Questions on MCT from the Reimagining Public Safety Task Force

1. **How is mobile crisis activated (is this through dispatch system or do people call mobile crisis directly)?**

   Mobile Crisis can be contacted through the dispatch system (911 or 981-5900) or via a direct phone message (981-5254). When contacting through dispatch, the caller can report a need and whether it is urgent or not. Urgent calls are dispatched immediately, and BPD will be activated and MCT if they are available. If MCT is not available, BPD will respond to the urgent call without MCT. A non-urgent call to dispatch can request that MCT call them back to consult, just like a direct voicemail to MCT.

   MCT can "activate" or go to a field call after being sent by the dispatch system, or they can activate themselves (by calling dispatch) after consulting on the phone with a community member. Either way, the dispatch system is involved in the activation of the MCT.

2. **How do you measure impact of effectiveness? For example, by comparing days mobile crisis is available versus not?**

   This is something we are still developing formally. We are in the process of finalizing a set of outcome measures as part of a mental health division wide effort to set Results Based Accountability measures for all internal programs.

   Informally, we have looked at the following items to get a sense of effectiveness:
   - Feedback from community (stakeholders like Mental Health Commission, community groups, etc.)
   - Feedback from clients served
   - Feedback from internal stakeholders (COB Divisions, including BPD)
   - % of calls 5150 calls that lead to a transport for to a receiving station (lower the better, this means more diversion) This could also mean that a higher rate of low acuity calls are being referred to MCT rather than a static acuity level of referrals being diverted to lower levels of care

   In a perfect world, we would want to measure things like percent of mental health crisis calls that involve a MCT response, but we do not have dispatch data to do this.

3. **What services do people need that are not currently available in Berkeley?**

   This is a really big question. From a crisis perspective, it's important to understand that COB services are focused on individuals who are eligible for Medi-Cal and that these services are part of the Alameda County Behavioral Healthcare Plan – we don't operate separately, but as part of a larger network.

   That being said, some of the needs identified in Berkeley include:
   - More permanent housing
   - More permanent supportive housing
   - More transitional housing
   - More acute and sub-acute setting where individuals in crisis can get care

- More options for individuals who are primarily experiencing substance use disorder caused crisis, including:
  - Sobering Centers
  - Treatment for stimulants
- Easier access to psychiatry services
- More Medi-Cal eligible therapy provider options
- More mental health prevention resources to promote resilience and prevent crises

4. **Do you provide case management (eg track clients who need intensive services)? If not, how do you coordinate services for a person who needs services?**

Crisis Services is one of three branches of Berkeley Mental Health's services (the other two are Adult Services and Family, Youth, and Children's Services), and this encompasses the Mobile Crisis Team (MCT), Transitional Outreach Team (TOT), and Crisis Access and Triage (CAT). MCT will see clients during field calls, and TOT is available to follow up after the crisis has passed to offer linkage to longer term services if the client is not already connected. This linkage can include short term case management to reconnect the client to previous services.

The CAT Team is the entry point for clients who are interested in getting linked to longer term services through Berkeley Mental Health; including residents who may qualify for a lower level of service than BMH provides. CAT provides engagement, assessment, information and referrals to mental health services with and outside of BMH. The CAT and TOT teams have recently been combined into a larger more flexible unit since their work is very similar along the continuum of access to services.

The bulk of Berkeley Mental Health services involve case management. The Division's Service teams include ongoing clinical case management as one of the primary methods of treatment. MCT is designed to be about 5% of BMH's staffing, whereas ongoing service teams make up approximately 56% of BMH's staffing. These long-term service teams coordinate care for clients who have opted in to mental healthcare and coordinate with the clients and other treatment team partners.

5. **Why has it been so difficult to staff the current team?**

Sustainable staffing for the team has been a challenge for a variety of reasons:

- The position requires non-traditional hours, including nights, weekends, and holidays from 11:30am-10pm.
- The position requires a very specialized skill set, and by individuals who want to have regular crisis involvement
- The position requires staff members who want to have a close relationship with BPD
- COB hiring freeze that occurred well in to the COVID-19 pandemic.
- The hiring process requires the use of lists, that until recently, where only renewed after an extended period (12-18 months). However, we recently partnered with HR to make a continuous list for the clinician positions – so its always an open recruitment
- Limited ability for HR to do a comprehensive recruitment for the specialized role. We are working on identifying ways in which we can build capacity

- There have been more options available during/after the pandemic for clinical staff to work in remote settings that provide flexibility for family and self-care, and MCT work is defined as field work.
- Other providers (including CBO's) have brought their salary and benefits packages up closer to parity with COB.

6. **If can't staff the current team, what prospects might there be for expansion of the MCRT role?**

   From our perspective, the general uncertainty of the future role of MCT vs. SCU makes expansion discussions premature. A critical component of Council's Omnibus package was to move toward having a Specialized Care Unit that can respond effectively and deescalate crises without involvement of the police. This has been a significant priority for many community members, including crises system users, for some time, and we are really working to honor this expressed need and expectation through our community engagement process and proposed model design. Our preliminary findings is that there is a need for an SCU that is valued and treated on the same level as police and fire that responds to non-criminal mental health, substance use, or other behavioral/emotional crisis. The role of the MCT in this model remains unclear.

   That said, if expanding the MCT was a priority for COB, we would develop a strategy that included recruitment, funding, and operating hours. Assuming that we are simultaneously talking about implementing the SCU, we would also have to develop clear roles and boundaries, how the two collaborate (and where they do not), and how they collectively engage with the police. One thing that would be strongly rejected by the SCU steering committee, and I believe all of the community members who advocated for the SCU, would be any model that prioritizes MCT or PD over the SCU. The SCU has to be an equal integral, and trusted partner within the crisis response system if it is going to have a chance to make a significant impact on crisis response in our community.

7. **How does inability to staff affect prospects for hiring other non-sworn reimaging functions:**

   This really depends on the function. In general, the more the hiring can be done flexibly, the better the chances for success. Also, if hiring other non-sworn reimagining functions were the were the top priority for the City, we would want to work with our human resources department and City leadership to prioritize as best we can while also meeting other critical city hiring needs.

8. **Is the issue the salary scale, the job functions, the hours or do mental health responders have better opportunities with less stress and better hours in other prospective employment?**

   It's a mix of these and other issues. And yes, there are other opportunities where mental health crisis workers may have commensurate or better compensation for similar or less demanding work. Many workers may also need to commute to get to a field position in Berkeley, and closer opportunities for similar work with similar or better pay are available now.