

Section A: Population of Focus and Statement of Need (10 points)

The current COVID-19 epidemic has led to increased stress that impacts all Americans. The epidemic has begun in New Hampshire and is expected to surge in late April 2020. As of April 8, 2020, 788 people are known to be infected, including cases in every single county. Almost 143 COVID-19 tests are pending, 118 people are hospitalized and 18 people have died. Testing is not yet widely available in our state, so many more people have been ill but not confirmed. Our state has been under a state of emergency for four weeks, with schools and non-essential businesses closed for a similar period. Both due to the viral infection and the state of emergency, people with serious mental illness (SMI), youth with serious emotional disturbance (SED) and new or early SMI (eSMI), general citizens, and health care professionals are expected to develop new behavioral health problems, or exacerbations of such problems, including increases in depression, anxiety, trauma, and grief. We also anticipate an increase in substance misuse as the epidemic impacts people and families in New Hampshire and across the world.

The New Hampshire (NH) COVID-19 Rapid Crisis Response Program (NH Rapid Response) will provide crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for youth and adults impacted by the COVID-19 pandemic. The purpose of this program is to address the needs of individuals with SMI or SED, with substance use disorders (SUD), and/or co-occurring SMI/SED and SUD who are under- or uninsured. We will also provide crisis services for other individuals in need of behavioral health supports, including health care personnel.

NH Rapid Response will be implemented within the existing NH community mental health system. New Hampshire's service delivery system includes 10 private, non-profit community mental health centers (CMHCs) providing comprehensive evidence-based behavioral health and rehabilitation services to people with SMI and SED in their region. They are in dire need of support to respond to the COVID-19 situation.

The ten CMHCs have already begun to prepare for and mitigate the impact of the epidemic. They have ramped up their ability to provide telephone and video assessment and treatment to individuals across the state. Additionally, they have reorganized their services to enable safe in-person assessment and treatment when necessary, minimizing contagion by using CDC-recommended procedures. Yet the CMHCs are strapped and need additional support to provide services to the ~20% increased inflow of people having new crises in this pandemic environment (see box). Additional staff are needed for assessment and evidence-based treatment, and peer support staff are needed to facilitate engagement into services and ongoing care.

"The police called us for help – a man blockaded in his trailer was in crisis - they thought he was infected and needed help responding to him."

"The Humane Society called us for help – people in crisis are giving up their pets due to new domestic violence, housing loss and other traumas – they can take pets but don't know how to help the people." -CMHC leaders

The NH Department of Health and Human Services (DHHS) invited all CMHCs to participate in this proposed project. All are interested, ready and poised to participate. These organizations will provide **NH Rapid Response** across geographically diverse regions of NH – from rural in the North, to urban in the south. All are part of regional Integrated Delivery Networks in which partners collaborate to improve integration and access to services that address social determinants of health in their regions. This grant will provide CMHCs vital support to enhance crisis services.

Section B – Proposed Implementation Approach (5-6 pages, 50 points)

B.1. Our goals and objectives include:

Goal 1. Increase the capacity of the New Hampshire community mental health system to respond to people with behavioral health crises who are impacted by the COVID-19 epidemic, including assess and treat youth with SED, adults with SMI, those with other behavioral health conditions and health care providers during the COVID epidemic using evidence-based practices.

Objective 1 CMHCs will hire and deploy additional staff to provide crisis services

Objective 1a. By month 4, the New Hampshire Department of Health and Human Services will have hired, trained and deployed one additional FTE Project Director to oversee the project.

Objective 1b. By month 4, all 10 CMHCs will have hired, trained and deployed one additional FTE masters-level personnel to provide trauma-informed crisis evaluation and services delivered 24/7 by CMHCs.

Objective 1c. By month 4, all 10 CMHCs will have hired, trained, and deployed one additional FTE peer support specialist to provide peer support and engagement for people seen for crisis and emergency services.

Objective 1d. By end of month 4, all 10 CMHCs will have trained and deployed staff to support program evaluation.

Objective 1e. By the end of month 4, all 10 CMCHs will have deployed a 0.1 FTE clinical administrator to oversee NH Rapid Response at the CMHC

Objective 2 NH DHHS and CMHCs will train staff on skills for NH Rapid Response

Objective 2a. By the end of month 4, all 10 CMHCs will be trained on the grants' goals and objectives.

Objective 2b. By end of month 5, all 10 CMHCs will have received training in COVID-19-related procedures, including screening for illness symptoms and when and how to use measures to reduce viral transmission.

Objective 2c. By end of month 5, all 10 CMHCs will have received training on the principles and practices of SAMHSA-guideline based crisis services.

Objective 2d. By end of month 5, all crisis staff will have received training on methods to provide and document crisis services via telephone and videoconference.

Objective 2e. By end of month 6, all CMHC clinical staff, administrators and peer support staff will have received additional training in trauma-informed care and CBT for PTSD.

Objective 2f. By end of month 6, all crisis staff will have received additional training on American Society of Addiction Medicine (ASAM) criteria for SUD services and the application of these criteria in identifying SUD treatment resources.

B-2. NH Rapid Response and Use of Evidence-Based Practices (EBP). DHHS will deploy clinician and peer staff across the state to enhance our crisis service system using

EBPs described below. New and existing staff will receive training on grant goals and objectives, COVID-19 related treatment adaptations including safety and telemedicine, guideline-based crisis intervention, trauma-informed care, and use of ASAM criteria for SUD services. People needing longer-term services will be referred to other EBPs, also described below. The additional staff and training will dramatically enhance the capacity of our service system to support people with behavioral health crises.

B-2.a. Crisis Services

B-2.a.1 Crisis intervention. NH Rapid Response will expand capacity to provide crisis intervention, using the SAMHSA-published guidelines.¹ Crisis and emergency services teams at CMHCs will conduct assessment and crisis intervention based on the 10 core values identified in these guidelines. First and foremost, teams will avoid harm. This will be enabled via trauma-informed care, as described below. Interventions will be delivered in person-centered ways, with clinicians seeking to understand each individual's needs and preferences. Crisis services will promote shared responsibility, in which the individual is helped to gain a sense of control over their situation. Teams will address trauma, by preventing harm, assessing for trauma, providing trauma-informed care, and providing treatments for mental health conditions resulting from trauma. Crisis team members will help individuals establish a sense of personal safety, and harness each person's strengths. Crisis teams will consider the whole person, including their concerns for their family, pets, home, etc. Each person is treated with respect as a credible source of information about the crisis, and helped to gain hope and reconnect with their goals towards recovery. Finally, teams will help people make plans and garner resources that will prevent future crises.

Several principles are important to implement crisis treatment values. Teams will provide timely access to services and supports in the least restrictive manner. Peer support is available to help engage and support people in managing their crisis. Adequate time is spent evaluating and treating people during crisis interventions, enabling a comprehensive understanding of the situation and time to help people gain a sense of control over their situation. Crisis plans are strengths-based and emergency interventions consider the whole context of an individual's plan of services. Crisis service providers are adequately trained and supervised to provide high quality care that is tailored to an individual's age, gender, race, and other individual characteristics. Any individual who feels they are in crisis is offered services. Recurring crises indicate a need to adjust the team's assessment and intervention strategies, and additional measures are taken to reduce the likelihood of future crises. Services are trauma-informed and, most importantly, people's rights are respected.

Each NH CMHC provides 24-hour crisis and emergency services, but NH Rapid Response will strengthen and expand their service to support response to the COVID-19 epidemic by increasing their workforce, training new staff, and supporting re-training in core principles and practices of crisis response for existing crisis intervention staff.

B-2.a.2. Trauma-informed care. Treatment and support services, including the crisis and emergency services at NH CMHCs, will provide trauma-informed care. This service model is informed by trauma theory and assumes that anyone may have experienced significant previous trauma that impacts their lives and their response to current stressors. This holistic approach endeavors to avoid re-traumatization, while

providing needed services and supports in the context of their current situation.

The six key principles of trauma informed care include Safety, Trustworthiness and Transparency, Peer Support, Collaboration and Mutuality, Empowerment, Voice and Choice as well as attention to Cultural, Historical, and Gender Issues. These principles align well with the recovery model of community mental health for people with SED and SMI, and with the resiliency and recovery oriented systems of care for SUD, in which providers endeavor to promote and support the ability of each individual to live a fulfilling life working towards their personal goals in the community.²

B-2.a.3. Assessment and referral for care. Crisis teams will provide assessment and crisis intervention to help people cope with and navigate the crisis. People who are already in care will be reconnected with their established care providers. People who are not yet engaged in behavioral health treatment will be assessed and linked to needed services for SMI, SED, SUD, and other behavioral health conditions.

B-2.a.4. Referral to community and social support services, including appropriate follow-up. CMHC case management and care coordination helps consumers who have needs the CMHC cannot directly meet. They will connect consumers to other services that can help. For example, case managers routinely help consumers connect to the Medicaid Office to obtain or maintain Medicaid benefits, and connect consumers with the Housing Authority for assistance with housing. Youth will be connected to NH YouthMove for leadership opportunities and Youth Peer Support. Caregivers will be connected to National Alliance on Mental Illness NH for Family Peer Support and the NH network of family support groups and services for people with SUD. Adults with SMI/SUD will be connected to their local Peer Agency or Recovery Community Organization for ongoing peer support services. CMHCs follow-up with consumers at least quarterly and as needed to ensure that all needs are met and to address social determinants of health.

B-2.b Services for Individuals and family support for adults with SMI

B-2.b. Overview The CMHCs provide a comprehensive array of individual and family support. Case management services help individuals and families identify services needs and link them to needed care. Functional Support Services Programs provided by CMHCs include flexible, home and community delivered services, such as Illness management and recovery (IMR); Supported Employment (SE), Assertive Community Treatment (ACT), Crisis intervention; Therapeutic behavioral services; Family support; and Medication support. These services are designed to meet people where they are at physically and psychologically, to provide support and skills training in people's own environments, and to help people live in recovery in their own communities. These support services are also utilized in the context of Supported Housing, in which people dealing with homelessness access rental vouchers and assistance finding and keeping housing of their choice in communities of their choice. People who need additional supports will be linked with additional supports and services.

B-2.b.1 Person-centered care planning, screening and education All consumers with SED and SMI who enter into a period of care will participate in developing a person-centered care plan when they begin services. Consumers and their families will be encouraged to be full participants in identifying personally relevant goals

and strategies to pursue those goals. They participate in updating this plan of care each quarter, as well as a comprehensive review of the plan each year, while enrolled in services. Crisis planning and education about the Crisis Services will take place during the quarterly person-centered care planning process.

B-2.b.2. Assertive Community Treatment (ACT) ACT is a way of delivering individualized, comprehensive, time-unlimited and effective services to consumers who have needs that have not been well met by traditional approaches to delivering services. ACT practitioners directly provide integrated, comprehensive services via a transdisciplinary team of 10 to 12 practitioners who provide services to about 100 people. ACT team members work together on assessments, treatment planning, and day-to-day interventions. Multiple controlled studies have shown that this service improves community tenure, housing status and reduces unwanted institutionalizations for people with SMI^{3,4}. All New Hampshire CMHCs provide ACT, including those participating in this proposal, to consumers who need more intensive services in order to attain recovery in the community. DHHS provides ongoing training and technical assistance to support high fidelity services.

B-2.b.3. Supported Employment and Education (SEE) SEE is an approach to vocational rehabilitation for people with SMI that emphasizes obtaining competitive work in the community and providing the supports necessary to ensure success in the workplace. SEE incorporates education for young people for whom it is developmentally appropriate. Eligibility is based on consumer choice, SEE services are integrated with mental health services, competitive employment or integrated education is the goal, and consumer preferences are important. Dozens of studies have shown that Supported Employment helps consumers achieve competitive work in the community⁵, and adaptations of SEE are effective⁶. All CMHCs assess consumers for involvement in and desire for work and education each quarter. DHHS provides ongoing training and technical assistance to support high fidelity SEE services.

B-2.b.4 Illness Management and Recovery (IMR) IMR is an evidence-based psychiatric rehabilitation practice whose primary aim is to empower consumers to manage their illnesses, find their own goals for recovery, and make informed decisions about their treatment by teaching them the necessary knowledge and skills. IMR includes several evidence-based approaches combined into one package^{7,8}. IMR includes psychoeducation about mental illness and treatment options, behavioral tailoring to manage daily medication, relapse prevention to identify triggers of past relapses, early warning signs of an impending relapse, and relapse prevention planning. It also includes coping skills training. Several studies have shown that IMR helps consumers manage their illness and experience a greater level of recovery⁹. All CMHCs in NH provide IMR to help consumers manage their SMI to the best of their ability.

B-2.c. Mental health EBPs for youth entering longer-term services

B-2.c.1. MATCH-The Modular Approach to Therapy for Children (MATCH) is designed to address Anxiety, Depression, Trauma or Conduct Problems in children. Unlike most treatments that focus on single disorder categories (e.g. anxiety only), MATCH is designed for multiple disorders and problems encompassing anxiety, depression, trauma, and disruptive conduct, including the conduct problems associated with ADHD. MATCH is composed of 33 modules, or specific treatment procedures

derived from decades of research. These modules can be organized and sequenced flexibly to tailor treatment to each child's characteristics and needs. In addition, MATCH can move easily from a focus on one disorder area to another (e.g. shift from anxiety to depression) if the child's presentation should change during treatment. Clinicians trained in this evidence-based approach can treat over 70% of typical problems presented in outpatient clinics ¹⁰. New Hampshire is now implementing MATCH in a stepped fashion: all centers will have implemented MATCH before the end of the grant period.

B-2.c.2. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based treatment for children and adolescents impacted by trauma and their caregivers. TF-CBT is for children and adolescents who have significant emotional problems (e.g., symptoms of posttraumatic stress disorder, fear, anxiety, or depression) related to traumatic life events. This therapy is the most well-supported and effective treatment for children who have been abused or traumatized ^{11,12}. TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences. This program is a structured, short-term treatment model that effectively improves a range of trauma-related outcomes in 12-25 sessions with the child or adolescent and caregiver. TF-CBT effectively addresses PTSD and many other trauma impacts, including affective (e.g., depressive, anxiety), cognitive and behavioral problems, as well as improving parent/caregiver distress about the child's traumatic experience, effective parenting skills, and supportive interactions with the child. All CMHCs in New Hampshire have clinicians trained to provide TF-CBT.

B-2.d Services for Individuals and family support for individuals with SUD NH is establishing a Resiliency and Recovery Oriented System of Care (RROSC). RROSC is a coordinated and diverse system of community services, strategies and supports that is person-centered and builds on the strengths and resiliencies of individuals, families. RROSC is operationalized through the continuum of care model that includes prevention, identification and early intervention, treatment, and recovery supports, and is integrated with primary and mental health care.

Clients receiving crisis services can access a comprehensive array of SUD treatment services including evaluations, withdrawal management (detoxification), outpatient counseling, residential services, and recovery support services. Strategies used to address SUD include, but are not limited to:

- Medication Assisted Treatment (MAT) – Use of FDA approved medications which help to treat the physiological and neuropsychological aspects of SUD.
- Cognitive Behavior Therapy (CBT) – CBT is an action-oriented technique that works to help individuals recognize and modify negative thoughts and behaviors.
- Motivational Enhancement Therapy (MET) – MET is a counseling approach that helps individuals build motivation to engage in treatment and change SUD behaviors.
- Seeking Safety – Highly flexible counseling that addresses both trauma and addiction.
- The Seven Challenges -- comprehensive counseling for youth and young adults that incorporates substance misuse strategies in a variety of settings and intensity levels.
- Brief Strategic Family Therapy (BSFT) – This is a short-term, structured, problem-focused, and practical approach to treat adolescent conduct problems, drug use and their accompanying maladaptive family interactions.

Based on their assessment of the client, the NH Rapid Response crisis teams will utilize the ASAM criteria to identify the appropriate initial level of care for individuals with SUD. They will assist clients with accessing care, including: identifying providers; assisting individuals with contacting providers and completing an initial screening for treatment services; and assisting individuals to meet admission requirements, including linking them with financial resources.

B-2.e. Services for Health Care Providers in crisis

The NH DHHS and each CMHC crisis service will ensure that all health care providers in their region are aware of the service and their capability to provide support to health care providers experiencing a behavioral health crisis. We will capitalize on our Integrated Delivery Networks to conduct strong messaging and marketing to health care providers about accessing care for behavioral health crises. Additionally, they will ensure that their own workers are aware of resources to support them through a behavioral health crisis during the COVID-19 epidemic.

B-3. Project Timeline

The activities outlined in the project goals and objectives will be carried out based on the timeline shown in the table below. The first quarter will include amending existing contracts to include grant activities, hiring, training, and preparation. NH Rapid Response staff will be deployed and data collection will begin by the 4th month of the grant. Training will continue in the second quarter. CMHCs and the evaluation team will report to DHHS quarterly, beginning in month 4. DHHS will report to SAMHSA as required in month 9 and month 16 at the end of the grant period.

Table: Timeline for NH Rapid Response Grant Activities																
<i>Grant Quarter</i>	QTR 1			QTR 2			QTR 3			QTR 4			QTR 5			Q 6
<i>Grant month</i>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<i>Anticipated month</i>	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
DEVELOPMENT																
Hiring of staff																
Training of staff																
SERVICE DELIVERY																
NH RResponse Staff Deployed				★												
Client Level Data collection																
REPORTING																
CMHC activity reports to DHHS																
Data analysis reports to DHHS																
DHHS reports to SAMHSA																

Section C. Staff and organizational experience (25 points)

C-1. The state mental health authority, the Bureau of Mental Health Services, and Children’s Behavioral Health, will lead and coordinate the program in concert with the Bureau of Drug and Alcohol Services. DHHS has 30 years experience facilitating and supporting the provision of emergency and crisis services within the community mental health and SUD treatment systems. **Diana Lacey**, a highly experienced project manager within DHHS will lead the project, reporting to Bureau Directors **Julianne Carbin**, **Erica Ungarelli**, **(Commons PD/PI)** and **Annette Escalante** weekly for 5 months and monthly thereafter. The NH Office of Health Equity will contribute expertise regularly.

C-2. Provider organizations Our ten CMHC provider organizations will provide direct client mental and substance use treatment services appropriate to the NH Rapid Response services. These experienced organizations have delivered community mental health services to people with SED and SMI, with and without co-occurring SUD, as well as to people with milder and shorter-term mental illness and SUD conditions, for 35 or more years. Further, they have provided emergency and crisis evaluation and services for the same period of time. Two CMHCs in more urban regions provide mobile crisis team services, with the ability for community-based assessment and crisis intervention. They are all fully capable of providing telephonic and videoconference care in the COVID-19 environment. Thus, they are amply qualified to provide the services that will meet the expanded need during the COVID-19 pandemic. The NH CMHCs currently comply with all applicable local (city, county) and state licensing, accreditation, and certification requirements, and are expected to continue to do so for the duration of the grant period.

C-3. Stakeholder Advisory Council DHHS will host a quarterly **advisory council** meeting. The Advisory Council which will include family, youth, peers, and consumer organizations in addition to experts in crisis response and community mental health care. The Council will provide guidance and feedback for quality improvement and sustainability of high quality crisis intervention in our community mental health system.

C-4. The Institute for Health Policy and Practice (IHPP) IHPP at the University of New Hampshire has extensive experience conducting program evaluations. **Ashley Wilder Peters, MPH**, has ten years’ experience managing evaluations. She will oversee the data analysis and reporting to DHHS. **Erica-Lyn Plante, MS**, has two years experience conducting data analyses with a variety of databases including large claims datasets. She will conduct data analyses and create data reports quarterly for DHHS.

C-5. Staff Positions The staff positions described below will participate in delivery of NH Rapid Response and management of the project. The FTEs in the budget include the time assigned to the project that cannot be reimbursed by usual billing strategies. The time designated below shows the time assigned to the project.

C-5.a. NH State DHHS Project Director: 1 FTE A Program Specialist with at least 2 years’ experience in project management, background in behavioral health service delivery, and 5 years of related experience. Must be able to track administrative aspects of contracts and grant activities with CMHCs, work with stakeholder advisory committee, and report to DHHS leaders. Will communicate with SAMHSA regarding all grant-related activities.

C-5.b. CMHC Clinical Project Director (0.1 FTE at each CMHC) A clinical leader at each CMHC will oversee the NH Rapid Response implementation and evaluation in concert with the State Project Director. The following leaders, each with a masters degree and more than two years experience leading crisis or emergency services, have been identified at each center: **Jessica Gagnon**, Director of Acute care Services for Greater Nashua Mental Health Center, **Suzanne Oleson** for Northern Human Services, **Willard Metcalfe** for West Central Behavioral Health, **Dave Tenney** for Monadnock Family Services, **Dennis Walker** for Seacoast Mental Health Center, **Jen Jackes** for Lakes Region Mental Health Center, **Jennifer Mulryan** for Riverbend Mental Health Center, **Steven Arnault** for Center for Life Management, **Anna Pousland** for Mental Health Center of Greater Manchester, and **Janet Salisbury** for Community Partners.

C-5.c Crisis Team Clinician (1.0 FTE at each CMHC) A masters level clinician with at least 2 years related experience will provide trauma-informed crisis and emergency assessment and treatment at each CMHC. The clinician will be supervised by the Clinical Service Director and the team physician.

C-5.d. Crisis Team Peer (1.0 FTE at each CMHC) A person with lived experience will be trained to provide peer support, crisis planning and project assessments at each CMHC. Peers will be supervised by Clinical Service Directors.

C-5.e. CMHC Administrative Support Person (0.2 at each CMHC) This person will have a bachelor's degree in a related field and will provide administrative support for evaluation activities of the crisis and emergency services teams at each center.

Section D. Data Collection and Performance Measurement (15 points)

D-1. Data Collection As required, we will collect and report certain data so that SAMHSA can meet its obligations under the Government Performance and Results (GPRA) Modernization Act of 2010. DHHS intends to contract with **The Institute for Health Policy and Practice (IHPP)** at the University of New Hampshire, an organization with extensive experience conducting program evaluations. Evaluation Director **Ashley Wilder Peters, MPH**, has ten years' experience managing evaluations. She will oversee the data analysis and reporting to DHHS. Evaluation analyst **Erica-Lyn Plante, MS**, has two years experience conducting data analyses with a variety of databases including large claims datasets. This experienced evaluation team that will work together with DHHS to conduct rapid data analysis and data reports.

The DHHS Project Director and Evaluation Director will train CMHC staff on principles and practices for data collection. Client-specific data will be collected by each New Hampshire crisis service team and entered into the SAMHSA sponsored online data system. Client-level data will be obtained by project staff at intake, every six months thereafter, and at discharge from services. While this data is usually collected with in-person interviews, processes will be adjusted in partnership with SAMHSA to ensure safety of staff and clients during the COVID-19 epidemic. We presume that most data will be collected via record review and client interview via telephone or videoconference. Data elements are expected to include, but are not be limited to, diagnoses, services received, criminal justice status, hospitalizations, employment, mental health functioning, social connectedness, and substance use. We plan to provide participants with \$20 giftcards to reimburse them for their time and effort in completing project interviews.

Additionally, the DHHS Project Director will collect data on project objectives

from CMHCs and compile them quarterly in the month following each quarter.

D-2. Data reporting Our Evaluation Data Analyst will download and analyze client-specific data each quarter and provide this to DHHS in the following month. Our Project Director will compile progress on objectives from CMHCs along the same timeline and combine them with client-specific data reports into a **quarterly project report** that will be used to inform DHHS leaders, the grand project director, the New Hampshire Rapid Response teams, and the Stakeholder Advisory Council. This information will enable quality improvement activities as the project unfolds.

D-3. Project Performance Assessment We will submit two progress reports to SAMHSA, including accomplishments, barriers, and a detailed summary of progress. One report will be submitted at the midpoint of the grant period and a final report will be submitted at the end of the grant period. We will also submit information on project progress to SAMHSA on an ad-hoc basis as requested throughout the grant period.

D-4. Quality Improvement The evaluators and DHHS Project Director, in concert with the stakeholder advisory Council, will make recommendations regarding quality improvement to each CMHC crisis service leader. DHHS also conducts an independent evaluation at CMHC services each year. In cases where quality improvement is needed, formal Quality Improvement Plans (QIPs) are developed and monitored quarterly.

Summary NH Rapid Response will enhance NH CMHC crisis services by providing vital additional staff and training. These services will support people with SMI, SED, and SUD, as well as those with other behavioral health conditions and health care providers experiencing crises during the COVID-19 pandemic.

References

1. *Practice Guidelines: Core Elements in Responding to Mental Health Crises*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration;2009.
2. Mihelicova M, Brown M, Shuman V. Trauma-Informed Care for Individuals with Serious Mental Illness: An Avenue for Community Psychology's Involvement in Community Mental Health. *Am J Community Psychol*. 2018;61(1-2):141-152.
3. Bond GR, Drake RE. The critical ingredients of assertive community treatment. *World Psychiatry*. 2015;14(2):240-242.
4. Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews*. 2003(2).
5. Kinoshita Y, Furukawa TA, Kinoshita K, et al. Supported employment for adults with severe mental illness. *Cochrane Database Syst Rev*. 2013;9:CD008297.
6. Nuechterlein KH, Subotnik KL, Turner LR, Ventura J, Becker DR, Drake RE. Individual placement and support for individuals with recent-onset schizophrenia: integrating supported education and supported employment. *Psychiatr Rehabil J*. 2008;31(4):340-349.
7. Mueser KT, Corrigan PW, Hilton D, et al. Illness management and recovery for severe mental illness: A review of the research. *Psychiatric Services*. 2002;53:1272-1284.
8. Mueser KT, Meyer PS, Penn DL, Clancy R, Clancy DM, Salyers MP. The illness management and recovery program: rationale, development, and preliminary findings. *Schizophrenia Bulletin*. 2006.
9. McGuire AB, Kukla M, Green A, Gilbride D, Mueser KT, Salyers MP. Illness management and recovery: a review of the literature. *Psychiatr Serv*. 2014;65(2):171-179.
10. Weisz JR, Chorpita BF, Palinkas LA, et al. Testing standard and modular designs for psychotherapy treating depression, anxiety, and conduct problems in youth: a randomized effectiveness trial. *Arch Gen Psychiatry*. 2012;69(3):274-282.
11. Nixon RD, Sterk J, Pearce A, Weber N. A Randomized Trial of Cognitive Behavior Therapy and Cognitive Therapy for Children With PTSD: Predictors and Outcome at 1-Year Follow-Up. *Psychological trauma : theory, research, practice and policy*. 2016.
12. Nixon RD, Sterk J, Pearce A. A randomized trial of cognitive behaviour therapy and cognitive therapy for children with posttraumatic stress disorder following single-incident trauma. *J Abnorm Child Psychol*. 2012;40(3):327-337.