SAMHSA's "Now is the Time" - Project Aware: A Toolkit for Applicants

Local Education Agency (LEA) Applications – No. SM-14-019 *Due June 16, 2014*
State Education Agency (SEA) Applications – No. SM-14-018 *Due June 16, 2014*

INTRODUCTION

The following Toolkit is designed to support organizations with Mental Health First Aid (MHFA) programs in assisting their partners within Local Educational Agencies (LEAs) and State Educational Agencies (SEAs), to respond to the recent Request for Applications (RFAs) issued by the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) under the authorization of "Now Is The Time" (NITT) – Project Aware.

NITT-AWARE-LEA provides for up to 100 grant awards to LEA applicants of up to $50,000 per year for two years.

NITT-AWARE-SEA provides for up to 20 grant awards to states of up to $1.95 million per year for up to 5 years. Of this amount, 13 percent of funds must be allocated to Component 2: Implement Mental Health First Aid/Youth Mental Health First Aid in State and Local Training Programs.

The NITT-AWARE grants are due **June 16, 2014**.

Note that applicants for Project AWARE must also apply for the Department of Education (DOE) School Climate Transformation grant (for LEAs or SEAs, as appropriate). The DOE grants are due June 23, 2014.

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 200,000 people have been trained in Mental Health First Aid through a network of more than 4,200 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 Project AWARE Toolkit

This toolkit is intended to support Project AWARE applicants in developing their own customized and localized approach to the SAMHSA applications. It offers sample guidance and is intended as a supplement to the instructions in the SAMHSA Request for Applications for LEA and SEA applicants, each of which outline the application requirements and provide sample materials.

This supplemental material includes the following parts:

1. **National data and data sources** regarding the prevalence of adolescent 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. 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 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. **Training selection considerations** for Mental Health First Aid (MHFA) and the Youth Mental Health First Aid (YMHFA) modality.
5. Summary of **essential partnerships**, including those partnerships required for LEA and SEA applications and the partnerships that are recommended for robust community-wide integration.
6. Outline of the **Project Coordinator Job Description.**
7. Guidance for developing draft **Letters of Commitment** from which your partners' customized letters can be crafted for your application, along with a **sample LOC**.
8. **Budget Guidance** and a **budget spreadsheet**, which can be used as a tool to develop your application's budget.

PART I: NATIONAL DATA ON ADOLESCENTS 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 in the development of Section A for your proposal. This section for Project AWARE-SEA is called the *Statement of Need* (15 points) and for Project AWARE-LEA it is the *Population of Focus and Statement of Need* (10 points). These are short but crucial sections, which 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/depression-in-children-and-adolescents.pdf)

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

- http://samhsa.gov/data/Spotlights.aspx
  - There are short summaries here of a variety of topics, including:
    - Needs of **teens in foster care**, with focus on substance abuse (schools in some urban districts may have large numbers of students in foster care; important population to address)
    - Increase in population who will get insurance under **Affordable Care Act**, either Medicaid or through Health Insurance Exchanges/private insurance (will affect schools' being able to offer more help)
  - Youth living in **poverty** at higher risk for depression: http://samhsa.gov/data/spotlight/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. SAMHSA Data on Mental Health and Trauma http://www.samhsa.gov/children/data.asp

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/teen-brain.pdf

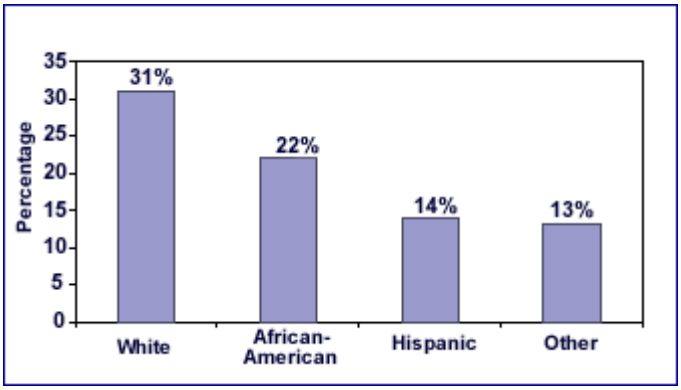
At these sites, you can find more data on the specific items identified:

- 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/pubs/issue_briefs/brain_development/how.cfm#adolescence

Disparities

For the LEA application and in the selection of three LEAs for the SEA application, you will need to understand the population being served. If the communities in which the schools operate are those with high prevalence of poverty or where racial/ethnic groups predominate, you will need to describe that and identify the extent. Usually, the LEA and the SEA will have this data. Should you be selecting such a community, use the following to support the need for programs and resources to overcome disparities that affect low-income communities or schools with significant populations that experience disparities.

Table: 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. Older adolescents have higher rates of mental issues than younger adolescents. 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), and 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

SAMHSA, *Serious Mental Health Challenges Among Older Adolescents and Young Adults*, http://samhsa.gov/data/2K14/CBHSQ173/sr173-mh-challenges-young-adults-2014.htm (This monograph has a great deal of useful data in it).

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

NOTE: School Counselors are not typically trained to provide treatment assistance and are more commonly expected to offer referrals to formal care. This is an important consideration for SAMHSA applications, in particular, as reviewers will want to ensure that treatment linkages are made to licensed providers and that informal and naturally occurring supports are leveraged, as well.

MHFA offers a vital response to access barriers by supporting those adults who have existing connections to young people in providing intervention and referral assistance. YMHFA and MHFA flexibly respond- to individuals where they are and provides the “glue” between existing systems. The description of how your proposed approach addresses the identified needs and gaps will begin in Section B for both the LEA and SEA applications, called the “Proposed Training Plan Approach” or the “Proposed Approach.”

PART II: LOCAL AND STATE DATA

Once you have demonstrated need at the federal level, you’ll want 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 to justify your “case” for state and/or local funding:

- The SEA has demographic data posted on its website, e.g., ethnic-racial background, income, disability, gender. There may be a drop-down menu by LEA name
- The SMHA (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
- The State Substance Abuse Agency has data on its website
- SAMHSA has state data on mental health and substance abuse, including demographic information:
  - http://samhsa.gov/data/States_In_Brief_Reports.aspx
  - http://www.samhsa.gov/dataoutcomes/urs/urs2012.aspx
- Data/demographic profile of school-aged youth in your LEA and community
  - It is likely that the applicant LEA will has demographic data, some of which may be posted on its website; other demographic and related data may be obtained from whatever office prepares grant applications to state and federal agencies
- 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/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html
  - 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
  - Casey Foundation/Kids Count has interesting data from some states
    - http://datacenter.kidscount.org/search/#q/mental%20health
      - Emergency room visits by children for mental health
    - http://datacenter.kidscount.org/data/tables/6031-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=1&loct=2#detailed/2/2-52/false/1021,18/any/12694,12695; Increase or decrease, by numbers and percentage, of children with one or more emotional, behavioral, or developmental conditions
  - School mental health: http://www.schoolmentalhealth.org/AboutUs.html

PART III: AN APPROACH FOR IDENTIFYING CURRENT RESOURCES

Within Section A of the proposal applicants must 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 this section to show the connections between education and behavioral health and to situate MHFA as an 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

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

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

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/YMHFA SELECTION CONSIDERATIONS

There are two types of Mental Health First Aid curricula -- adult and youth. The adult MHFA curriculum is appropriate for individuals, 18 years of age 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 MHFA, as distinguished from the adult MHFA curriculum, is designed to teach adults, 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. For background information on MHFA and YMHFA, refer to Appendix H of the RFA.

Choose the MHFA Curriculum that meets identified local needs for your target population.

In deciding which Mental Health First Aid training course to select, keep the following in mind:

- YMHFA is a modality distinguished from the standard MHFA curriculum in order to specifically address the needs of youth;
- YMHFA is designed to teach parents, family members, teachers, school staff, peers, and others, including emergency responders, how to help an adolescent age 12-18 who is experiencing a mental health or addictions challenge or is in crisis.

Some applicants may opt to conduct standard MHFA trainings in order to meet the needs of older students, but analyze your target population in order to select the right curriculum – Youth MHFA, Adult MHFA, or both- and justify your selection within the proposal.

PART V: COLLABORATIVE PARTNERS

A. Local Education Authorities-Required Partners

1. Partnership requirements related to the ***implementation of MHFA*** are described in Section 2.1.2 of the RFA for LEAs:

Required partnerships at the local level:

- Local Educational Authority (LEA)
- Local mental health authority and non-profit agencies
- Local law enforcement

Other partners should include:

- Emergency First Responders
- Child Welfare Agency
- Faith Based Organizations
- Families and Caregivers

Those targeted for training 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

2. Partnership requirements related to ***Experience and Credentials for Partners Providing MHFA*** Training are described in Section 3.2

If the LEA proposes to have a community organization provide MHFA or YMHFA training:

- the **community organization must be included as a required partner**;
- **the organization must have been providing services to the target population (i.e., school-aged youth) for at least two years;** and

- a letter of commitment must be submitted with the application from any organization that has agreed to participate in the project (see LOC guidance, below)

B. State Education Agency-Required Partnerships

1. Partnerships Required for ***implementation of MHFA*** and the State Management Team:

- State educational authority (SEA)
- Leadership of three LEAs
- Youth and Family Representative
- Representatives from the State Departments of Mental Health/Substance Abuse Services
- State criminal/juvenile justice agencies

2. ***Additional Partners*** encouraged within the RFA:

- State Medicaid Directors
- Child welfare agency
- Early childhood agency or representatives
- Faith-based organizations
- Family and Youth Representatives

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. All partners described in your proposal must provide a Letter of Commitment that is included within the application package in Attachment 1.

Name of Partner	Contribution to Project	Services Provided

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

PART VI: LETTERS OF COMMITMENT (LOC)

- Letters of commitment are described on p. 13, Section 2.2.5 of the RFA for SEAs and p. 14, Section 3.2 of the RFA for LEAs.
- Letters of Commitment must be included in Attachment 1, which cannot be more than 30 pages.
- A letter of commitment is required from any organization that agrees to be a partner in the project.

Further guidance is provided below for LEA and SEA applicants, and a sample LOC is offered as an attachment to this toolkit:

1. LEA Letters of Commitment

Letters of commitment are required from collaborating partners and must specify the contribution to the project (e.g., outreach, providing a venue, receiving training, providing training, etc.), the current capacity of the organization, and any in-kind services or resources to be provided (if applicable).

For ***LOC from partners proving MHFA training***, the letter must also describe current capacity to provide Mental Health First Aid training, numbers trained to date, and compliance with the RFA requirement that partners have a minimum of two years experiencing serving school-age youth.

***SAMPLE* approach:**

Dear SAMHSA Administrator:

The XXX name of specific organization enthusiastically commits to collaborating with the (NAME) School District to carry out a Now is the Time-Project AWARE project with federal SAMHSA funds.

Our Agency/Program now provides services to NUMBER OF PEOPLE in GEOGRAPHIC LOCATION. We are the organization that other providers rely on to do XXX, YYY, ZZZ. We collaborate with first responders, other mental health providers, and (Whoever else).

Should this grant be funded, our Agency/Program commits to providing the following in-kind resources and staff to the joint project: DESCRIBE.

We look forward to working with you to implement this Mental Health First Aid project with you and other partners.

Sincerely yours,

AUTHORIZED REPRESENTATIVE

2. SEA Letters of Commitment

The SEA application must include the following Letters of Commitment (LOC):

1. ***An LOC from the SEA***- detailing how the SEA will support the Project Coordinator to lead, oversee, and manage all grant activities and be the liaison between the other state agencies, the State Management Team, and the three LEAs.

2. ***LOCs from each of the required partners*** (i.e., state offices of mental/behavioral health, and criminal/juvenile justice and the superintendents from each of the three LEAs) as well as youth and family representatives or organizations participating on the State Management Team (SMT).

The LOCs must be ***signed by the authorized representative*** from each of the required partners and must include the following information:

- The organizational capacity of the agency or authority and its commitment to supporting the NITT-AWARE-SEA program.
- A statement of the willingness of the agency or authority to partner and collaborate on NITT-AWARE-SEA program.
- A description of the available resources, including staff, from each agency or authority that can be leveraged to support the development and implementation of the NITT-AWARE-SEA coordination and integration plan.
- A description of past experience with building collaborative relationships that engage state and community members in developing and implementing child and youth-focused programs.
- Identify a representative to serve as a member of the State Management Team (SMT).

SAMPLE SEA Letter

Dear NAME:

The XXX name of specific organization enthusiastically commits to collaborating with the (State NAME) State Educational Authority to carry out a Now is the Time-Project AWARE statewide initiative.

Our Agency/Program provides XYZ services to NUMBER OF PEOPLE in GEOGRAPHIC LOCATION. We are the organization that other providers rely on to do XXX, YYY, ZZZ. We collaborate with first responders, other mental health providers, and (Whoever else).

Our capacity to continue to provide services will be expanded through this grant. Should this grant be funded, our Agency/Program will commit to DESCRIBE ROLE IN COLLABORATION and the grant-funded and in-kind contributions planning.

Our representative on the State Management Team will be NAME.

We look forward to partnering in this historic initiative and fully support the goals of this project.

NAME OF AUTHORIZED REPRESENTATIVE

PART VII. PROJECT COORDINATOR DESCRIPTION

The Project Coordinator job description 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 LEA and community where program will be implemented

Supervisory relationships:

The Project Coordinator will report to XXXXXXX. 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 SPREADSHEET

The budget spreadsheets provided for LEA and SEA applicants are tools that can be used to customize the required SAMHSA budgets, per the RFA guidance. Sample numbers are provided, which need to be customized to reflect your proposed project and the allowable/required limits for this specific program. See RFA for details.

As a guide, the following cost estimates were included in the RFA for MHFA:

Item	Estimated Cost
Instructor Training	$3,000 to $4,000 per instructor
MHFA or YMHFA "First Aider" Training	$50 to $150 per person
MHFA or YMHFA Training Materials	$20 per person
Cost for substitute teachers	$100 per substitute teacher

Once you have developed your program costs, based on the RFA guidance, you can transfer the line items to SAMHSA's format within the electronic grants.gov application.

CONCLUSION

We hope that this toolkit is a valuable resource.

Please visit **www.MentalHealthFirstAid.org** or 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 Mental Health First Aid.

Mental Health First Aid USA is a collaboration between the National Council for Behavioral Health, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health.

The National Council for Behavioral Health is the unifying voice of America's community mental health and addictions treatment organizations. Together with our 2,000 member organizations, we serve our nation's most vulnerable citizens — the more than 8 million adults and children living with mental illnesses and addiction disorders. We are committed to ensuring all Americans have access to comprehensive, high-quality care that affords every opportunity for recovery and full participation in community life. The National Council pioneered Mental Health First Aid in the U.S. and has trained more than 200,000 individuals to connect youth and adults in need to mental health and addictions care in their communities. Learn more at www.TheNationalCouncil.org.