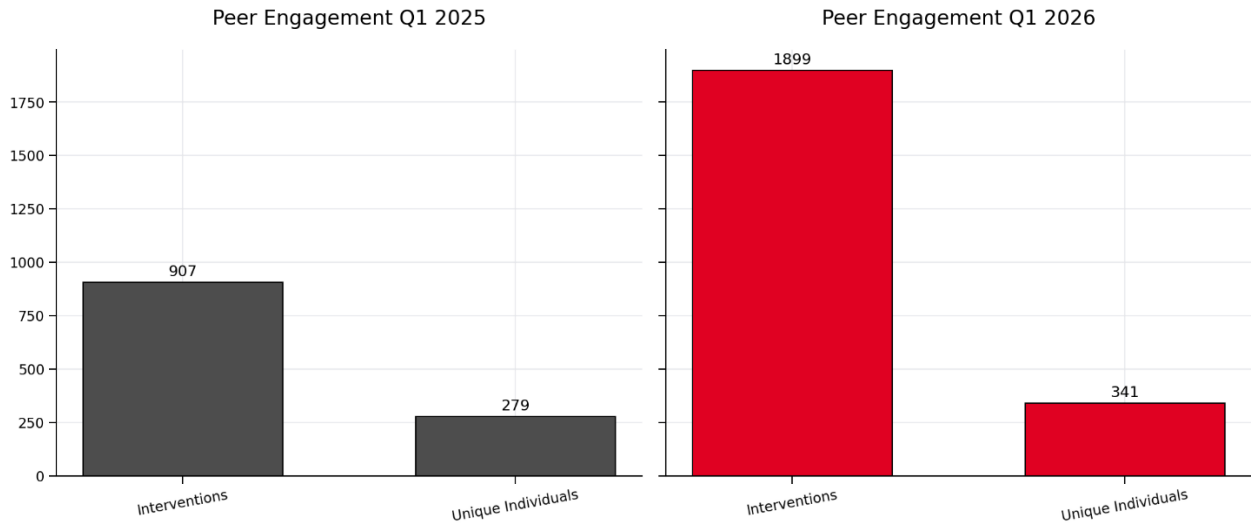
Resource Responding	Quarter 1Count	Quarter 1 Percentage
MCT Only	328	26%
MCT with Law Enforcement	886	70%
MCT with Partner Agency	22	2%
MCT with EMT/EMS	25	2%
Consult Only	590	32%**no in-person response*

MOBILE CRISIS PEERS

Peer Support Specialists provide follow-up after Mobile Crisis encounters to help individuals stabilize and connect with ongoing care. These services focus on engagement, emotional support, and removing barriers during the critical period immediately following a crisis.

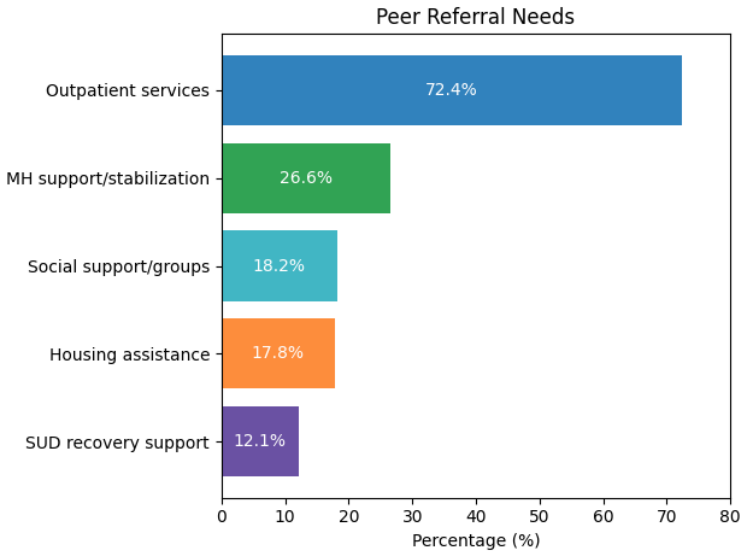
Peer support acts as a bridge between crisis stabilization and long-term care. The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes peer support as an evidence-based practice associated with cost-effectiveness, reduced hospitalizations, increased engagement in treatment, and decreased behavioral health symptoms.

In Q1 2026, Peer Support Specialists delivered nearly 2,000 interventions and reached 341 unique individuals. This includes those engaged through co-response with clinicians during Mobile Crisis Team runs, as well as follow-up and discharge-related interactions.

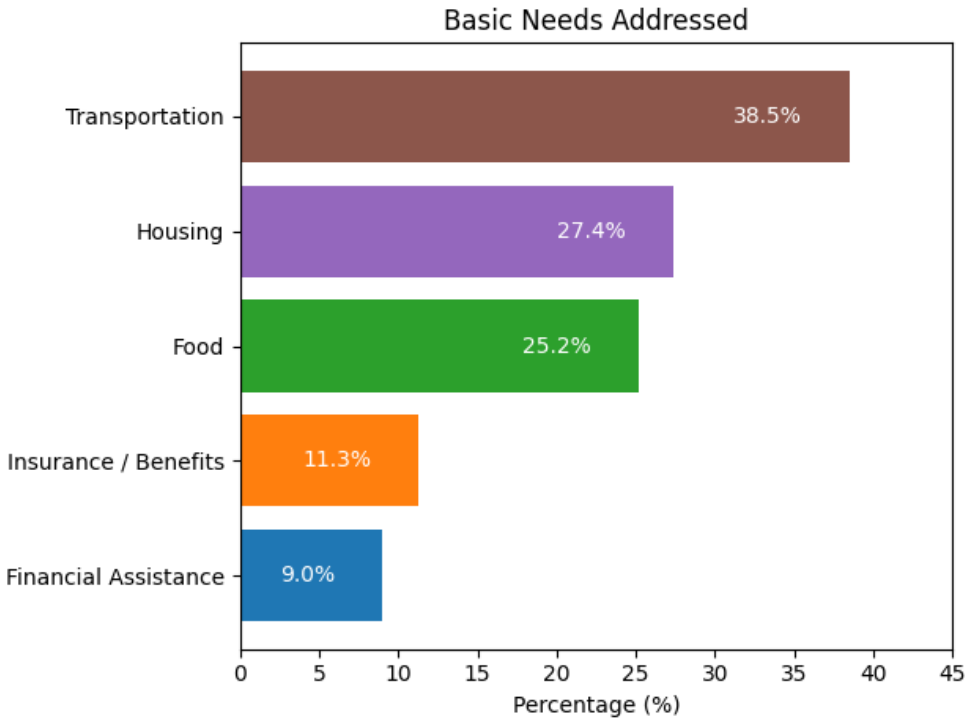


Referrals and Identified Needs

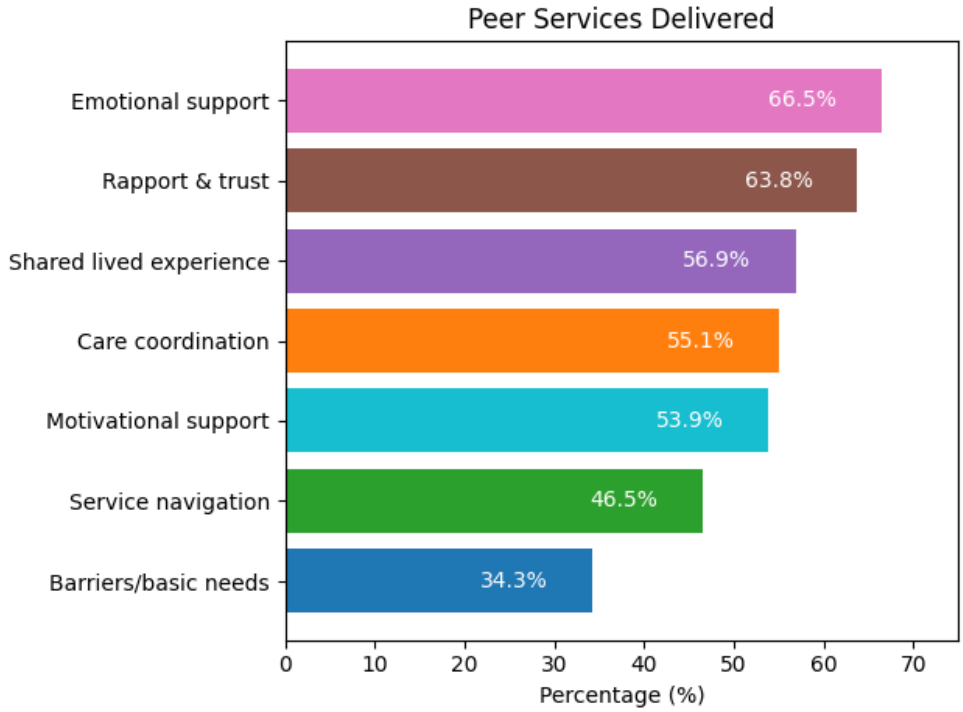
Referrals represent individuals requiring ongoing peer follow-up beyond initial engagement. From January- March 2026, the peer team received 214 referrals. The most common needs identified Are listed below. Many individuals were referred with multiple needs



When basic needs were addressed, the most common areas included:



Among cases where peer services were delivered, the most common services included:



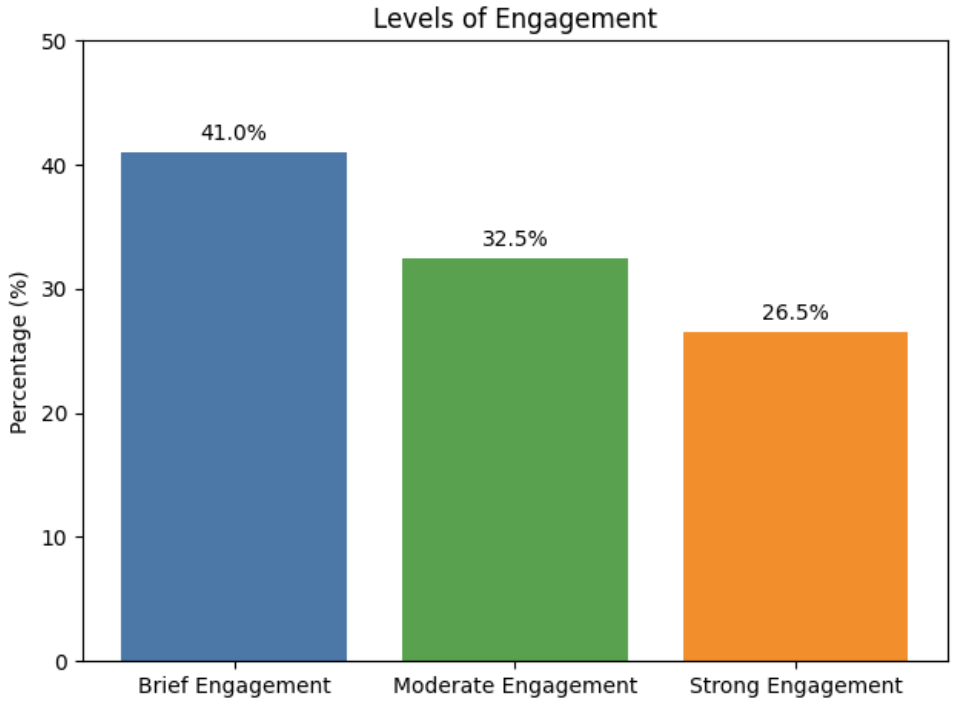
Peer support services provided during engagement reflect a combination of emotional support, relationship building, and practical assistance aligned with national peer support competencies.

Peer Engagement and Follow-Up

Across all referred cases, 70.8% of individuals were successfully contacted by a Mobile Crisis Peer Support Specialist. Most individuals required multiple outreach attempts prior to successful engagement.

In addition to outreach efforts, Peer Support Specialists are responsible for daily review of individuals identified as “Left in Community” with a safety plan. This includes completing a follow-up call within 24 hours to assess current safety, reinforce use of the safety plan, and provide ongoing support and resources.

For referred cases, engagement was categorized based on the level of interaction between the Peer Support Specialist and the individual.

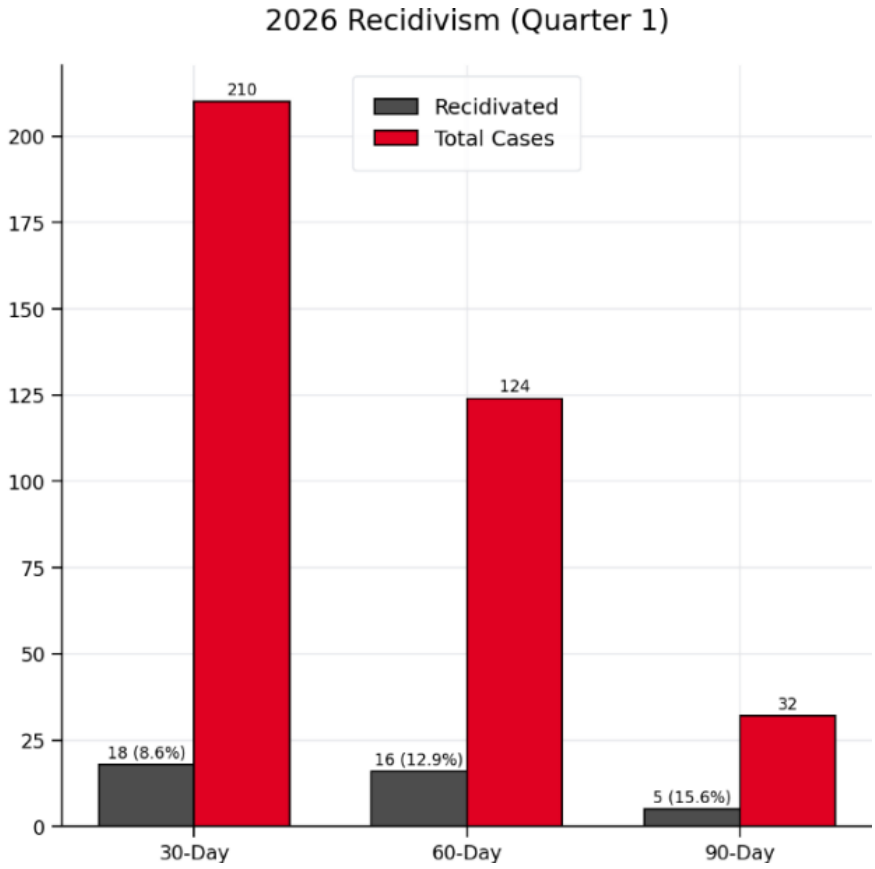


Peer Recidivism Data

Recidivism is defined as a return to crisis-level services (emergency department, psychiatric emergency services, mobile crisis, or hospitalization) for behavioral health needs. It is measured at 30, 60, and 90 days post case closure via chart review.

National estimates indicate that 11.1% of emergency department visits for psychiatric conditions involve co-occurring substance use disorder (NIH). Relapse rates range from 40–60% for substance use disorders and up to 80–90% for opioid use disorder within six months (SAMHSA).

Peer Support interventions are associated with reduced hospitalizations, increased outpatient engagement, and decreased substance use and psychiatric symptoms, supporting lower recidivism rates.



In calendar year 2025, 77.2% of individuals engaged with Mobile Crisis Peer Support did not return to crisis-level care within 90 days.

For Q1 2026, recidivism rates were 8.6% at 30 days, 12.9% at 60 days, and 15.6% at 90 days. These outcomes are substantially lower than national relapse and return-to-care estimates, which range from 40–90%, indicating improved outcomes among individuals engaged in peer support services.

Referral sources reflect high-acuity settings: 24.3% originated from Psychiatric Emergency Services (PES), 3.3% from inpatient units, and 1.9% from Bridge Clinic discharges in Q1 2026.

Evidence indicates that timely post-crisis follow-up is critical, as the immediate period after a crisis is associated with elevated risk for return to services.

OUTREACH AND EDUCATION

MCT participated in over 10 outreach and education events in Q1 2026. Some of the events included:

- 513 Relief Bus Services
- Mental Health Education for Huntington's Disease
- CIT Steering Committee Data Presentation
- Education/Presentation for Loveland Police Department
- Collaboration with the Hamilton County Health Department
- Together Tuesdays
- City Gospel Missions Community Event
- Community Food Drive
- Winton Woods High School Mental Health Awareness Event
- Mental Health lunch and learn for Seniors

Upcoming for Q2 2026:

- 513 Day
- Letteria Dalton Foundation Walkathon & Wellness Event
- The Help Squad
- Hartwell Food Pantry
- One Stop (Re-entry)
- Mt. Healthy Care Connection
- Turner Construction Helping Hands at main Library
- UC Health Day
- Together Tuesdays

SUCCESSES AND OPPORTUNITIES

Fire/EMS Collaboration

Grant funding has been approved to expand collaboration between the Mobile Crisis Team (MCT) and Fire/EMS. Implementation is underway, with staffing in progress. This initiative is expected to strengthen interdepartmental coordination and increase community impact.

Peer Specialist Capacity and Training

The Peer team is nearing full staffing (5.0 FTE). Team members have completed 988 crisis call training, enhancing their ability to support triage efforts and expand community availability.

Staffing

Staffing shortages in Q4 resulted in increased workload and strain on existing staff. Active recruitment and hiring efforts are underway to fill open positions.

Training and Workforce Development

A standardized onboarding and training curriculum has been implemented for new staff, including clinical competencies, on-the-job training, and six weeks of shadowing. Leadership conducts final evaluations to assess readiness.

Safety Training

MCT clinicians are participating in safety and situational awareness training in collaboration with CPD. These trainings are designed to improve staff safety and confidence in the field.

Hospitalization Rates

The percentage of individuals transported to hospitals on a Statement of Belief decreased by four percentage points from FY23–24 to FY24–25, despite increased intervention volume. This reduction is attributed to enhanced clinical skills (e.g., de-escalation and stabilization) and increased peer engagement. Further reductions are anticipated with the opening of Hamilton County's Crisis Receiving Center.

Sustainable Funding

Securing long-term funding remains a priority. Continued investment from county and city sources will be essential to sustain and expand 24/7 operations and staffing.

Peer Program Development

In early 2026, a Peer Supervisor role was established to support increased referral volume, improve consistency in follow-up and outcomes, and provide additional program structure as services expand.