

Step 2: Identify the unmet service needs and critical gaps within the current system.

SUBSTANCE ABUSE TREATMENT: Drug and Alcohol Branch Services – “New Beginnings”

The Drug and Alcohol (D & A) Branch, under the umbrella of the Department’s Division of Clinical Services will continue in FY 2017 and FY 2018 to comply with its mandate to provide comprehensive inpatient (residential) and outpatient substance treatment services for the entire Territory of Guam, considering that it’s a small island with a small population. The Branch adopted the American Society of Addiction Medicine (ASAM) Criteria, 3rd Revision to define its substance treatment levels of care. The Drug and Alcohol Branch plans to be the gateway to provide substance abuse early identification, substance treatment and recovery support services for adult and adolescent individuals who are uninsured or for those insured but recommended services are not covered by their insurance provider (i.e., Medicaid) for the entire Territory.

Each year the D&A Branch and its contractors serve approximately 1,200 clients. The Branch will continue to provide ambulatory services including ASAM Level 0.5 Education/Brief Intervention, Level 0.7 Recovery Support Services, Level I Outpatient, and Level II Intensive Outpatient. ASAM Level III.7 Semi-medically managed for co-occurring disorder clients is being planned for implementation in FY 2016 using local funding. Clients with no DSM-V diagnosis but have a substance episode will receive education/brief intervention services and clients with a substance related disorder or with co-occurring disorders will receive Outpatient or Intensive Outpatient services. The Branch will continue to utilize evidenced-based models and practices in all of its levels of care. These include the Matrix Model, Driving With Care Model, Dual Diagnosis Recovery Counseling (DDRC), Dialectic Behavior Therapy (DBT), Motivational Interviewing, and Recovery Oriented Systems of Care (ROSC). Cultural adaptations with these models are ongoing as the process continues to translate materials to other island languages and aligned them into the context of the various ethnic populations being served.

GBHWC’s D&A Branch will also continue to contract and partner with non-profit community-based organizations to provide the following substance treatment levels of care. These include ASAM Level I Outpatient, Level II Intensive Outpatient, Level III.2-D Social Detoxification Services, and Level III.5 Short and Long Term Residential Services. The contracts will require the use of evidenced-based models, particularly the Matrix Model and Driving With Care. All potential non-profit organizations have already been trained in Matrix. The Drug and Alcohol Branch became a certified Matrix Facility in August 2013 by the Matrix Institute Office in LA, California. The Branch will continue its role to monitor awarded non-profit contractors to perform the levels of care at optimal level and the implementation of Matrix at fidelity level. The Branch will also support the contractors by identifying essential trainings that will enhance their abilities to better perform the scope of services as outlined in contracts.

To assess the strengths and needs of the service system to address specific population the Branch will continue to host the monthly Community Substance Abuse Planning Development” (CSAPD) Group. The Group is comprised of SSA providers, contracted providers of SSA, certified or licensed substance abuse counselors, stakeholders, former treatment consumers, and interested individuals in the community wanting to improve Guam’s substance treatment delivery system. The role of CSAPD is to strengthen collaboration among providers and lead in

the planning and development of substance abuse treatment infrastructure and processes for establishing territory-wide, data-driven treatment priorities. Some areas of focus include improving access to treatment, identifying pertinent data to collect, and addressing workforce development issues and training. CSAPD group's top priority continues to be developing a substance treatment benefits package for reimbursable services under the Medicaid Territory Plan. There is clear intention to propose for amendments in the Guam Medicaid Plan to include evidenced-based substance treatment models to become reimbursable services. Another priority has been to propose a career ladder for substance abuse treatment counselors and peer recovery coaches. There are only 25 certified substance treatment counselors on Guam yet the island needs at least 40 to address the growing treatment population (Data by Pacific Substance Abuse Mental Health Certification Board).

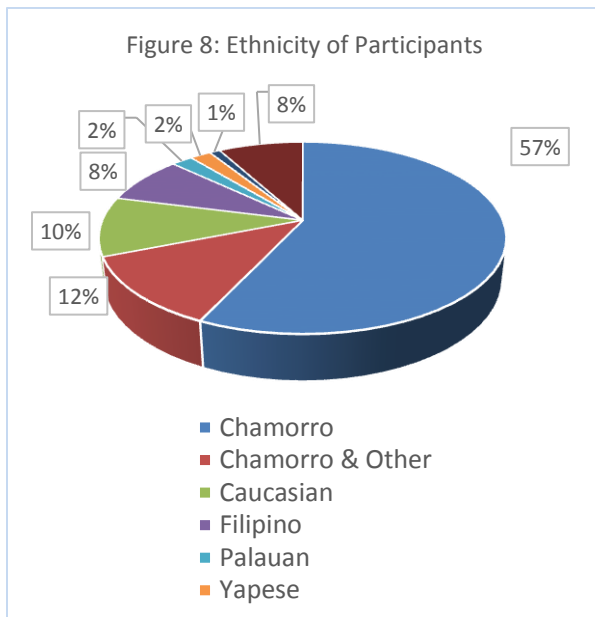
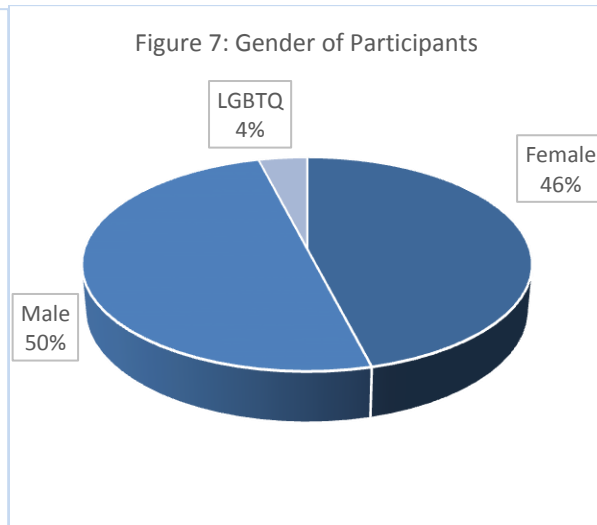
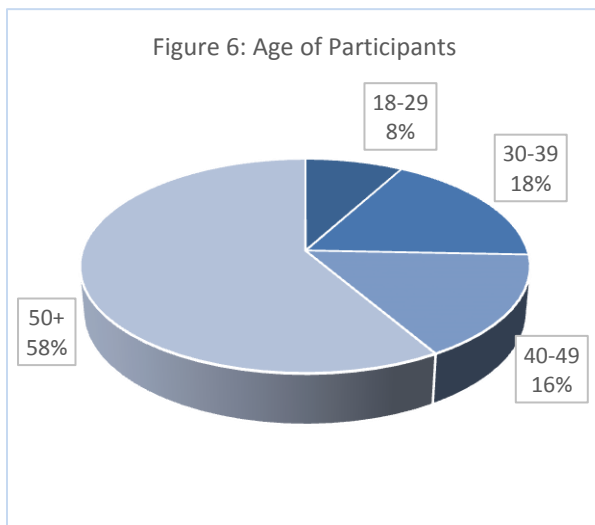
In 2015 the program was awarded the BRSS TACS grant. One of the main objectives of the BRSS TACS grant was to provide a Strengths & Needs assessment in the recovery community. The information presented in this report was compiled through the means of a needs and strengths assessment conducted on the island of Guam from September through November 2016. The assessment was funded by a grant from the Guam Behavioral Health and Wellness Center. The key purposes of the study were to identify: a) existing strengths and resources for treatment and recovery within the community, b) barriers to participation and services, and c) perceived needs for long-term support as related to individuals with substance use, mental health, and co-occurring disorders.

Participation for the study was promoted through invitation during Recovery Month Open House events held at New Beginnings, Lighthouse Recovery Center (LRC), Oasis Empowerment Center (OEC), and Sanctuary Incorporated. All four agencies provide substance abuse treatment on Guam. New Beginnings being the SSA also provides direct patient care and the other three agencies are contracted non-profit community-based organizations.

Initially, community members were invited to complete a Screening Survey (Appendix A) which would verify that the person met the requirement of participation, as well as to inform the Principal Investigator of their willingness to complete the Needs and Strengths Assessment Survey and/or to participate in a focus group. The majority of the Needs and Strengths Assessment Surveys were completed during Guam's Recovery Month Open House events following completion of the Screening Survey. Invitations for participation were also sent via E-mails to service providers and posted on the Alcoholics Anonymous Facebook page. Some Needs and Strengths Assessment Surveys were completed at the beginning of focus group sessions in cases where community members had been unable to attend Open House events but knew of the focus group sessions or were attending the venue of the focus group sessions and wanted to take part.

One hundred and twenty-one community members completed the Needs and Strengths Assessment Surveys of which 102 participants met the screening requirements: at least 18 years of age, **and** had been or was currently engaged in recovery services/programs on Guam **or** had a family member who had been or had been or was currently engaged in recovery services/programs on Guam **or** had been or was currently employed as a service provider for recovery purposes on Guam.

A convenience sample of 138 community members (68 females, 65 males, and five transgender) took part in the study (Figure 6). This number is roughly 10% of the number of people reported to be receiving services for substance abuse issues each year. The majority of the participants (73%) were between the ages of 30 and 49 with the largest percentage (39%) specifically between the ages of 30 and 39 (Figure 6). Those identifying themselves as Chamorros comprised the majority (57%) of the participant population (Figure 8). The demographics of the participants were representative of the overall population engaged in recovery services in terms of age and ethnicity with exception that more females were engaged in the study (46%) than are represented overall within recovery services (19%). The majority of participants (c.85%) identified themselves as being engaged in services for substance abuse (past and/or current), while the other 15% identified themselves as either being related to someone who had been or currently was engaged in services or were engaged as a provider of services.



Four key aspects were cross-verified: key components noted for recovery, the greatest barriers of recovery, key strengths of the current programs and services on Guam, and suggestions for improving recovery programs and services.

Support was noted as a key component for recovery (Figure 20). General support was noted in 83% of the focus groups with family support noted specifically within 50% of the focus groups, while family (58%) and peer (47%) support were the two most important types of support identified by survey participants. Hence, in combining the survey and focus group data, family support was identified by both groups as being highly significant in recovery.

Figure 20: Key Components of Recovery – Combined Data

	Survey	Focus Groups
Support in general		83%
Family support	58%	50%
Peer support	47%	33%
Community support		33%
Government support		33%
12-Step programs		33%
Counseling	2%	33%

Participants identified several crucial barriers to or in recovery (Figure 21). The three barriers most commonly referred to within the focus groups were 1) stigma, 2) the fact that the community and/or family is not a safe environment, and 3) the limited numbers of staff, services, resources, centers, and choices. Survey participants identified three main barriers: 1) limited number of staff, services, resources, centers, and choices; 2) lack of transportation; and 3) family members in denial or not understanding (lack of family support). Participants in 50% of the focus groups also talked about the lack of transportation, financial problems, and denial within the family.

Figure 21: Greatest Barriers in Recovery – Combined Data

	Survey	Focus Groups
Stigma		67%
Community & family not safe		67%
Limited staff, services, resources, centers, choices	55%	67%
Lack of transportation	56%	50%
Financial problems		50%
Family in denial or not understanding (lack of family support)	46%	50%

The fact that the aspect of family support was identified as being a vital part of recovery as well as the greatest barrier in recovery was discussed in three of the focus groups. Participants noted that sometimes family members may have good intentions, but in cases of denial or if there is

substance use at family gatherings (for example), then it would be challenging for those in recovery.

Five key strengths of current programs and services were noted by survey and focus group participants as listed from most mentioned to least mentioned: 1) that there are services and programs, 2) 12-step programs/meetings, 3) family support, 4) peer support 4) connectivity of services (and/or potential for).

Participants identified five main suggestions which they believe would strengthen the current recovery programs and services leading to greater potential for long-term recovery: 1) more public awareness, education, and outreach programs, 2) more agencies, services, & providers (long-term treatment, longer inpatient treatment, longer aftercare, more counselors who are qualified, more counseling/support group sessions, more options for women & youth, more options not requiring a specific church attendance), 3) more opportunities for healthy activities, 4) better transportation options, 5) creation of 'centers' ("retreat" centers for re-centering, meditation, yoga – spirituality or drop-in centers run by peers).

While a number of clients could be classified as having co-occurring diagnoses (i.e. addiction and mental illness issues), there were clear issues in obtaining participation of those whose main diagnosis was related to mental health issues. There were also issues in obtaining current data from providers who worked with this population. These facts would imply that there is a need for further and longer-term studies of those whose main diagnosis relates to mental health issues. One-on-one interviews may be beneficial as a means of limiting potential confusion of questions and responses. It was clear to the Principal Investigator that communication was enhanced through more direct conversations in the case of visiting Sagan Mami. There would also need to be greater collaboration and effort between the Principal Investigator and service providers of mental health clients to engage clients in such a study. In the case of this study, the limitations of time (i.e. two months) may have been a barrier to acquiring greater input from this population. It would also be beneficial for providers to have current data in terms of numbers of clients receiving services, recidivism of services for clients, and effectiveness of services.

- Implications based on an analysis of the findings revolve around four key themes: 1) existing strengths and resources Guam provides valuable services and programs related to recovery on Guam, (12-Step programs and meetings are a vital dimension of long-term recovery on Guam and there is great potential for enhanced connectivity of services which would be significantly beneficial for long-term recovery. 2) The need to a peer advocacy workforce, Peer support is vital to sustained recovery. (Peer support is most often available through 12-Step meetings as well as treatment and counseling programs and support groups. And while peer support is noted as being important for sustained recovery, there is a notable lack of peer-led support programs and services currently available. 3) Barriers to participation in services are a lack of education and awareness regarding addiction and mental health issues results in social stigmatization which leads to blaming, shaming, and ostracizing community members who are in recovery. A general acceptance and perpetuation of substance use and abuse within the community as a social norm creates an unsafe environment for those who are in

recovery. The lack of professional counselors, centers and resources can impede recovery efforts, particularly at crucial times such as when an individual is seeking help that is not immediately available. Limited transportation services and options can impede efforts in attending meetings, accessing recovery programs and services, and meeting requirements (i.e. acquiring documents) of service providers.

4) Needs, (There is a need for heightened efforts within the community to create greater awareness and understanding of substance abuse and mental health issues through community outreach programs as well as educational programs within the public schools. There is a need for a greater number of services and service providers including qualified counselors and longer-term treatment vis-à-vis inpatient and aftercare services. Participants identified the importance of and need for peer support and peer-led organizations such as the 12-Step programs. Peer-run centers were also mentioned as valuable and desired.

The purpose of this study was to survey community members knowledgeable of current recovery services and programs linked to substance abuse and mental health wellness in an effort to ascertain their perceptions of the strengths and areas of need within current services and programs in addressing the needs of community members involved in or requiring said services. Survey responses and focus group conversations elicited several main points: 1) The main strength of treatment and recovery services and programs within the community is that there are such services; however, there is a great need for additional services such as more counselors, more treatment facilities, and programs which provide longer-term services. 2) There is a need for a peer advocacy programs which are led by those in recovery. Other programs such as 12-Step programs, while essential for sustained recovery, are limited by the guidelines and 'traditions' of the program. 3) The key barriers to participation and services are the lack or limitation of services, programs, counselors, and access (i.e. transportation, affordability) to such services and programs. 4) Long-term support needs for those in recovery are multi-faceted: community awareness and education related to substance abuse, mental wellness, and co-occurring issues; long-term treatment and support for those in recovery as well as family members; community support in assistance efforts such as acquiring legal documents, employment, and transportation as a way to help those in recovery to support themselves and their families.

Future studies would be beneficial in monitoring the implementation of recommendations, evaluating progress of recommendations, and seeking further input from community members. Certainly the purpose of this study extends beyond the role of documentation to that of action.

GBHWC will also continue to utilize its annual data collection for clients served by SSA direct services and its contracting partners. This is a standardized data collection using excel format for the SSA and its contractors to collect client data including NOMS and reported on a quarterly basis. Data showed in FY 2015, 958 clients were served. Of this amount, 783 or 81.8% male and 176 or 18.2% female. The top 3 in ethnicity were Chamorros at 449 Clients or 49.6%, followed by Chuukese at 244 or 25.5%, and mixed race was at 103 or 10.8%. The Data also shows that 451 clients or almost 47.1% that were in treatment were high school graduates and drop-outs. Therefore, treatment curriculum warrants for adaptations for easy comprehension. Particularly for the Chuukese population where they come from islands with little to no education systems and have limited English proficiency skills. The top 3 referral source includes

the Court with the highest at 621 clients or 64.8%, followed by self-referral at 140 clients or 14.7%, and the hospital and GBHWC mental health programs at 120 clients or 12.5%. The top 3 primary diagnosis includes alcohol at 371 clients or 38.8%, followed by Methamphetamine at 350 clients or 36.5%, and Mixed (alcohol and drugs) at 121 or 12.7%. These data results will continue to guide the SSA to make services data driven and to improve services and maintaining optimal care.

Through screening, the Drug and Alcohol Branch will entertain all referrals from the criminal justice system, other government agencies, schools, private companies, military, faith based organizations, as well as self-referrals or walk-ins. Individuals found eligible will be admitted into a level of care provided by the SSA or by its contractors. Individuals found ineligible will be referred to their insurance provider. Uninsured Individuals who qualify will be assisted with enrollment to Medicaid with the Guam Department of Public Health and Social Services.

The Branch will continue to provide American Society of Addiction Medicine (ASAM) level 0.5 education and brief intervention services for individuals with no DSM-V substance related diagnosis but experienced a substance related episode. For individuals needing substance treatment will be served by the SSA's ambulatory services or by its contractors.

For individuals needing recovery support services will be served by the Recovery Oriented Systems of Care (ROSC) also provided by the SSA. The primary purpose of ROSC is to assist individuals gain recovery support systems to strengthen their recovery and maintain sobriety. These recovery support systems include but not limited to stable housing, reliable transportation, gainful employment, access to healthcare, access to education, purpose and responsibility in the community. The SSA will continue to serve criminal justice clients who completed the Residential Substance Abuse Treatment (RSAT) from the Department of Corrections (DOC) and needing 6 months of aftercare/continued care. The Guam Behavioral Health and Wellness Center (GBHWC) is a subgrantee of the Edward-Byrne grant that provides the staffing funding for the ROSC program. The Edward-Byrne grant is administered by the Bureau of Statistics and Plans under the supervision of the Governor's Office. GBHWC will continue to work closely with the Bureau and DOC to improve recovery support services.

The GBHWC Drug and Alcohol Branch will continue to lead in addressing the special substance treatment needs of the various ethnic populations being served in the Territory's continuum of care. For example, an evidenced-based model for the DUI population is currently being translated into the "Chuukese" language. The Chuukese population is the second largest (GBHWC Data) ethnic group in Guam's treatment system. A Chuukese Fellowship Program will continue to train two Chuukese in using the Driving with Care Model. The Branch will also continue to support trainings and forums in making cultural adaptations so that racial and ethnic issues are addressed resulting in optimal care. In addition, the Branch hosted substance treatment training for Guam clinicians aimed for serving LGBTQ population in recent past. The Branch plans to host follow-up trainings in FY 2016-2017 including a TOT in serving the LGBTQ population. Furthermore, the Branch plans to conduct trainings on the Matrix Model, Driving With Care Model, Motivation Interviewing, DSM-V, Addiction Severity Index (ASI), Ethics, Confidentiality, Trauma Informed Care, PTSD, TBI (Trauma Brain Injury) and other trainings identified by SSA, CSAPD or Focus Group. The Branch will continue to support

individuals pursuing certification by providing trainings consistent with the four domains of the alcohol and drug counselor credential with IC & RC (International Certification & Reciprocity Consortium) or via education courses with the Guam Community College human service associate's degree program. Overall, the Branch will continue to work with its partners by providing contracts and monitoring and to ensure treatment systems are improved and addresses the needs of diverse racial, ethnic and sexual gender minorities, pregnant women, women with dependent children, LGBTQ, military, criminal justice, homeless, individuals with HIV/STIs, as well as children and youth who are often underserved.

SUBSTANCE ABUSE PREVENTION: Prevention and Training Branch

The Guam Behavioral Health and Wellness Center (GBHWC) is a CARF accredited organization, most recently receiving a Three-Year Accreditation in June 2017. GBHWC is committed to offering programs and services that are measurable, accountable, and of the highest quality. Its leadership demonstrates a strong commitment to providing quality, culturally responsive, evidence-based treatment to the various cultural populations served. This is GBHWC's first attempt to seek CARF accreditation. GBHWC and its leadership have been preparing for this for the past two years, and have made great strides in understanding and meeting the standards.

The three year accreditation includes the following programs:

- Mental Health Outpatient
- **Substance Use Outpatient (Drug and Alcohol Branch)**
- Crisis Stabilization (Inpatient)
- Crisis Intervention (Healing Hearts)
- Residential
- **Prevention (Prevention and Training Branch)**

Survey results provided by the CARF Accreditation's team of surveyors reported that the Guam Behavioral Health and Wellness Center's has strengths in many areas:

- GBHWC's leadership demonstrates strong commitment to providing quality, culturally sensitive, and evidence-based treatment.
- Leadership has made great efforts to improve processes in service delivery, address gaps in services, improve outcomes, and promote community integration throughout the programs.
- Strong positive partnerships with various community stakeholders.
- Website is easy to navigate and includes helpful materials for education about mental health and substance use for the people of Guam.
- The Prevention and Training Branch served 2,563 individuals for direct services who were trained or participated in prevention programs that provide technical assistance, training and resources to communities throughout Guam. Prevention programs that are data driven, evidence-based initiatives promote health and wellness related to suicide prevention, alcohol, drug and tobacco problems, and behavioral health issues. Services are provided to special populations such as youth, young adults, LGBTQ, and those of Micronesian decent.

The Prevention and Training Branch (PTB) has identified the following areas of unmet needs and critical gaps (systems, data collection, and service):

Systems Gaps:

The GBHWC continues to make improvements in the behavioral health, substance abuse treatment and primary prevention services delivery.

As part of the work to obtain CARF accreditation, GBHWC has implemented AWARDS (Affordable Wide Area Relational Database Software) as the electronic health records system for the department. The software has been implemented but work continues to ensure that all staff are trained properly and timely in the use of the software to record client care.

The Prevention and Training Branch (PTB) under the Clinical Services Division oversees and administers the prevention set-aside funds for the SAPT block grant as well as the implementation of the Synar amendment. The Branch continuously develops mental health and substance abuse prevention and treatment services that will be strategically aligned and guided with SAMHSA's Strategic Prevention Framework (SPF) and its five steps comprised of 1) conducting need assessment, 2) mobilization and capacity building, 3) planning, 4) implementing evidenced based strategies, and 5) monitoring and evaluation.

In addition, the Branch has two staff that has recently completed the Data for Decision-Making (DDM) training course for the Pacific funded by the Regional Partners of the Pacific Public Health Surveillance Network (PPHSN). The staff completed the courses in August 2015 and serve as members of Guam's SEOW. The purpose of this training course is to build core public health functions in Pacific Island countries and territories for the long-term improvement of the effectiveness of national health services. Despite the successful completion of these two staff members, Guam sees the need to continue to provide and promote trainings similar to DDM so that the process of utilizing analyzed data to guide decisions is ingrained in all aspects of the behavioral health field on the island.

Data Collection Gaps:

For 2015 Guam Epi Profile, an additional section on mental health indicators is included. Each section provides trends, comparisons with the US national average, and when data is available, among population sub-groups. In general, summary statistics for Guam are compared with nationwide averages. Whenever possible, data is disaggregated by sex, age group, income, education and ethnicity/racial group. As much as possible, ethnicity categories are reflective of the various ethnic groups that make up the Guam population. For several indicators, the numbers of observations are small (e.g. suicide deaths, numbers of specific ethnic groups) and caution is required when interpreting changes across time or across groups; in these cases, a footnote alerting the reader is provided.

One question that is frequently asked is: "How can Guam's statistics be compared to the mainland when Guam's population is so much smaller than that of the United States?" For this reason, the statistics describing tobacco, alcohol and illicit drug consumption are in percentages, and data on suicide are in rates per 100,000 to allow comparisons across populations. That is, the consumption of these substances is reported as a fixed proportion of the total population. Thus, even if the absolute numbers of individuals reporting the use of these substances are much smaller than the US numbers, the magnitude of the problem in relation to the total population can be compared.

Because the projected audience of this report is a diverse one, we have purposely attempted to keep the language as simple as possible, and to avoid highly technical terms.

Data Issues and Limitations

Youth Data

Data on youth smoking is largely provided through the Guam Department of Education (GDOE) Youth Risk Behavior Survey (YRBS), for which biennial information is available for the years 1995-2007, and 2011-2015. Additional sources of information include smaller scale surveys conducted by GBHWC, Sanctuary Inc. and the Department of Youth Affairs (DYA). Data from the YRBS for the years 1999, 2001, 2003 and 2005 were not reported in national databases because the data were not weighted. The withdrawal of several private schools from the survey, after sampling was already carried out, resulted in low overall response rates for 1999-2003. In 2005, a number of sites failed to comply with the sampling methodology. This profile uses the unweighted data from those years. Therefore, care must be taken when comparing the results from 1999 – 2005 with US national medians. In 2009, a shift in school policy regarding the procedure for parental consent resulted in a significantly lower turnout in respondents, leading the GDOE to invalidate the survey. Hence, no data are available for 2009.

An additional challenge is the change in coding categories for ethnicity/race over the different survey years. For this profile, categories were collapsed to: Filipino, Other Asian, Chamorro, Micronesian Islanders, White and Others. However, only Chamorro, Filipino and Micronesian Islanders were retained consistently throughout the various survey years.

Adult Data

With regards to adult data, the US Centers for Disease Control and Prevention (CDC), which administers the BRFSS, introduced a new weighting methodology, replacing the “poststratification” method with “raking” or iterative proportional fitting in 2011. This more sophisticated method for weighting survey data makes adjustments for each variable individually in a series of data processing-intensive iterations. As each variable in the weighting process is included, the weights are adjusted until the sample weights are representative of the population (CDC 2012). These changes resulted in an upward shift of prevalence trends for certain risk factors, such as smoking. To avoid misinterpretation of trend line shifts artificially resulting from improved methods of measuring risk factors, CDC recommends caution in interpreting 2011 prevalence data. The Guam SEOW concurs with this recommendation, and no longer uses pre-2011 BRFSS data for trend analysis. Instead, 2011 BRFSS data now serves as the baseline for forward trend analysis. Thus trends for adult data begin with 2011 data.

Guam’s SEOW has made strides in closing data gaps that were once present at the conception of SEOW in 2004. Gaps that continue to exist include capturing data from Guam’s military population as well as beginning to link primary health with behavioral health. Although there are no immediate plans to begin collecting data from military personnel and dependents on Guam, Guam’s SEOW has agreed to begin analyzing primary health data to determine any relationships present with behavioral and primary health. As mentioned in the systems gaps description, the understanding of and utilization of analyzed data to drive decision making throughout the entire behavioral health field on Guam is something to be addressed.

Service Gaps:

The PTB has prioritized the creation of a workforce development plan to address identified service gaps related to the prevention workforce. Guam is a member of the Pacific Behavioral Health Collaborating Council (PBHCC). PBHCC's Certification Review Board, under the IC&RC, administers certifications toward prevention specialists, mental health specialists and substance abuse treatment counselors to members in the Pacific Region (Palau, FSM, CNMI, Guam, American Samoa, and RMI). In collaboration with PBHCC, the Pacific Behavioral Health Initiative (PBHI), which is funded through a grant from DHHS' Health Resource Services Administration, is offering a Para-professional Workforce Education Training Program for Addiction Counselors and Prevention Specialists. The purpose of the PBHI is a regional workforce development project intended to increase the number of skilled behavioral health paraprofessionals to serve the needs and challenges of at-risk youth and families, with a special emphasis on transitional-age persons 16 to 25 years old who are at risk for mental illness, substance abuse, and suicide, and among the least likely to seek continuous help. The project will support tuition, course, certification and testing fees for up to 120 native Pacific Islanders in a 12-month training period. PBHI's goal was to approve 20 applicants from each PBHCC member island; however, only 17 applications for the program were received from Guam. One determinant identified resulting in the lack of interested applicants is that there is no incentive for current employees to seek certification as a substance abuse treatment counselor or prevention specialist. Employees are not rewarded for receiving certification in their field. Tying in certification to promotions and salary increases in the career ladder will not only address retaining qualified and competent personnel but will also attract new individuals to the field of behavioral health.

In addition, GBHWC is in partnership with Guam Community College (GCC) to further workforce development in behavioral health care services by offering behavioral health-related courses as part of a Certificate Program or Industry Certification with the issuance of CEUs and/or community college credits.

Also, GBHWC received a grant award for the Transformation Transfer Initiative contract funded by the National Association of State Mental Health Program Directors (NASMHD) to support the strengthening of Guam's mental health system of care workforce. This includes building local capacity (public and private sector providers) in the field of behavioral health.

Guam plans to meet these unmet service needs and gaps.

Examination of alcohol, tobacco, and other drug use consumption and consequence data (derived from the Youth Risk Behavior Survey (youth) and the Behavioral Risk Factor Surveillance System (adults), the Office of Vital Statistics of the Department of Public Health and Social Services, the Uniform Crime Report from the Guam Police Department, and the Guam Department of Education's student discipline records) disaggregated for ethnicity, age, and sex revealed that Chamorro and other Micronesian (particularly the Chuukese) youth and young adults are at highest risk for increased vulnerability (high prevalence of risk factors), actual consumption and health and social consequences. According to the 2010 Guam Census, the Chuukese on Guam only accounts for 7% of the population but account for 28.8% of those seeking drug and alcohol treatment. The Chuukese population is also over-represented in

Guam's criminal justice system. Guam's youth population, those in middle and high schools, also present with higher consumption rates for current tobacco use, current smokeless/other tobacco use, lifetime and current marijuana use, and lifetime methamphetamine use. We have identified them (youth, Chamorros, and Chuukese – Micronesian Islander) as the populations who are at most need of primary prevention services and who will be the focus of primary prevention activities under the Prevention and Training Branch as well as the Partnership for Success Grant.

Initial works to address disparities in these populations, particularly the Micronesian Islander population who are often of limited English proficiency, include the translation of prevention resources into the Chuukese language. The Prevention and Training Branch has been an active member of CLASP to ensure that our services align with the CLAS standards. The Prevention Briefs reporting epidemiological data on substance abuse consumption and consequence rates has been translated into the Chuukese language. Translation of other educational prevention resources and brochures must be continued and expanded in order to reach the Micronesian Islander populations. The Branch has also been proactive in actively engaging grassroots non-profit organizations that work closely with these targeted populations to ensure that primary prevention services are delivered in a responsive and respectful manner. The Micronesian Islander population are often hard to reach not only due to language barriers but often also due to transportation issues. Working with existing grassroots organizations that already provide services to this population increases the opportunities to capture this population and overcome the language and transportation hurdles.

Work is also continuing with the non-profit organization, Youth for Youth LIVE! Guam (YFYLG), to ensure that primary prevention services are tailored to and for the youth on Guam. Youth for Youth LIVE! Guam is adapted from the evidence based program, Youth to Youth, and delivers a peer led and peer mediated prevention program for youth in middle and high schools. This program not only focuses on substance abuse prevention but also works in strengthening coping and life skills and promotes healthy decision making. The branch, in collaboration with YFYLG, conducts an annual summer program and youth conference for youth. Both of these programs utilize the peer led and peer mediated model. The summer program targets youth ages 5 – 15 years old. This program services a little over 200 youth annually. The youth conference recruits participants of middle and high school age and garners over 300 youth participants on Guam, the Northern Mariana Islands, Republic of Marshall Islands, and Palau. In all strategies and programs conducted, we make efforts to recruit participants that are of high risk of substance use, inclusive of participants that are of Micronesian Islander descent. The Prevention and Training Branch will support these activities and ensure that primary prevention services to youth are done in an efficient and effective manner.

The Prevention and Training Branch also utilizes technology in the dissemination of prevention education messages. The Branch has been active in posting positive behavioral health messages in the most popular youth social media sites and ensures that our website (peaceguam.org) is kept up to date with relevant prevention materials and information. The media campaigns targeting the prevention of underage drinking and tobacco and suicide prevention have gone through focus groups to determine the best strategies to use to target our high risk populations (youth, Chamorros, and Chuukese). The Prevention and Training Branch will continue to

produce media campaigns that are responsive to the needs of our targeted populations. Realizing that substance use is associated with non-communicable diseases (NCD), the Prevention and Training Branch has been active in Guam's NCD Consortium, particularly the alcohol control, tobacco control, and data action teams of the consortium. This active participation has helped garner attention to the need for alcohol and tobacco prevention and the promotion of positive behavioral health.