Mental Health First Aid
Grant Applicant Toolkit

INTRODUCTION

The following Toolkit* is designed to help organizations that are seeking funding for Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) training programs by responding to Requests for Applications (RFAs). It is intended to support applicants in developing their own customized approach to submitting a grant application and should be used as a supplemental resource to conduct a needs analysis and develop a program design.

*IMPORTANT NOTE: This toolkit is not intended to be a comprehensive document for all request for applications (RFAs). This document should be used as a support to other guidance provided by the RFA issuer. The RFA issuing organization and the formal RFA documents should be used as the final authority on any content that should be included in your application.

WHAT IS MENTAL HEALTH FIRST AID?

Mental Health First Aid USA is a live training program — like regular First Aid or CPR — designed to give people the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The course uses role -playing and simulations to demonstrate how to recognize and respond to the warning signs of specific illnesses.

Mental Health First Aid teaches participants a five-step action plan, ALGEE, to support someone developing signs and symptoms of a mental illness or in an emotional crisis:

- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies

Since 2008, More than 300,000 people have been trained in Mental Health First Aid through a network of more than 6,000 certified instructors.

Those trained include family members of persons with mental health challenges, healthcare professionals, first responders, law enforcement officials, public service employees, school and college staff, clergy and caring citizens.

WHY MENTAL HEALTH FIRST AID?

Mental Health First Aid helps people know that mental illnesses are real, common, and treatable and that it's OK to seek help. Research has demonstrated the effectiveness of this program to improve knowledge of mental disorders and substance use, remove fear and misunderstanding, and enable those trained to offer concrete assistance.

The program is listed in SAMHSA's National Registry of Evidenced Based Programs and Practices. Mental Health First Aid is a low-cost, high-impact program that generates tremendous community awareness and support.

HOW TO USE THIS TOOLKIT

This supplemental material includes the following parts:

1. **National data and data sources** regarding the prevalence of adolescent and transition age youth (TAY) mental health problems, including trauma and Adverse Childhood Experiences (ACEs). It also provides data sources for topics related to mental health for youth, such as child development, mental health disparities, and the impact of poverty. Special issues faced by special populations are also addressed, including needs related to adolescents, transition age youth, youth who are in foster care, those who are homeless, disconnected youth, and those involved in juvenile justice. This section additionally provides a research summary regarding typical barriers to mental health treatment access for youth and the impact associated with treatment delay for children and young adults.
2. **Guidance to support your search for local data sources** necessary to document the need for this program within your target area(s) and to justify your particular project, respective of local gaps in the system of care and challenges faced within individual states and local communities.
3. **An approach for conducting an environmental scan and identifying current resources,** including connections between education and behavioral health, and guidance regarding how to situate Mental Health First Aid (MHFA) within your current system of care.
4. **MHFA and YMHFA selection considerations** for Mental Health First Aid (MHFA) and the Youth Mental Health First Aid (YMHFA) modality.
5. **Summary of and guidance for establishing collaborative partnerships**—guidance in selecting and documenting connections to promote robust community-wide integration, with a chart template that can be completed for your project.
6. **Data collection and performance measurement guidance**
7. **Outline of a job description for a Project Director**
8. **Budget guidance** and a **budget spreadsheet**, which can be used as a tool to develop your application's budget.
9. **APPENDIX A: Sample Grant Template**

PART I: NATIONAL DATA AND DATA SOURCES

Below, you will find:

- National data sources related to adolescent mental health problems, with hyperlinks to the original resource, for material related to:
  - General prevalence data
  - Trauma
  - Prevalence of Adverse Childhood Experiences (ACEs)
  - Developmental issues
- Data on disparities and access barriers

These data sources can assist you in demonstrating the need for MHFA. Most grant applications include a *Statement of Need,* which is often a short but crucial section as it must demonstrate why this program will be a valuable asset within your state/ community. Concise summaries of important relevant data that highlight or compare your local needs with “the national picture” help to make a compelling case and create a meaningful first impression for the reviewer.

Prevalence Among Youth 12-18

A large national survey of adolescent mental health reported that about 8 percent of teens ages 13-18 have an anxiety disorder, with symptoms commonly emerging around age 6. However, of these teens, only 18 percent received mental health care. (http://www.nimh.nih.gov/health/publications/anxiety-disorders-in-children-and-adolescents/index.shtml)

About 11 percent of adolescents have a depressive disorder by age 18 according to the National Comorbidity Survey-Adolescent Supplement (NCS-A). Girls are more likely than boys to experience depression. The risk for depression increases as a child gets older. According to the World Health Organization, major depressive disorder is the leading cause of disability among Americans age 15 to 44. Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child who shows changes in behavior is just going through a temporary “phase” or is suffering from depression. (http://www.nimh.nih.gov/health/publications/depression-in-children-and-adolescents/index.shtml)

In the United States, one in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment (Burns, et al., 1995; Shaffer, et al., 1996). Yet, in any given year, it is estimated that about one in five of such children receive specialty mental health services (Burns, et al., 1995). Unmet need for services remains as high now as it was 20 years ago. Recent evidence compiled by the World Health Organization indicates that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent, internationally, to become one of the five most common causes of morbidity, mortality, and disability among children. (Report of the Surgeon General’s Conference on Children’s Mental Health, 2000: http://www.ncbi.nlm.nih.gov/books/NBK44233/)

“The findings converge in demonstrating that approximately one fourth of youth experience a mental disorder during the past year, and about one third across their lifetimes. Anxiety disorders are the most frequent conditions in children, followed by behavior disorders, mood disorders, and substance use disorders. Fewer than half of youth with current mental disorders receive mental health specialty

treatment. However, those with the most severe disorders tend to receive mental health services." (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2807642/)

Additional Prevalence Data
http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf

- On P. 17, Exhibit 4. Percentage of persons aged 8 to 15 with any mental disorder and any disorder with severe impairment in the past year, by sex and age group, United States, 2001–2004
- Youth living in poverty at higher risk for depression: http://www.samhsa.gov/data/sites/default/files/CBSHQ_Spotlight_064_Poverty_2012/CBSHQ_Spotlight_064_Poverty_2012.pdf

http://www.cdc.gov/mentalhealth/data_stats/nspd.htm

- Comprehensive data on behavioral health but not on adolescents

http://www.nami.org/

- National Alliance on Mental Illness – advocacy organization

https://www.ffcmh.org/publications

- National Federation of Families for Children's Mental Health – advocacy organization

Prevalence: Trauma
Trauma is a major factor in adolescent mental health challenges. In a national survey of 17-year-old youth, 8 percent reported a lifetime prevalence of sexual assault, 17 percent reported physical assault, and 39 percent reported witnessing violence. Among middle and junior high school students (n=2248) in an urban school system, 41 percent reported witnessing a stabbing or shooting in the past year. This website provides these and other facts and figures on prevalence and epidemiology: National Child Traumatic Stress Network http://www.nctsnet.org/resources/topics/facts-and-figures

In a nationally representative survey of 12-to 17-year old youths and their trauma experiences, 39 percent reported witnessing violence, 17 percent reported physical assault, and 8 percent reported a lifetime prevalence of sexual assault.

Prevalence: Adverse Childhood Experiences (ACEs)
Nearly half (47.9%) of US children age 0-17 years experienced one or more of the nine Adverse Childhood Experiences (ACEs) asked about in the 2011/12 National Survey of Children's Health (NSCH) survey. (http://www.childhealthdata.org/docs/drc/aces-data-brief_version-1-0.pdf?Status=Master)

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. (http://www.cdc.gov/violenceprevention/acestudy/)

Developmental Issues: Adolescence vs. Adulthood
An understanding of how the brain of an adolescent is changing may help explain a puzzling contradiction of adolescence: young people at this age are close to a lifelong peak of physical health,

strength, and mental capacity, and yet, for some, this can be a hazardous age. Mortality rates jump between early and late adolescence. Rates of death by injury between ages 15 to 19 are about six times that of the rate between ages 10 and 14. Crime rates are highest among young males and rates of alcohol abuse are high relative to other ages. Even though most adolescents come through this transitional age well, it's important to understand the risk factors for behavior that can have serious consequences. Genes, childhood experience, and the environment in which a young person reaches adolescence, all shape behavior. Adding to this complex picture, research is revealing how all these factors act in the context of a brain that is changing, with its own impact on behavior. (http://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/index.shtml)

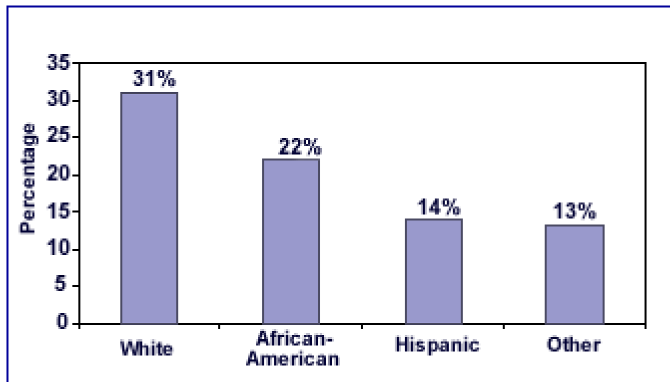
At these sites, you can find more data on the specific items identified:

- Information on developing brain with implications for anxiety disorders and depression in children and adolescents (http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml)
- Information from a child welfare point of view (https://www.childwelfare.gov/topics/can/impact/development/brain/)

Disparities

If the targeted communities are affected by a high prevalence of poverty or where racial/ethnic groups predominate, you will need to describe that and identify the extent. The following section can support the need for programs and resources to overcome disparities that affect low-income communities or schools with significant populations that experience disparities.

Table 1: Children and Youth Receiving Needed Mental Health Services Based on Race



Source: RAND Health Research Highlights. Calculations are based on data from the National Health Interview Study, 1998.
Cited on Website of Center for Health and Health Care in Schools, February 2012, http://www.healthinschools.org/News-Room/Fact-Sheets/MentalHealth.aspx

According to the U.S. Surgeon General, the burden and disability in the United States from mental disorders is carried disproportionately by children/youth and people of color. They have lower utilization of services, worse quality of care, and more serious consequences from untreated mental illness. (U.S. Department of Health and Human Services (1999) *Mental Health: A Report of the Surgeon General. MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services*

Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, Cited in:
http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/Child_Youth_Families_PEIFirst3Yrs_052413.pdf

Service use and payment data for children in ethnic/racial groups: http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/04fallpg5.pdf

National summary of state Medicaid managed care programs:
http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/2010NationalSummaryPub.pdf

Access Barriers
Treatment access barriers that support the need for this program as well as underscore the needs and gaps within the care delivery system may help to justify your program:

Delays between onset of symptoms and when youth receive treatment
Half of all lifetime cases of mental illness begin by age 14, and despite effective treatments, there are long delays — sometimes decades — between first onset of symptoms and when people seek and receive treatment. A major study indicates that the U.S. mental health care system is not keeping up with the needs of consumers and there is a need to speed initiation of treatment as well as enhance the quality and duration of treatment. For instance, over a 12-month period, 60 percent of those with a mental disorder got no treatment at all. This information and more from National Institute of Mental Health Press Release, June 2005. (http://www.nimh.nih.gov/news/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml)

Non-receipt of services
Combined 2010 to 2012 National Survey on Drug Use and Health (NSDUH) data indicate that 1 in 10 older adolescents aged 16 to 17 had a major depressive episode (MDE) in the past year.

- One in five young adults aged 18 to 25 (18.7 percent) had any mental illness (AMI) in the past year and 3.9 percent had a serious mental illness (SMI).
- The prevalence of major depressive episode (MDE) and Substance Use Disorder (SUD) generally increases with age through the adolescent years.
- Studies have shown that there is nearly a twofold increase in mood disorders from the 13-to-14-year-old age group to the 17-to-18-year-old age group.
- Young adults have higher rates of co-occurring mental illness and SUD than older adults.
    - When compared with adults aged 26 or older, the rate of SUD among young adults aged 18 to 25 is more than twice as high (19.1 vs. 6.8 percent)
    - Young adults also have higher rates of co-occurring mental illness and SUD than adults aged 26 or older.

Although older adolescents and young adults have mental health vulnerability, many do not receive mental health services. Of the 214,000 older adolescents who had both MDE and SUD in the past year:

- 53.3 percent did not receive treatment for depression or specialty substance use treatment;
- 40.7 percent received treatment for depression only;
- 0.5 percent received specialty substance use treatment only; and

- 5.5 percent received both treatment for depression and substance use treatment

Useful source of detailed data: SAMHSA, *Serious Mental Health Challenges Among Older Adolescents and Young Adults, http://samhsa.gov/data/2K14/CBHSQ173/sr173-mh-challenges-young-adults-2014.htm.*

Over one tenth (11.5 percent) of adolescents received mental health services in an educational setting, with 9.7 percent indicating that they had received services from a school counselor or school psychologist or through regular meetings with a teacher. Receiving mental health services from a pediatrician or other family doctor in a general medical setting was mentioned by 2.8 percent of adolescents. One in twenty (5.1 percent) adolescents received services in both a specialty mental health setting and an educational or general medical setting in the past year. SAMHSA, *The NSDUH Report: Adolescent Mental Health: Service Settings and Reasons for Receiving Care, http://www.samhsa.gov/data/2k9/youthMHcare/youthMHcare.htm*.

MHFA offers a vital response to access barriers by supporting those adults who have existing connections to people in providing intervention and referral assistance. YMHFA and MHFA flexibly respond to individuals where they are and provide the “glue” between existing systems. The term “referral” can include clinical referrals as well as referrals to other supports, including self-help resources and other support strategies. The description of how your proposed approach addresses the identified needs and gaps is typically the approach section of the grant proposal.

Mental Health Risks/Needs Unique to Transition Age Youth

Coordinating systems to support transition age youth with mental health needs | FindYouthInfo. (n.d.). Retrieved from http://findyouthinfo.gov/youth-briefs/mental-health-youth-brief-intro

- Research has demonstrated that as many as one in five children/youth have a diagnosable mental health disorder (New Freedom Commission on Mental Health, 2003) and that as many as three million young people may have a serious emotional disturbance that severely disrupts life at home, school, and in the community (American Academy of Child and Adolescent Psychiatry, 2010).
- Needs vary by socioeconomic status and involvement in some form of child-service system.
- Research has found that youth from low-income households are at increased risk for mental health problems (Howell, 2004) and that a greater proportion of children and youth in the child welfare (50%) and juvenile justice (67-70%) systems have mental health problems than children and youth in the general population (Burns et al., 2004; Skowyra & Cocozza, 2006).
- Studies have also shown that the majority of young people in need of mental health services (75-80%) do not receive them (Kataoka, Zhang, & Wells, 2002).

Facts on transitional services for youth with mental illnesses|The Bazelon Center for Mental Health Law. (n.d.). Retrieved from www.bazelon.org/LinkClick.aspx?fileticket=B06EN2VmTWM%3D&tabid=247

Prevalence

- Adolescents transitioning to adulthood with a Serious Mental Illness are three times more likely to be involved in criminal activity than adolescents without an illness.
- Incarcerated youth age 18-22 are more likely to have a mental illness than younger adolescents in the juvenile justice system.
- Transitional age youth with a Serious Mental Illness have higher rates of substance abuse than any other age groups with mental illness.
- Rates of Serious Mental Illness are highest among young adults age 18, and rates decrease for each year thereafter.

Unmet Needs and Consequences

- Education and Employment. Young adults with a Serious Mental Illness face many challenges when transitioning from school to adulthood.6 Over 60 percent of young adults with a Serious Mental Illness are unable to complete high school. These young adults are often unemployed, unable to participate in continuing education, and lack successful skills necessary for independent living.
- Increased Risk of Suicide. An estimated 20 percent of youth receiving treatment for emotional or behavioral problems have either contemplated suicide or attempted suicide. Less than 40 percent of youth at risk of suicide receive treatment. Suicide is the third leading cause of death among young adults age 15 to 24.

Pottick, K. J., Warner, L. A., Stoep, A. V., & Knight, N. M. (2014). Clinical characteristics and outpatient mental health service use of transition-age youth in the USA. The Journal of Behavioral Health Services & Research, 41(2), 230-243.

- This study examines diagnostic and service utilization patterns of transition-age youth in outpatient care derived from the 2007 nationally representative Client/Patient Sample Survey. Comparisons between 16–17, 18–21, and 22–25 year olds are highlighted.
- Among transition-age outpatients, the oldest youth had the highest rates of depression and bipolar disorder and co- occurring medical and substance use problems.
- Controlling for sociodemographic and clinical characteristics, 18–21 year olds were less likely to receive individual therapy than 16–17 year olds, but there were no age group differences in receipt of specialized therapy or psychotropic medication.
- Female gender and Hispanic ethnicity were positively associated with the number of services received and specialized service use, respectively; youth with private insurance were more likely than those with public insurance to receive psychotropic medication.
- Among all transition-age youth, the most common primary diagnosis were:
    - Depression (21.6%);
    - Bipolar (14.6%), disruptive (14.2%), and anxiety (12.9%) disorders.
    - Comorbidity is common, with approximately 60% having more than one diagnosis; 41.0% have a co-occurring medical problem, and 20.3% a substance use problem.

Background on Specific Populations

Foster Care Youth

Promises2Kids. (n.d.). Foster care facts. Retrieved from http://promises2kids.org/facts-figures/

- Foster youth who experience more placements are nearly 15% less likely to complete high school when compared to their peers
- 24% of foster youth struggle with disabilities while in school
- Across the United States, 52% of foster youth attend schools that rank in the lowest 30 percent
- Only 50% will receive a high school diploma
- Only 10% of former foster youth will attend college and, of that 10%, only 3% will graduate.

Congressional Coalition for Adoption Institute. (n.d.). Facts and statistics. Retrieved from http://www.ccainstitute.org/index.php?option=com_content&view=category&layout=blog&id=25&Itemid=43

- In the U.S. 397,122 children are living without permanent families in the foster care system.
- In 2012, 23,396 youth ages out of the U.S. foster care system without the emotional and financial support necessary.
    - Nearly 40% had been homeless or couch surfed.
    - Nearly 6050 of young men had been convicted of a crime.
    - Only 48% were employed.
    - 75% of women and 33% of men receive government benefits to meet basic needs.
    - 50% of youth who aged out were involved with substance abuse.

Specific Mental Health Concerns

- The Child Welfare League of America (2009) reported that those who live in foster families or group homes have the probability of developing serious psychiatric disorders at a rate 4 times higher than children who are raised by their birth family. Despite this, less than 33% of youth in the foster care system actually receive mental health services (Child Welfare League of America, 2009).
- Youth transitioning out of the foster care system often do so with little support and can face high rates of joblessness, homelessness, incarceration, substance abuse, sexually transmitted infections, teen pregnancies, and mental health concerns (Galehouse, Herrick, & Raphel, 2010; Zlotnick, Tam, & Soman, 2012).
- Mental health concerns in transitional age youth serve as an obstacle to independent living, learning to take responsibility, caring for oneself, creating an emotionally and physically supportive environment, and securing and maintaining employment (Love, Koob, & Hill, 2008).

Homeless Youth

Safe Horizon. (n.d.). Homeless youth statistics & facts. Retrieved from *http://www.safehorizon.org/page/homeless-youth-statistics--facts-69.html*

Homeless Youth & Teen Statistics & Facts

- Approximately 1.7 million young people call the streets home every year.
- Nearly 20,000 homeless people 24 years old and younger live in New York City.
- Children under 18 accounted for 39% of the homeless population.
  - Of that number, approximately 42% were younger than age
- Approximately 40% of homeless youth identify as LGBT.
- Every year, approximately 5,000 homeless young people will die because of assault, illness, or suicide while trying to survive.

What are the cause of youth and teen homelessness?

Young people are at far greater risk of becoming homeless if:

- Their parents engage in substance abuse or have mental health problems.
- They suffered or witnessed child abuse or neglect in the home.
- The family has been homeless previously.
- They identify themselves as lesbian, gay, bisexual, or transgender.
- They have been in foster care.
  - Children who have been in foster care are at greater risk of becoming homeless at an earlier age and to remain homeless for a longer period of time than other youth.

How is child abuse related to youth and teen homelessness?

- 46% of homeless youth escaped a home where they suffered physical abuse.
- 17% left because of sexual abuse.

What happens to homeless youth and homeless teens on the streets?

Young people who are too old for foster care, yet too young to apply for social services are often forced into homelessness. Homeless youths can face devastating short and long-term consequences.

- Nearly 43% of homeless young men and 39% of homeless young women say they were assaulted with a weapon while living on the streets.
- Homeless youth suffer significant mental health problems including: depression, substance abuse, suicidal thoughts, anxiety, and post-traumatic stress disorders.
- Homeless youth are approximately 75% more likely to self-medicate and abuse substances as a means to deal with trauma and abuse.
- Children living on the streets are more likely to engage in “survival sex” – trading sex to gain food, clothing, drugs, money, or just for a safe place to sleep at night.
- According to a San Francisco government study, 17% of homeless youth are HIV-positive.
- Homeless youth who identify as lesbian, gay, bisexual, or transgendered are more likely commit suicide than other youth.

Specific Mental Health Concerns
Saperstein, A. M., Lee, S., Ronan, E., Seeman, R., & Medalia, A. (2014). Cognitive deficit and mental health in homeless transition-age youth. PEDIATRICS, 134(1), 138-145.

- Participants (N = 73) were recruited from a vocational support program at Covenant House New York, a care agency for homeless youth. Assessments included diagnostic assessment for mental health disorders and evaluation of neuro-cognition and vocational outcomes.
- Youth demonstrated histories of academic instability, academic achievement below expectation, and high rates of untreated psychiatric disorders, the most prominent of which were anxiety, substance use, and mood disorders. Of those who had a mental health diagnosis, more than half demonstrated cognitive deficits.
- Performance on measures of working memory and verbal memory was 70% of that of the age-matched normative population. Cognitive impairment was associated with a significant risk for making a wage insufficient for independent living.

Disconnected Youth
Sharps, S., & Lewis, K. (2012). One in seven: ranking youth disconnection in the 25 largest metro areas. Retrieved from Measure of America of the Social Science Research Council website: http://ssrc-static.s3.amazonaws.com/moa/MOA-One_in_Seven09-14.pdf

- One in seven American adolescents and young adults ages 16 to 24 is neither working nor in school; we call such status "disconnected."
  - 5.8 million young people in all: This number swelled by over 800,000 during the Great Recession.
- African Americans have the highest rate of youth disconnection, at 22.5 percent.
- Demographics:
  - 47% female; 53% male
  - 39% lives in a poor household
  - 33% dropped out of high school
  - 46% highest degree is high diploma or equivalent
  - 13% with a disability

Youth Involved in the Juvenile Justice System

Zajac, K., Sheidow, A., & Davis, M. (2013, September). Transition age youth with mental health challenges in the juvenile justice system. Retrieved from http://www.tapartnership.org/docs/TransitionAgeYouthWithMentalHealthChallengesJJ_10-17-13.pdf

- Each year, more than 2 million children, youth, and young adults formally come into contact with the juvenile justice system, while millions more are at risk of involvement with the system for myriad reasons (Puzzanchera, 2009; Puzzanchera & Kang, 2010).
- The transition from adolescence to adulthood represents a unique developmental period, with significant changes in educational, vocational, and relational roles and expectations in the face of reduced family influence and changing social networks (Arnett, 2000).

Specific Mental Health Concerns

Zajac, K., Sheidow, A., & Davis, M. (2013, September). Transition age youth with mental health challenges in the juvenile justice system. Retrieved from *http://www.tapartnership.org/docs/TransitionAgeYouthWithMentalHealthChallengesJJ_10-17-13.pdf*

- Of children, youth, and young adults [involved in the justice system], a large number (65–70 percent) have at least one diagnosable mental health need, and 20–25 percent have serious emotional issues (Shufelt & Cocozza, 2006; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002).
- Transition age youth with mental health problems are at increased risk for involvement in the justice system compared with their peers (Davis et al., 2007; Grisso, 2004).
- Similar to non-justice-involved youth, comorbidity rates are high for justice-involved youth, with an estimated 79 percent of youth with one mental health disorder also meeting diagnostic criteria for at least one other disorder, and more than 60 percent meeting criteria for a substance use disorder (Shufelt & Cocozza, 2006).
- Youth in the justice system often come from economically disadvantaged, single-parent households (Foster & Gifford, 2005).
- Following reentry, transition age youth display low rates of engagement with community-based services such as mental health treatment and vocational rehabilitation. In one study, only 35 percent of juvenile offenders had been engaged in such services during the six months following reentry (Chung, Schubert, & Mulvey, 2007).

PART II: GUIDANCE TO SUPPORT YOUR SEARCH FOR LOCAL DATA SOURCES

To “paint a picture” of state and local needs that highlight why your application stands out in comparison to other proposals from across the country:

Here are some ideas for finding state and local data:

- Demographic data by state, county, city or town
http://www.census.gov/quickfacts/table/PST045214/00

- SAMHSA provides National and State level data on Mental Health; data can be viewed by state, census bureau, and by metro area.
http://www.samhsa.gov/data/node/20

- Adolescent Behavioral Health Barometer by SAMHSA (by state)
http://www.samhsa.gov/data/topics-a-z-index/reports-by-topic?topic=1

- Kids Count Data Center provides data by state, county, city, congressional district, etc. This data includes demographic data and health/mental health data
http://datacenter.kidscount.org/locations

- Additionally Kids Count Data Center has data available by topic area including demographics, economic well-being, education, health, family & community, safety & risky behaviors, and etc.
http://datacenter.kidscount.org/topics

- Here’s a link regarding school mental health: http://www.schoolmentalhealth.org/AboutUs.html

- Community commons allows you to create a community health needs assessment and/or a vulnerable population footprint
http://www.communitycommons.org/maps-data/

- State Medicaid agencies/CHIP (Child Health Insurance Program)
http://www.medicaid.gov/chip/reports-and-evaluations/reports-and-evaluations.html

- Your State Education Agency may have a drop down menu for Data/demographic profiles for school-aged youth by Local Education Agency and community
- Your State Mental Health Authority has data on its website
  - The State Mental Health Plan it submits to SAMHSA
  - Other data it collects, usually by region and/or county
- Description of service needs and system gaps and extent of need (prevalence rates or incidence data, service utilization)
  - You may find data in the State Mental Health Plan your state submits to SAMHSA – see above

- State Medicaid agencies/CHIP (Child Health Insurance Program)
http://www.medicaid.gov/chip/state-program-information/chip-state-program-information.html
- State adolescent and child health data: http://childhealthdata.org/
- Focus on violence prevention in schools and among young people
http://www.thecommunityguide.org/violence/school.html
- Emergency room visits for adolescent psychiatric problems have increased
http://pediatrics.aappublications.org/content/127/5/e1356.full
http://www.sacbee.com/2014/02/02/6120993/mental-health-hospitalizations.html

PART III: AN APPROACH FOR CONDUCTING AN ENVIRONMENTAL SCAN AND IDENTIFYING CURRENT RESOURCES

As part of the statement of need, it is important to identify the gap that MHFA or YMHFA can address within the care delivery system. Commonly, applicants are asked to describe currently available resources/capacity, including current infrastructure, i.e., "here's what we have and here's what we need in order to maximize our capacity and build a more effective system."

- You can use GoogleMaps to identify specific resources within your catchment area
- Your Department of Health, Department of Mental Health, Child Welfare, Juvenile Justice Agency, etc. may include a list of their sites and contractors
- Local available mental health providers/services can be found at: https://findtreatment.samhsa.gov

You can use this section to show the connections between education and behavioral health and to situate MHFA as essential "glue" to connect resources together.

One approach for identifying currently available resources/capacity is a basic public health model for schools and mental health/human services agencies that commonly differentiates among three basic levels of interventions:

- positive child, youth, and family development as well as prevention of problems, for **all** children (universal), for example, bullying and violence prevention, enrichment programs, transition supports, parent support, before and after-school programs, public health and safety programs, mentoring, improving the physical environment of the school, strengthening connections between schools and families; Positive Behavioral Interventions and Supports (PBIS) represents an approach to all children that also covers the full continuum
- early intervention for some children, timely and targeted interventions and supports for moderate mental health and behavioral needs and situational stresses, for example, learning and behavior accommodations, behavioral support plans, short-term counseling, therapeutic after-school, health services for specific conditions;
- intensive interventions and supports covers more intense and sustained services, including access to individualized and systems of care, for a few children, those with serious emotional and behavioral challenges, for example, intensive special education, mental health treatment

It can be useful to identify what programs, services and interventions exist at each of these levels and to show how MHFA or YMHFA can serve as the connective tissue among them. MHFA or YMHFA can address:

1. Universal level of intervention, i.e., for all children, by providing public education and combating stigma
2. The middle level, i.e., an early intervention for children who exhibit signs of mental health distress, by providing this connective resource to build the capacity of the LEA and partners.
3. The most intense level, i.e., services and supports, by ensuring that students receive the appropriate level of care

Educational Outcomes are Improved with Behavioral Health Interventions

You can support the relevance of MHFA or YMHFA in schools and with school partners by citing the literature that shows that behavioral health interventions improve educational outcomes:

Universal school-based behavioral health interventions are associated with improved academic achievement and related behavior known to influence academic success, such as increases in school grades, standardized test scores, grade point averages, and teacher-rated academic competence. Students who received a behavioral health intervention showed greater resilience and emotional functioning as evidenced by increased academic motivation, self-efficacy, commitment to school, and stability during grade-level transitions. At the school level, intervention sites reported less violence, bullying, and other problem behaviors among students. *The Impact of School-Connected Behavioral and Emotional Health interventions on Student Academic Performance: An Annotated Bibliography of Research Literature, May 2014.*
http://www.healthinschools.org/en/School-Based-Mental-Health/Revised-Annotated-Bibliography.aspx

Mental disorders were found to be significantly associated with termination of schooling prior to completion of each of four educational milestones (primary school graduation, high school graduation, college entry, college graduation), with odds ratios in the range of 1.3 to 7.0.
Mental Disorders and Subsequent Educational Attainment in a US National Sample
http://www.journalofpsychiatricresearch.com/article/S0022-3956(08)00024-1/abstract

Additional Data Sources

- Look at the data (sources above) re: disparities (access barriers are greater for children living in poverty, for children from African-American and Latino/a communities, for children attending under-resourced schools, for children in foster care
- Early intervention level programs tend to be underfunded, both in schools and in the community; funded programs tend to be outpatient clinics (with waiting lists) or inpatient residential treatment centers
    - Summarize data on waiting lists
    - Describe gaps in coordination types of activities (“glue”)
- Many families living in poverty are working two jobs, jobs at unusual hours
    - If possible, describe parental employment challenges and transportation gaps

PART IV: MHFA AND YMHFA SELECTION CONSIDERATIONS

Mental Health First Aid is a public education program that introduces participants to the risk factors and warning signs of mental health problems, builds an understanding of the importance of early intervention, and overviews common supports. This 8-hour course uses role-playing and simulations to demonstrate how to offer initial help in a mental health or substance use crisis through a 5-step action plan, with the ultimate goal to connect persons to appropriate professional, peer, social, and self-help care. The program also teaches the common risk factors and warning signs of specific types of illnesses like anxiety, depression, substance use, bipolar disorder, eating disorders, and schizophrenia. Participants are introduced to local mental health resources, national organizations, support groups, and online tools for mental health and addictions treatment and support.

Originating in Australia in 2001, Mental Health First Aid has since expanded to more than 20 countries. The National Council for Behavioral Health, in partnership with Missouri and Maryland state departments of mental health, introduced Mental Health First Aid in the United States in 2008. These entities are collectively known as the National Authorities of Mental Health First Aid USA and authorize all Mental Health First Aid certification in the United States. To date, more than 160 thousand individuals have been certified as Mental Health First Aiders, and more than 4 thousand have been certified as instructors.

The MHFA curriculum is offered in two core formats to participants 16 years and older. The adult curriculum is available in both Spanish and English. The course uses role-playing and simulations to demonstrate how to assess a mental health crisis; select interventions and provide initial help; and connect persons to professional, peer and social supports as well as self-help resources.

Youth Mental Health First Aid, as distinguished from the Adult MHFA curriculum, is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including ADHD), and eating disorders. Applicants should select whichever course (MHFA or YMHFA) is developmentally appropriate for the selected population of focus. The Youth curriculum will be available in Spanish beginning June 2015.

Mental Health First Aid USA is managed, operated, and disseminated by the National Council for Behavioral Health, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. Applicants from Maryland or Missouri should contact their respective state agency to get more information about Instructor training. All other applicants should contact the National Council for information about Instructor training. Only these three agencies are authorized to train individuals to be MHFA or YMHFA Instructors. A "train-the-trainer" option is not offered.

Curriculum modules are sets of materials designed for MHFA or YMHFA instructors to use when training key audiences. MHFA modules are currently available for the following audiences: Rural, Public Safety, Higher Education, Faith-Based organizations, and Military Members, Veterans, and their families. The YMHFA curriculum is currently available in both English and Spanish.

MHFA and YMHFA Instructor certification is offered through a five-day (40-hour) course which introduces the interactive program, overviews adult learning styles and teaching strategies, and provides in-depth instruction on implementing and managing the program in diverse communities. In order to attain certification, instructor candidates must demonstrate mastery of the program through a written exam and an evaluated presentation.

There are more than 7,000 MHFA instructors across the country. We would encourage you to find existing instructors in your area using the following website:
http://www.mentalhealthfirstaid.org/cs/take-a-course/find-a-course/
Search for your area and then scroll to the bottom of the page to find a list of instructors.

Estimated costs for implementing MHFA or YMHFA are included in the budget section, (see below).

Please note that once certified MHFA and YMHFA Instructors are required to teach at least three 8-hour First Aider courses per year to maintain certification. The recommended MHFA/YMHFA class size and Instructor ratio for the 8-hour MHFA or YMHFA First Aider course is 2 Instructors for every 25 to 30 participants. Applicants for the NITT-AWARE-C program must include in their budget sufficient funds for MHFA or YMHFA Instructor Training and MHFA or YMHFA First Aider manuals to ensure that all Instructors can maintain their certification.

For more information about MHFA, please go to:
http://www.mentalhealthfirstaid.org/

For more information about YMHFA, please go to:
http://www.mentalhealthfirstaid.org/cs/take-a-course/course-types/youth

For more information and guidance on how to set up MHFA/YMHFA training program in your community, please go to:
http://www.mentalhealthfirstaid.org/cs/become-an-instructor/start-a-local-program/

PART V: SUMMARY OF AND GUIDANCE FOR ESTABLISHING COLLABORATIVE PARTNERSHIPS

Federal grants supporting MHFA have typically encouraged partnerships among the following systems:

- Local Educational Authority (LEA)
- Local mental health authority and non-profit agencies
- Local law enforcement
- emergency first responders
- the child welfare agency
- faith based organizations
- families and caregivers

Those targeted for training commonly include:

- Teachers
- Other school staff: student support personnel (guidance counselors, nurses, psychologists); principal and assistant principals, special educators, after-school staff, directors of bullying prevention or violence prevention programs
- Child welfare/child protective authority if your target population includes significant numbers of children in foster care
- Peers, e.g., student council, informal groups of students
- Local substance abuse authority and agencies
- Health and human services personnel, e.g., school-based health or mental health program, substance abuse prevention or intervention program, youth group/recreation program, public agency such as financial assistance, , local hospital
- Emergency first responders
- Faith-based organizations – local churches, synagogues, mosques, other

It is common to include a letter of commitment from those agencies that will be providing behavioral health services to those for whom a referral to treatment is needed.
The following charts can be customized as tools to help you identify your project's partners and/or indicate the specific contributions of your key partners.

Note that these are only optional tools and should be customized if you choose to use one or both of them within your proposal.

Name of Partner	Contribution to Project	Services Provided

Partner Name	Outreach/Engagement	Youth Development Services	Youth Recreation	Family Services	Child welfare	Prevention	Subst. Abuse Treatment	Emergency Responders	Family Advocates Programs	Financial Assistance	Hospital	Trauma Treatment	Peer/ Family Support Services	Social/Holistic Services	Mental Health Treatment	Employ/Vocational Svc.	Transportation	Juvenile Justice

PART VI: DATA COLLECTION AND PERFORMANCE MEASUREMENT GUIDANCE

Outcome and Performance Measurement

In order to establish a baseline against which you'll measure impact, the following resources can be useful:

SAMHSA population data

- http://www.samhsa.gov/data/population-data-nsduh - National
- http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/Maps/NSDUHsaeMaps2013.pdf - State maps (both transition-aged youth & adolescent data available)

Adolescent or Transition-aged youth outcome

- Decreased reports of depression by youth
  http://www.samhsa.gov/data/sites/default/files/National_BHBarometer_2014/National_BHBarometer_2014.pdf

- PHQ9 for adolescents
  http://www.integration.samhsa.gov/images/res/8.3.4%20Patient%20Health%20Questionnaire%20(PHQ-9)%20Adolescents.pdf
    - Community or population level outcome
        - Percentage of adults within catchment area trained as MHFA or YMHFA instructors and first aiders
        - Measured by using tools to compare number of MHFA or YMHFA instructors and first aiders to number of instructors and first aiders prior to program implementation
    - Outcome related to provision of BH services in the geographic catchment area
        - Increase in the number of youth referred to BH service screening, assessment, or treatment
        - Measured by local reporting tool

PART VII: OUTLINE OF A JOB DESCRIPTION FOR A PROJECT DIRECTOR

MHFA Project Director/Coordinator job descriptions can be customized based on the following outline, and other project staff job descriptions can follow this outline:

Job Description

The Project Coordinator will oversee and manage all aspects of the XXX program and ensure that all NAME OF APPLICANT resources are available for program support. The Project Coordinator will be responsible for coordinating DESCRIBE ROLE CONVENING/COORDINATING PARTNERSHIPS and overseeing credentialing and tracking activities to ensure that the program meets its goals and achieves its objectives.

Responsibilities

- Plans, directs, and coordinates all program services
- Responsible for program evaluation issues, including interface with Project Evaluator
- Oversees policies and procedures related to MHFA/YMHFA training
- Establishes meetings with trainers [HOW OFTEN?]
- Authorizes and monitors all training offered by the MHFA/YMHFA trainers
- Approves all new hires, terminations and salary adjustments
- Monitors program budget
- Ensures that all program requirements are met

Qualifications for position

- At least two years of experience providing outreach, engagement and services to the target population
- Professional degrees
- Credentials?
- Familiar with culture, demographics, and languages of the community where program will be implemented

Supervisory relationships

- The Project Coordinator will report to [insert position/name]. Supervisory meetings will be held [HOW OFTEN?]

Skills and knowledge required

- Familiar with culture, demographics, and languages of LEA and community where program will be implemented
- Trained to provide MHFA/YMHFA by Month X of the project
- Familiar with the LEA community and its services, supports, and systems serving youth and families
- Experience providing training

Personal qualities

- [SAMPLE] This individual will possess excellent written and verbal communication skills and must be comfortable working with an array of community partners, including speaking publicly on behalf of the project. In order to promote effective community saturation of the MHFA model, this individual should possess a strong commitment to the program's transformative potential within the system of care.

Amount of travel and any other special conditions or requirements

Salary range

Hours per day or week

PART VIII: BUDGET GUIDANCE AND SPREADSHEET

The budget spreadsheets are tools that can be used to customize required federal or state budgets, but must be adapted per the RFA guidance. Sample numbers are provided, which need to be customized to reflect your proposed project and the allowable/required limits for the specific program. See RFA for details.

As a guide, the following cost estimates were included in the SAMHSA Now is the Time RFA for MHFA:

Item	Estimated Cost
On-site MHFA or YMHFA Instructor Training	$35,000 for up to 30 participants. This training is conducted by the National Council for Behavioral Health. 5 days, 40 hours.
Off-site MHFA or YMHFA Instructor Training	$2,000 per participant + travel and per diem costs. 5 days, 40 hours.
Instructor Training Upgrade (i.e., already a MHFA Instructor but wants to become a YMHFA Instructor)	$950 per Instructor, exclusive of travel and any per diem costs; 2 ½ day, 20 hours
MHFA or YMHFA “First Aider” Training	Approximately $25 to $150 per person for training space, easel pads, and any other needed supplies. 1-day 8-hour training.
MHFA or YMHFA Manuals	$20 per person (this includes the cost for the Manual + shipping and handling costs)
Cost for substitute teachers	Approximately $100 per substitute teacher

Once you have developed your program costs, based on the RFA guidance, you can transfer the line items to the required format, which is within the electronic grants.gov application for federal grants.

CONCLUSION

We hope that this toolkit is a valuable resource.

Please contact us if there are further materials that we might provide to assist you in applying for this grant or of you require additional information about MHFA or YMHFA.

info@mentalhealthfirstaid.org

APPENDIX A: SAMPLE GRANT TEMPLATE

Mental Health First Aid® USA

Organization Name

Executive Summary
This section summarizes what the program is, the need for it, and the specific monetary ask based on what you propose to do. Following is an example for the National Council.

For too long, mental illnesses have been treated as separate and tangential to our overall health and wellbeing. Because of this, accessing mental health services is not as simple as making an appointment with your family doctor. The stigma surrounding mental illness often prevents people from seeking treatment, and those that do want help are not sure where to turn.

The National Council for Behavioral Health (National Council) spearheaded the adoption of Mental Health First Aid™ USA, an innovative public education program that addresses this pervasive and persistent challenge in communities across the United States. Mental Health First Aid is an evidence-based in-person training to teach individuals how to recognize and respond to the warning signs of mental and substance use disorders and link people with appropriate treatment. Mental Health First Aid increases the understanding that mental illnesses are real, common, and treatable.

The National Council's goal is to make Mental Health First Aid as common as First Aid. Originating in Australia in 2001, Mental Health First Aid has expanded to more than 23 countries. Since the program was introduced in the U.S. in 2008, more than 6,500 instructors have been certified to teach the program and more than 300,000 Americans have been trained as "Mental Health First Aiders."

[Organization Name] requests your consideration of a grant in the amount of [*enter amount*] to support Mental Health First Aid in our community. Mental Health First Aid is a low-cost, high-impact program that generates tremendous community awareness and support, and enables thousands of individuals to be trained with a small investment.

> *"Mental Health First Aid is truly a population-based health initiative. The response we have gotten to this program has been tremendous. We are very excited about this initiative and the impact that we believe it will have on community health. We see this initiative as an important component of our public health approach to behavioral health issues. It's been one of the best things to happen to the field."*
>
> Dr. Arthur Evans, Commissioner, Philadelphia Department of Behavioral Health and Intellectual disAbility Services

Needs Assessment
Add local or state statistics in addition to some of these statistics; approximately 5 total is recommended.

A 2012 national survey reveals that one in five Americans — 45.9 million adults aged 18 or older—experience mental illness in any given year. An estimated 8.7 million American adults had serious thoughts of suicide in the past year, 2.5 million made suicide plans, and 1.1 million attempted suicide.

Mental illnesses are just as treatable as other health conditions, yet only about 4 in 10 people experiencing a mental illness in 2011 (39.2 percent) received mental health services. If left unacknowledged and untreated, mental illnesses can result in disability, substance abuse, suicide, lost productivity, and family discord.

According to the World Health Organization, mental illness accounts for more disability in developed countries than any other group of illnesses, including cancer and heart disease. Having a mental illness or addiction can have damaging and costly effects on a person's life, such as job loss, school dropouts, relationship issues, and drug and alcohol problems. Beyond the impact on the individual experiencing the illness, the cost and consequences of untreated mental illness affects families and caregivers, employers, and tax paying citizens. The economic impact of mental illness in the United States is substantial—about $300 billion annually. Much of this is due to lost productivity in the workforce, but also includes the use of emergency services, involvement of the justice system, and other social supports.

The effects of untreated mental illness and addiction need not be so widespread. There are many reasons that people do not seek help for these concerns. Often, people may not know where they can get help, if they can get help, or may feel ashamed of their condition due to widespread stigma toward people with mental illnesses and addictions. Mental Health First Aid addresses these barriers directly – offering a forum for understanding and discussing mental health and addiction, outlining resources for where to turn for help, and encouraging people to be the first line of help that so many Americans need.

Program Overview
Good to include some specific information on Mental Health First Aid's presence and presentation in your organization here, as well as some information on the national program overall, as described below.

Mental Health First Aid gives people the skills to help someone who is experiencing a mental health crisis and how to intervene early to help someone with a mental health or addiction concern. The program is based on the principle that early intervention prevents mental illness from becoming more severe by encouraging people to seek help early. Participants learn a 5-step action plan encompassing the skills, resources, and knowledge to help connect an individual in crisis with appropriate professional, peer, social, and self-help care.

Mental Health First Aid is proven to improve mental health literacy and reduce the stigma surrounding mental illness. Mental Health First Aid is listed in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices. Evaluations demonstrate that the program saves lives, improves the mental health of the individual administering care *and* the one receiving it, expands knowledge of mental illnesses and their treatments, and reduces negative attitudes and discrimination toward individuals with mental illnesses.

More than 300,000 people from all 50 states and the District of Columbia have completed the training. The training has broad applications with a diverse range of audiences, including law enforcement, schools, primary care, veterans and members of the military, and employers. The program is available in both English and Spanish. Youth Mental Health First Aid, which rolled out in the Fall of 2012, specifically addresses strategies for assisting youth ages 12-18.

The support for Mental Health First Aid is evidenced in support from state and federal governments to expand the program. As part of the "Now is the Time" initiative, the Obama Administration sought funding from Congress for mental health initiatives, including $15 million for Mental Health First Aid training for teachers and others who work with youth to "understand, recognize, and respond to signs of mental illness or substance abuse in children and youth, including how to talk to adolescents and families experiencing these problems so they are more willing to seek treatment." State and local education authorities across the country applied to receive the funding for Mental Health First Aid initiatives in their area.

As of 2015, more than 20 states have appropriated funds towards Mental Health First Aid initiatives, primarily for particular groups, including teachers and public safety professionals.

Organizational Capacity and Administration
Give organizational history and overview here; good to include example of organizational success. Following is an example for the National Council.

The National Council for Behavioral Health (National Council) is a not-for-profit 501(c)(3) association that acts as the unifying voice of America's behavioral health organizations. Together with our 2,200 member organizations, we serve our nation's most vulnerable citizens – more than eight million adults and children with mental illnesses and substance use disorders. We are committed to providing comprehensive, quality care that affords every opportunity for recovery and inclusion in all aspects of community life.

The National Council advocates for public policies in mental and behavioral health that ensure that people who are ill can access comprehensive healthcare services. We offer state-of-the-science education, and practice improvement resources so that services are efficient and effective. These services are offered to state and local governments, as well as health and human services organizations. The National Council provides trainings, technical assistance, consultation, and public education to address organizational leadership and strategy, workforce development, systems change, best practices implementation, outcomes measurement, and community understanding and support.

Mental Health First Aid is the National Council's premier public education program and benefits from the active participation of senior leadership and staff at the National Council. The National Council is staffed and resourced to offer instructor and community trainings in response to growing demand; develop curriculum; and offer strong support to the instructor network to help them roll out community trainings.

The National Council developed the Mental Health First Aid USA curriculum and training program in collaboration with the Maryland Department of Health and Mental Hygiene and the Missouri

Department of Mental Health, building upon the foundation of the evidence-based Mental Health First Aid Training and Research Program in Australia. The program was developed using the consensus of international expert panels involving mental health consumers, caregivers, and professionals.

Methodology

Also include specific information on your organization's Mental Health First Aid audience types, how many instructors you have on staff, how many courses are typically offered, etc.

The National Council trains, certifies, and supports instructors. Instructors serve as ambassadors for the program in their communities — generating awareness and demand — in addition to teaching the course and providing local resources for treatment and help.

Mental Health First Aid participants typically include law enforcement and corrections officers; emergency first responders; human resources professionals; nurses and other primary care workers; secondary education and university faculty, staff, and student leadership; library personnel, corporate human resource managers, faith community leaders; veterans, national guard and military families; mental health/substance use patients and family members; and other caring citizens.

Once certified, an instructor is required to teach at least three community trainings per year to maintain certification. Ideal class size for a community training is 25-30 people. The intent is for instructors to offer the program free or for a nominal fee, even though program expenses — instructor time, participant manuals, venue and audio-visual costs, etc. — are significant. Instructors are often able to work with regional and local certifying bodies to award Continuing Education credits to multiple groups of professionals who take the course.

The National Council trains and manages the national instructor network; consults on program implementation, growth, and marketing; analyzes evaluations from community courses; continuously enhances and updates the curriculum; and provides live and virtual refresher and upgrade courses for instructors. Technical assistance visits are carried out nationwide to ensure fidelity to the core program model. In addition, the National Council staff delivers the course in Washington, D.C. and nationally to opinion leaders, key influencers, and the general public.

Goals & Objectives

Propose organization's goal(s), and expected objectives here. Following is an example of a previous goal for the National Council.

The National Council believes that Mental Health First Aid can change the way America thinks about mental illness — that this simple yet powerful program holds the key to increasing understanding, promoting health, and connecting people to care.

Goal: Our goal is to have 250,000 individuals trained and certified as Mental Health First Aiders by 2015.
Process Objective: To facilitate the training and certification of an additional 110,000 people throughout the US, for a total of 250,000 individuals trained since 2008.
Outcome Objective: By 2015, approximately 0.08% of the total American population will be trained in Mental Health First Aid, and be better equipped to handle mental health issues.

Action Plan & Timeline
Give organizational timeline based on goals and objectives stated in previous section.

Quarter 1
Invite applications from instructors for financial support for local program delivery; establish selection criteria (population target, instructor experience, and financial needs and ability to provide/raise matching funds); complete selection process.

Quarter 2
Have selected instructors schedule community courses, engaging local partners in audience outreach and marketing; and organize all training logistics. Provide marketing/PR and technical assistance as needed by instructors.

Quarter 3
Delivery of community courses; monitor course completion and feedback through reported evaluations; ongoing marketing/PR and technical assistance support.

Quarter 4
Complete delivery of community courses; confirm number of new Mental Health First Aiders and review all course feedback to develop final grant report.

Outcomes Measurement Plan
List all outcome indicators that your organization will use to assess progress and achievement of goals, and explain how this will be done.

Outcome indicators will be based upon:

- The total number of people trained and certified in Mental Health First Aid

Instructors are required to register individuals for subsidized courses through a national web-based information management system [WIMS] that tracks program delivery. Upon course completion, instructors also must submit, through the WIMS, standardized evaluations completed by each participant. The National Council will use WIMS data to track and confirm the number of Mental Health First Aiders certified through grant-subsidized programs. The evaluation and data collection instruments are based on a review conducted by the University of Maryland, as part of an independent national fidelity study of Mental Health First Aid USA.

The National Council also will conduct a limited number of technical assistance visits to ensure fidelity to the core program model. Qualitative and anecdotal data about the impact of Mental Health First Aid will be gathered through national online communities and forums of instructors and Mental Health First Aiders.

Budget Narrative

Create based on specific grant to describe how the funding will be used, and what expenses will be incurred. A sample budget template is available from the instructor website.

A [*enter amount*] grant will provide the resources to accelerate the growth of the Mental Health First Aid program, allowing the National Council to fund the delivery of courses across the country.

- ➔ Local communities will receive a grant not to exceed $5,000 based upon their training capacity. Local sites will compete through an RFP process. The National Council's Mental Health First Aid team will establish and implement the selection criteria.
- ➔ The amount of funding per site will be dependent upon the communities' local financial needs. The costs per training include facilities, manuals, staff time, and supplies.

Personnel

Give names and titles of the individuals who manage the Mental Health First Aid program, including any instructors who will be teaching the course using grant funds. Be sure to emphasize or highlight any relevant experience of team members related to the grant (e.g., work with law enforcement if planning to teach public safety professionals).

The National Council's Mental Health First Aid team includes:

- Linda Rosenberg, President and CEO *(Corporate Oversight)*
- Betsy Schwartz, Vice President, Public Education & Strategic Initiatives

- Meghan Bragg, Program Associate
- Bryan Gibb, Director of Public Education
- Tasnia Habib, Program Associate
- Susie Morrison, Program Associate
- Laira Roth, Project Manager
- Jessica Steltzriede, Program Associate
- Tramaine Stevenson, Director of Program Development and Operations
- Mary Wichansky, Instructor and Curriculum Support Manager

Appendices

Additional attachments may include any of the following items.

501c3 IRS determination letter
Board of Directors List
Overall Organizational budget
Letter(s) of support
Recent press coverage
Overview of program testimonials