

A Framework for Responding to COVID-19 Impacts

Draft for Discussion / December 4, 2020

SUMMARY

The Legislature, informed by the Commission's success in building capacity for system-level improvements, directed the Commission in the 2020-21 Budget Act to help local governments and community partners improve their response to COVID-19. This framework distills information about the impact of the pandemic on mental health needs and the service system and identifies strategic opportunities for the Commission to consider in determining how to allocate those funds to catalyze improvement in services.

OVERVIEW

The pandemic has simultaneously aggravated conditions for mental health consumers and family members, has expanded risk factors such as anxiety and isolation for all Californians, and has disrupted the ability to provide services to those needing and seeking care. Advocates and service providers are particularly concerned that pre-existing disparities in terms of access to quality care have worsened for some racial, ethnic and cultural communities.

After months of scrambling to adapt services to changing needs, public agencies and service providers are recognizing that what had been viewed as temporary shifts now need to further adapt to meet the longer lasting impacts on the economy and jobs, on home life and social activities, and on the prevalence and characteristics of health and mental health needs.

The Legislature, recognizing the value of the Commission's efforts to drive improvements, authorized the Commission in the 2020-21 Budget to spend \$2.02 million to fortify the public mental health system's response to COVID-19. That spending authorization was in addition to, and was coordinated with, the \$2 million authorized to support implementation of *Striving for Zero*, the state suicide prevention strategic plan. To inform the Commission's decision on how to allocate the COVID-related funds, this framework describes:

1. The intended scope of activities expected by the Governor and Legislature.
2. The needs as expressed to the Commission and reported elsewhere, which are presented here as opportunities for impact.
3. The Commission's strategic priorities as reflected in existing initiatives.
4. Emerging public priorities, especially addressing cultural, ethnic, and racial disparities.
5. The Commission's core capacities and approaches for leveraging change.

Within the scope of the legislative intent, the Commission is most likely to have a significant impact on COVID-related needs by authorizing activities and expenditures that align its strategic priorities and its capacities to drive targeted improvement in the mental health system.

1. LEGISLATURE'S SCOPE OF INTENDED ACTIVITIES

Discussions with legislators and their staff produced two possible objectives for the project:

- ✓ Support county behavioral health agencies and their community-based service providers to adapt to the three-fold challenge of 1) meeting the changing and increasing mental health needs associated with the pandemic, 2) providing services in ways consistent with public health requirements, and 3) sustaining essential services with declining revenues.
- ✓ Engage other community government partners such as schools, as well as private sector health providers and employers and other potential allies, to develop and scale mental health models that would respond to the broader public mental health needs resulting from the pandemic.

2. NEEDS AND OPPORTUNITIES FOR IMPACT

Studies by the Centers for Disease Control and others have documented increased incidents of anxiety and depression, suicidal ideation and substance use as a result of the pandemic, the social disruptions and economic fallout. The impacts have exacerbated pre-existing economic, health and mental health disparities in low-income communities with high concentrations of people of color. The Commission augmented that baseline information with the following:

- ✓ Staff interviewed Triage grantees early in the epidemic and documented disruptions to the service system and the adaptations made to keep staff safe while maintaining crisis services and adjusting to virtual service delivery. Attachment A summarizes those interviews.
- ✓ The Commission distributed a survey to county agencies, community service providers and stakeholders and received more than 200 responses. Respondents validated an increase demand for services, while also struggling to connect with individuals in need of care. The rapid shift to tele-mental health services raised concerns that clients without digital access will be left further behind. Providers anticipate long-term challenges associated with declining staff and revenues. Attachment B summarizes key findings of the survey.
- ✓ The Commission launched a Rapid Response Network with Social Finance, which developed detailed expert responses to challenges facing counties, community service providers and county First Five Commissions. The requests are one indicator of how the pandemic stressed the service system. Requests included information regarding telehealth and other adaptations of care, managing the needs of homeless individuals, evaluating adaptations and business operations. The project also documented the value of rapidly providing specific information to service providers adapting to a changing environment. Attachment C summarizes those activities.
- ✓ The Commission and its subcommittees also have received comments in public meetings throughout 2020. The Client and Family Leadership Committee will meet December 9, 2020 to provide feedback on this framework and to solicit additional public input.

- ✓ The Commission has received two direct requests for funding. On June 16, Teachers for Healthy Kids requested \$50,000 to provide training to mental health practitioners in schools. On September 8, the Cross Population Sustainability Steering Committee of the California Reducing Disparities Project urged the Commission to allocate \$2 million to Community-Defined Evidence-Based Practices to address the impacts of systemic racism compounded by COVID-19.

3. COMMISSION'S STRATEGIC PRIORITIES

The Commission, often in consultation with the Administration and Legislature, has prioritized issues where innovations and improvements in the service system can significantly improve outcomes for individuals and communities and reduce economic losses, public costs and personal hardship. The Commission has pursued these priorities with a portfolio of activities, which have directed resources and attention, are building capacity and momentum, and are having impact. The following initiatives could be expanded to address pandemic related needs.

- ✓ **School mental health.** The Commission is promoting the recommendations in *Every Young Heart and Mind: Schools as Centers of Wellness*, implementing the Mental Health Student Services Act and Triage grants, and exploring ways to increase federal funding.
Opportunities to link and leverage:
 - Support sustainable community partnerships. The Commission could fund technical assistance to some or all of the 40 counties that were interested in MHSSA grants but did not receive funding. The technical assistance could help them develop partnerships with available funds, including using Innovation funds that are at risk of reversion, and improving access to federal funds.
- ✓ **Early Psychosis Learning Healthcare Network/EPI+.** The Commission is supporting the development of a healthcare learning network focused on responding early to psychosis, using the nationally recognized Coordinated Specialty Care model. In partnership with UC Davis, the Commission has helped establish a learning collaborative with 11 county and community partners. The Commission has authorized \$5 million to expand access to care, improve awareness, increase diversity in the workforce, and study barriers to services for diverse groups and reimbursement mechanisms for public and private insurers.
 - Early Psychosis and COVID. Stress can trigger psychotic symptoms for those who are at high risk. Expansion of services for first episodes of psychosis could be a critical step to meeting emerging needs; focus could be placed on reducing racial, ethnic and cultural disparities exacerbated by the pandemic.
- ✓ **Youth Empowerment.** The Commission is partnering with Stanford to launch and scale allcove, has funded five youth drop-in centers, supported a series of youth innovation labs and is implementing the state Suicide Prevention Plan, an issue of particular concern during the pandemic.

- Youth and COVID. The Commission could support increased collaboration among partners working on school mental health, youth drop-in programs, suicide prevention and early psychosis programs to improve the integration of these services. Children, youth and families need these programs, which are largely operated independent of each other, to work seamlessly as youth and families move along a continuum of needs.
- ✓ **Prevention and Early Intervention.** The Commission’s project to advance prevention and early intervention is exploring the imperative to increase awareness and connect people and families to mental health supports and services as early as possible. This need is elevated by the increased depression, anxiety and other mental health needs associated with the pandemic, especially in underserved communities.
 - Support county responses to timely access. The Commission could support training and a learning community to help counties deploy respectful and culturally and linguistically competent engagement with communities that are disproportionately impacted by the pandemic, including the development of networked partnerships with cultural brokers, traditional healers and other culturally diverse service providers.
- ✓ **Workplace Mental Health.** Low-wage “essential workers” and their families, who are disproportionately people of color, have been particularly hard hit by COVID-19. The stigma associated with acknowledging a mental health issue in the workplace is compounded by the different characteristics of stigma in distinct racial, ethnic and cultural communities.
 - Support employer-advocate partnerships. The Commission could explore partnerships between employers, employer associations, labor unions, community organizations and stakeholder groups to build awareness, counter stigma and connect workers to services.

4. EMERGING PUBLIC PRIORITIES

- ✓ **Disparities / Diverse communities.** The disproportionate impacts of the pandemic and renewed calls for social justice have amplified the need to address racial, ethnic and cultural disparities. Solano County presented at the Commission’s November meeting on a successful Innovation project that engaged diverse communities to better understand their needs and to tailor strategies and services to those communities.
 - Support a learning community to adapt the Solano model. Nearly 40 counties have expressed interest in learning more about the Solano process. The Commission could support learning, adaptation and replication of the community engagement and design process to respond to historic disparities that have grown worse during the pandemic.
- ✓ **Behavioral Health Disaster Planning.** As the pandemic worsens, officials are equally concerned about the impact of multiple and diverse disasters. The Department of Health Care Services drafted an emergency preparedness plan that would benefit from increased public engagement and review. Butte County responded to the Paradise fire with an Innovation project to pilot a recovery center to support mental health needs.

- Support county mental health disaster planning. The Commission could support training and a learning exchange for counties that want to improve capacity to respond to the mental health impacts of COVID-19 and future disasters.
- ✓ **Rapid Response Network 2.0.** The Rapid Response project tapped into a national network of experts and practitioners to distill the best available information to specific and urgent challenges facing service providers. The project also revealed the potential for a knowledge network to drive cooperative improvement across systems.
 - Connect community partners with information. The next iteration of the Rapid Response Network could focus on aligning and meeting the information needs of community partners who need to work together to support those most impacted by the pandemic.

5. OPPORTUNITIES TO LEVERAGE CHANGE

To advance these priorities, the Commission has developed strategic approaches to drive transformational change, including research and evaluation, policy development, financial incentives, and technical assistance and capacity building. The following opportunities align prioritizes and strategic approaches to benefit Californians most impacted by the pandemic.

Strategic Project Opportunities			
Priorities	Strategic Approach	Impact on Individuals	System-level impacts
School Mental Health	T/A for new county-school partnerships	Strengthen connection and services to children	Partnerships can link funding, other resources
Early Psychosis	Expand learning network to reach culturally and geographically isolated	Connect and serve high-risk and underserved individuals	Fill high priority service gaps for high-risk underserved individuals
Youth	Support youth leaders to identify and fill gaps	Strengthen services for high-risk individuals	Increase peer voice and leadership
Prevention & Early Intervention	Promote awareness and connection to support	Reduce suffering from unmet needs	Fortify effective outreach to reduce disparities
Workplace Mental Health	Engagement with employer community	Improve access for low-wage essential workers	Reduce stigma, build workplace awareness
Reducing Disparities	Learning collaborative to adapt Solano INN project	Increase peer voice and services to underserved	Strengthen community engagement throughout
Behavioral Health Disaster Planning	Link state-county efforts to improve response	Serve most vulnerable during emergencies	Develop models for replication elsewhere
Rapid Response Network	Link knowledge with critical service needs	Adapt services to those most impacted	Develop a model to accelerate learning

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Attachment A: COVID-19 Impact on SB 82 Triage Programs

Shortly after the Coronavirus struck California, in late March and early April 2020, the Commission's Triage team contacted all 30 triage programs established under Senate Bill 82 (Adult/TAY, Ages 0-21, and School Collaboration). At that time, the onset of COVID-19 was still recent, and the programs were adjusting to the shelter-in-place recommendation and county public health guidelines while preparing for a surge in COVID-19 cases and mental health crisis calls.

Highlights:

- The COVID-19 outbreak is causing delays in triage program implementation and expansion, specifically, in Los Angeles and Sacramento Counties.
- Due to the overall COVID-19 impact, many families are struggling and putting services on hold, which negatively impacts the triage programs' revenue and billable services. Flexibility is needed to allow billing for multiple shorter sessions during the week.
- Many of the triage programs would benefit from standardized materials and/or trainings on how to conduct mental health services more effectively using telehealth methods.

Common Experiences:

- Focus on prevention of mental health crisis and unnecessary hospitalization
- Initial decrease in mental health crisis calls, followed by a steady increase
- Difficulty obtaining PPE
- Preparing for overcrowded ERs and requesting a temporary exclusion to the IMD waiver from DHCS to increase bed capacity for clients experiencing psychiatric emergencies
- Hiring freeze
- Increase in staff absences
- Lack of communication with the homeless population
- Increased responsiveness from TAY clients and families through utilization of telehealth methods

Program Modifications:

- Ramping up telehealth options for mental health screenings and diversion from ERs
- Moving other staff into triage roles to address mental health crisis needs
- Minimizing face-to-face contact with clients unless necessary to prevent further mental health crisis
- Proactively contacting high utilizers of mental health or special education services to address mental health needs and provide navigation to services
- Launching or expanding warm lines to address COVID-19 specific anxiety and depression
- Rehabilitating existing facilities for use as additional Mental Health Rehabilitation Centers with DHCS certification
- Adjusting staff's work schedules to accommodate uptick in crisis calls occurring later in the day
- Obtaining telehealth consent verbally
- Developing practices for a digital warm handoff to link families to services via conference calls
- Inquiring with families about their technological capacity, food stability, and support needed in applying for benefits

Attachment B: Survey of COVID-19 Related Impacts

December 2, 2020

SUMMARY

The Mental Health Services Oversight and Accountability Commission (MHSOAC) requested information from county behavioral health agencies, community services providers, peers, family members, and stakeholders to better understand the impact of the pandemic on Californians and the system designed to meet their mental health needs. The responses are consistent with the findings in more scientific studies, which underscore and validate the impacts of the novel Coronavirus 2019 (COVID-19), including the necessary public health restrictions and the negative impacts on the economy and employment. The survey is part of the Commission's public engagement effort to inform activities to help the mental health system better serve Californians most impacted by the pandemic.

METHODOLOGY

The MHSOAC created two surveys, one for service providers and another for stakeholders, to assess the impact of COVID-19 on mental health services across California. Services providers include county behavioral health departments and mental health service providers. Stakeholders are defined as community-based organizations that provide outreach and advocacy for specifically defined populations, including immigrant groups and other underserved communities. The Commission, for instance, received responses from the Hmong Cultural Center in Butte County, the Friendship House Association of American Indians, the Center for Sexuality and Gender Diversity, and the La Familia Counseling Center. The Commission heard from county First 5 Commissions, school districts and county offices of education. Survey respondents were not randomly selected. Survey respondents included individuals with first-hand knowledge of the pandemic's impact identified through targeted outreach.

All county behavioral health departments and mental health service providers with a prior partnership or association with the MHSOAC received a survey. The MHSOAC received 165 responses. Responses were received from 31 of the 59-county behavioral health agencies and 134 community service providers. The MHSOAC received 107 responses from stakeholders. The breakdown of respondent occupations is displayed in Figure 1 and Figure 2 below.

Survey Design and Limitations

Both surveys included the same 13 opened-ended, closed, Likert-scale, and multiple-choice questions tailored to the appropriate audience. Both surveys shared the same survey limitations, which include non-response to questions, response bias, question interpretation, and other mediating factors.

Figure 1. Service Provider Survey Breakdown of Respondent Occupations

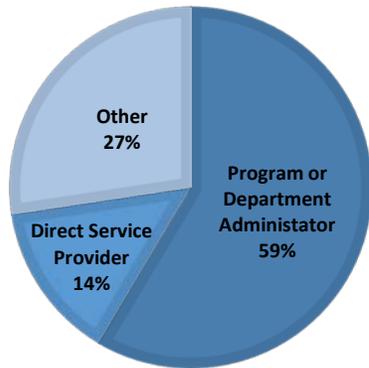


Figure 1. displays the occupation of service provider respondents: program or department administrator (59%), direct service provider (14%), and other (27%), which includes program coordinators and program analysts.

Figure 2. Stakeholder Survey Breakdown of Respondents Occupations

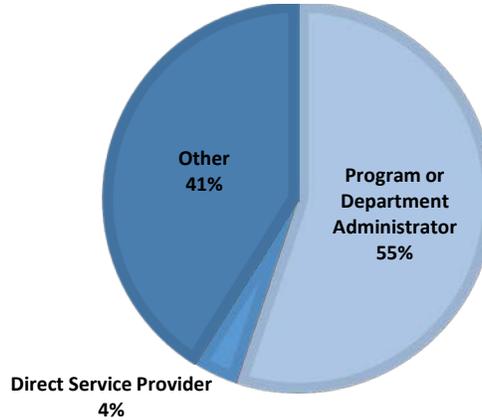


Figure 2. displays the occupation of stakeholder respondents: program or department administrator (55%), direct service providers (4%), and other (41%) which includes program coordinators and program analysts..

Table 1: Geographic Distribution of Respondents

Geographic Distribution of Respondents		
Region	Service Providers	Stakeholders
Far Northern California	26.7%	28.9%
North Coast	5.6%	5.3%
San Francisco Bay Area	16.1%	13.2%
Northern San Joaquin Valley	8.7%	7.9%
Central Coast	3.7%	8.6%
Southern San Joaquin Valley	19.3%	14.5%
Inland Empire	2.5%	3.3%
Los Angeles County	6.2%	13.2%
Orange County	9.3%	2.0%
San Diego-Imperial	1.9%	3.3%

Table 1. displays percentages of the geographic distribution of survey respondents. This distribution uses the US Census Bureau 2020 California Regional map to display results. Superior California is labeled as Far Northern California.

Far Northern California and Southern San Joaquin Valley had the highest response rates. Far Northern California had the highest response rates. Sacramento County represents 51.1% of respondents in Far Northern California. Butte County represented 30.2% of stakeholder respondents for this region. Southern San Joaquin Valley had the second highest response rate. 61.3% of service provider respondents were from Kern County. Followed by 86.4% of stakeholder respondents from Fresno County.

San Diego-Imperial and Inland Empire had the lowest response rates. San Diego-Imperial region had the lowest response rate with 1.9% of service providers and 3.3% of stakeholders completing the surveys. The Inland Empire had a comparably low response rate with 2.5% of service providers and 3.3% of stakeholders completing surveys.

KEY FINDINGS

The following toplines highlight the COVID-related concerns and service barriers.

Impacts on Clients

- Service providers reported a somewhat to significant increase among clients in terms of: family stress (95.4%), isolation (93.4%), school-related stress (88.7%), increased trauma symptoms (86.5%), unemployment (81.5%), clients need for services (82.5%), need for housing support (80.1%), and physical health concerns (75.8%).
- Stakeholders reported similar findings of a somewhat to significant increase among clients in terms of: Isolation (93.9%), increased trauma symptoms (90.7%), need for housing support (83.7%), unemployment (82.47%), need for crisis services (81.6%), and physical health concerns (72.9%). In addition, stakeholders identified a somewhat to significant increase in medication issues (52.58%).
- Additionally, service providers and stakeholders provided further insight of trends prevalent among clients as a result of COVID-19. These trends include increases in domestic abuse, violence in the transgender community, mental health concerns and gaps in services in the LGBTQ+ community, underreporting of child abuse, intergenerational trauma, and substance abuse. Isolation and lack of motivation stemming from limited social connectivity and distance learning challenges are especially prevalent in high school students.

Impact on Service Delivery

- Service providers identified the following types of services as either challenging or extremely challenging to deliver during the pandemic: group therapy (68.9%), interactive therapy (60.6%) individual therapy (58.5%), family therapy (57.0%), drop-in centers (51.8%), and wraparound services (48.9%).

- Stakeholders reported that the following types of services as either challenging or extremely challenging for clients to obtain: group therapy (69%), drop-in center services (63.5%), interactive therapy (62.8%) family therapy (56.5%), individual therapy (56.3%), and wraparound services (48.2%).

Service Delivery Modifications

- Service providers identified the greatest changes in service delivery: individual therapy via telemental health (TMH) (87.0%), in-person visits with PPE (61.8%), group therapy via TMH (51.2%), alternative care outside the office setting (49.6%), and hybrid treatment model (48.1%).
- Stakeholders indicated the following modifications to be most prevalent: individual therapy via telemental health (89.7%), in-person visits with patients requiring PPE (65.5%), group therapy via telemental health (60.9%), and hybrid model of treatment (60.9%).

Target Population Outreach

- The following target populations have become hardest to reach for service providers: homeless/transitionally housed (61.1%), older adults (48.9%), and younger adults (45.8%). Stakeholders identified homeless/transitionally housed (66.7%), older adults (51.7%), and rural/remote residents (52.6%) as hardest to reach because of the COVID-19 pandemic.
- Respondents to both surveys also indicated difficulty reaching young children, teens, families, LGBTQ+ individuals, the English language learner community, people with disabilities, those with substance use disorders, those without access to technology (Wi-Fi or devices), farmworkers, Native American reservation inhabitants, and those with serious mental illnesses.

Gaps in Service

- Service providers identified the following needs: adequate and accessible technology (64.0%), outreach to specific racial, ethnic, and cultural communities (48.8%), community engagement and planning (46.4%), and group sessions via telemental health (41.6%). Stakeholders reported the following needs to build capacity to provide services: outreach to specific racial, ethnic, and cultural communities (69.0%), community engagement and planning (67.9%), individual sessions via telemental health (65.5%), group sessions via telemental health (61.9%), in-person visits with patients requiring PPE, and crisis services (including warmlines).
- Other gaps in services mentioned in both the service provider and stakeholder survey include housing assistance, medication support services, language support, equal access to technology and adequate training, culturally relevant warmlines and other services,

crisis intervention resources, PPE for crisis intervention professionals and in-person service providers, and safety equipment to allow for compliance with social-distancing and all other COVID-19 public health mandates.

Anticipated Impacts on Service Providers

- Service providers anticipate a decrease in availability of in-person appointments (50.8%) and a higher client-to-staff ratio due to revenue decline (46.2%). Also, stakeholders anticipate need for additional staff (55.4%) and a higher client-to-staff ratio because of COVID-19 (48.2%).
- Other anticipated impacts identified by services providers and stakeholders include: Zoom fatigue, limited assessment capability, staff layoffs, physical location closure, decreased training, increased demand for services, and increased need for providers.

CONCLUSIONS AND CONSIDERATIONS

All of the data points underscore the concerning mental health impacts on Californians, and particularly on those who were most at-risk of trauma and stress, those most vulnerable to disruptions in the economy and housing, and those historically underserved.

While the pandemic is still surging, the factors associated with the social determinants of mental health, such as housing and unemployment, may have some of the most significant lasting impacts that will not be addressed by vaccines and a reduction in disease prevalence.

The data also elevate concerns exacerbated by the pandemic and amplified by the potential loss and long-term impacts on vulnerable and young Californians, such as the prevalence among high school students of “isolation and lack of motivation stemming from limited social connectivity and distance learning challenges.”

As expressed in the Commission’s Framework for Responding to COVID-19 Impacts, these emerging and concerning needs could be met by partnerships to broadly deploy the latest insights and protocols for dealing with stress and trauma in ways that simultaneously address both historic and aggravated racial, cultural and ethnic disparities.

Attachment C: Rapid Response Support Center

Meeting the information demands of emergent pandemic-related mental health challenges

Executive Summary

Learning from the Rapid Response Network pilot. Beginning in early April, the Mental Health Services Oversight and Accountability Commission partnered with nonprofit Social Finance to pilot a new county support mechanism. The Rapid Response Network enabled county officials to easily elevate issues and connect with organizations or experts with relevant information. Over six months, the RRN completed nearly 30 requests. Early requests were largely focused on telehealth and care adaptation; later requests focused more on business and staff planning, evaluation, and care coordination.

The project experienced significant and sustained demand from public leaders for rapid, low-barrier technical assistance. County capacity has been strained to the breaking point by the pandemic. Easy and fast access to expert perspectives and literature reviews helped counties adapt to changing conditions.

Looking toward the future. The pandemic's long-term fallout will be considerable and ongoing: waves of deferred mental health needs; reduced access due to county budget reductions; demand surges and shifts from the evolving economic paralysis; stresses on children in constantly changing care arrangements; novel criminal justice diversions and release programs—all buffeted by an unpredictable disease and a challenging funding environment.

Feedback from the Rapid Response Network has been overwhelmingly positive. As detailed below, nearly every respondent rated the service as a 10/10; many have submitted multiple requests.

There is a promising opportunity to expand, strengthen, and improve these efforts. A steady flow of counties has requested support, despite almost no outreach. More substantial marketing efforts—including a monthly “pulse check” to understand key issues; an opt-in list to alert partners about new responses; and publishing select findings—would expand the pool of partners.

Looking ahead, a Rapid Response Support Center could proactively research emerging priorities—such as children zero through five; school-based mental health; aging; and criminal justice re-entry. As described below, this would enable a range of activities to support agile evolution of programs to better serve those most impacted.

Background

The global pandemic has tested California counties and their community allies in new ways. The behavioral health system, already strained, has been forced to stretch and adapt at breakneck speed; each day has required complex decisions, often with few precedents. Agencies are overwhelmed. Even where additional resources are available, defining the needs, identifying useful resources, and procuring support can be onerous. And while local leaders receive waves of general information, they lack the time and resources to triage that information and adapt the most relevant aspects to their specific challenges.

The Rapid Response Network was designed to meet these specific circumstances. The RRN has replied to dozens of requests, largely from county behavioral health agencies and First 5s. [Examples of those responses](#) are posted on the Commission’s website.

The Network has four operating criteria: (1) provide demand-driven responses to the needs of behavioral health leaders; (2) make it radically easy for partners to initiate a request; (3) provide specific information responsive to the circumstance; (4) provide fast responses to maximize usefulness (vs. “perfect” answers).

The Network also committed to respond to every request and if the Network could not meet the need, to find an appropriate resource that could. No request was declined.

Evolving Information Needs Require a Responsive Platform

During the first six months, 28 requests were fielded. The median time between request initiation and draft response was just over two weeks. (In response to an urgent request, the response was completed within 48 hours.)

Requesters most commonly asked the Network to contact, interview, and summarize perspectives from experts; review, synthesize, and present emerging literature; and benchmark COVID-19 responses from analogous jurisdictions, accelerating information flow across jurisdictions.

OVERVIEW OF RESPONSES

As of October, the Rapid Response Network completed 28 requests. The most common topics included telehealth (7 requests), staff and business planning (6), evaluation planning (5), care adaptation (5), field interactions / street medicine (2), homelessness (2), and eviction prevention (1).

Most commonly, requests asked for the network to summarize expert perspectives, conduct literature reviews, and to learn from comparable jurisdictions through case studies and data benchmarks.

Feedback has been positive. The Net Promoter Score is a commonly used metric for customer satisfaction. Requesters were asked: How likely is it that you would recommend the Rapid Response Network to a relevant colleague, with 1 being “not at all likely” and 10 being “extremely likely”? The Network received an average score of 10. Additional feedback suggests that responses were successful at informing department’s priorities, policies, or decisions; that they were a good use of time; and that requesters would use this service again. Many requesters did reuse the service: one submitted six requests; two others submitted four; and four others were repeat clients.

Qualitative feedback has been positive as well. As one county behavioral health director wrote:

“Well, I did not know what to expect as [this was the] first time to work with you all. This is great. Very good

and useful information. We will implement some of these strategies. Today. Some we have already implement[ed] so this gives us acknowledgement that we are on the right track. I am meeting today with our management team and this will be used to kick off our meeting. Thanks so much.”

Piloting a longer-term Rapid Response Support Center

Based on our experience thus far, this short-term, low-barrier and timely technical assistance fills an important gap for busy county leaders. The implications of the pandemic continue to evolve; and while the urgency of adaptation has decreased, new challenges continue to arise.

More recent requests focused less on immediate practice changes and focused more on evaluating changes; navigating long-term remote working policies; and adapting emerging telehealth networks for greater cultural competency. For counties that were stretched before the crisis, we believe that “surge capacity”—trusted technical assistants able to take on time-bound, discrete research and analytics—can play a valuable role in informing hard decisions.

Potential Adaptations

MHSOAC and Social Finance have identified ways to mature the Network into a virtual Rapid Response Support Center to help counties and communities struggling with pandemic.

- **Strengthening demand generation.** The initial round of requests arose from a very limited outreach effort, supplemented by word-of-mouth. This allowed for quick responses to

every request. However, the only insight into on-the-ground needs came through time-sensitive requests, limiting the Network’s ability to invest in responses that may be less urgent yet have broad relevance.

A more substantial outreach and engagement effort could include overview documents and a dedicated web presence; a simple, fast, monthly “pulse check” to communicate key issues; and partnerships with networks (such as the First 5 Association, County Offices of Education, California Behavioral Health Directors Association, and others) to ensure partners are aware of the service offerings.

- **Improving distribution.** During the initiation phase, responses were largely intended for individual requesters. In addition, most were posted on the MHSOAC website.

Potential Focus Areas for Second Phase of RRN

Operations

- Perform literature reviews and expert outreach to respond to novel operational conditions.
- Analyze programmatic data to inform operational issues, such as service gaps.
- Facilitate discussions among counties on best practices and lessons learned.
- Benchmark the performance of community initiatives against similar communities.

Policy

- Identify innovative responses to unprecedented issues.
- Help counties determine best use cases for federal, state, and local COVID-19 funding.
- Conduct cost-benefit analyses of programs.

Capacity building

- Construct evaluation frameworks to help counties determine what works during the response to COVID-19.
- Structure performance management systems to manage fiscal pressures.
- Lead scenario-planning workshops to help agencies respond to changing client needs.

Looking ahead, distribution efforts could include an opt-in list to alert county partners about new responses; host regular webinars; proactively publish select findings as white papers; and, where appropriate, partner with journalists to reach a wider set of stakeholders.

- **Defining focus areas.** Requests could be clustered to enable proactive research and publication of emerging priority issues—such as school-based mental health, aging, provider workforce and/or reentry. This also will support sharing information among like agencies.

The Center also could work closely with other state-level agencies—sharing knowledge and resources with others working on similar issues, such as the Department of Aging, the Department of Corrections and Rehabilitation, and the Department of Public Health.

Timeline

The initial phase of the Network is drawing to an end as external grant resources are exhausted.

The Network could be developed to relaunch early in 2021. The next phase of this work would extend for 12-18 months.