Guam

UNIFORM APPLICATION
FY 2020/2021 Substance Abuse Prevention and Treatment Block Grant Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/27/2019 4.54.41 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State DUNS Number

Number 855031402

Expiration Date 8/21/2020

I. State Agency to be the Grantee for the Block Grant

Agency Name Guam Behavioral Health and Wellness Center

Organizational Unit Drug and Alcohol Branch

Mailing Address 790 Governor Carlos G. Camacho Road

City Tamuning

Zip Code 96931

II. Contact Person for the Grantee of the Block Grant

First Name Theresa

Last Name Arriola

Agency Name Guam Behavioral Health and Wellness Center

Mailing Address 790 Governor Carlos G. Camacho Road

City Tamuning

Zip Code 96931

Telephone 671-647-5330

Fax 671-649-6948

Email Address theresa.arriola@gbhwc.guam.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 9/27/2019 4:53:44 AM

Revision Date

V. Contact Person Responsible for Application Submission

First Name Athena

Last Name Duenas

Telephone 671-475-5440

Fax 671-649-6948

Email Address athena.duenas@gbhwc.guam.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

UFISINAN I MAGA'HÅGA
OFFICE OF THE GOVERNOR

M'd 07/30 @ 1/9
GBHWC-DOH
07/30/19-19

LOURDES A. LEON GUERRERO
MAGA'HÅGA • GOVERNOR

JOSHUA F. TENORIO
SIGUNDO MAGA'LÅHI • LIEUTENANT GOVERNOR

Transmitted Via Central Files/GBHWC

July 12, 2019

ODESSA CROCKER
Grants Management
Division of Grant Management
OPS, SAMHSA
5600 Fishers Lane, Room 13-103
Rockville, Maryland 20857

Re: Delegation of Authority

Dear Ms. Crocker:

Buenas yan Håfa Adai!

I hereby delegate authority to the Director or Acting Director of the Guam Behavioral Health & Wellness Center to sign funding agreements and certifications. This authority is intended to provide assurance of compliance to the Secretary and perform similar acts relevant to the administration for the Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG), and the Projects for Assistance in Transition from Homeless (PATH) Formula Grant, until such time this delegation of authority rescinds.

Senseremente,

LOURDES A. LEON GUERRERO
Maga'hågan Guåhan
Governor of Guam

cc: *Sigundo Maga'låhen Guåhan* (via email)
Director Theresa Arriola, Guam Behavioral Health & Wellness Center

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Guam

Name of Chief Executive Officer (CEO) or Designee: Theresa C. Arriola

Signature of CEO or Designee[1]: 

Title: Director

Date Signed: 9/24/19

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

UFISINAN I MAGA'HÅGA
OFFICE OF THE GOVERNOR

W'd 07/30 @ 1:19
GBHWC-DOH
07/30/19-19

LOURDES A. LEON GUERRERO
MAGA'HÅGA • GOVERNOR

JOSHUA F. TENORIO
SIGUNDO MAGA'LÅHI • LIEUTENANT GOVERNOR

Transmitted Via Central Files/GBHWC

July 12, 2019

ODESSA CROCKER
Grants Management
Division of Grant Management
OPS, SAMHSA
5600 Fishers Lane, Room 13-103
Rockville, Maryland 20857

Re: Delegation of Authority

Dear Ms. Crocker:

Buenas yan Håfa Adai!

I hereby delegate authority to the Director or Acting Director of the Guam Behavioral Health & Wellness Center to sign funding agreements and certifications. This authority is intended to provide assurance of compliance to the Secretary and perform similar acts relevant to the administration for the Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG), and the Projects for Assistance in Transition from Homeless (PATH) Formula Grant, until such time this delegation of authority rescinds.

Senseremente,

Lou de Guerrero

LOURDES A. LEON GUERRERO
Maga'hågan Guåhan
Governor of Guam

cc: *Sigundo Maga'låhen Guåhan* (via email)
Director Theresa Arriola, Guam Behavioral Health & Wellness Center

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Theresa C. Arriola

Title

Director

Organization

Guam Behavioral Health and Wellness Center

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name Theresa C. Arriola

Title Director

Organization Guam Behavioral Health & Wellness Center

Signature: x Theresa C. Arriola Date: 9/24/19.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

TOBACCO USE

Risk factor 1

Baseline:

The Tobacco Control Action Team (TCAT) met its 2014-2018 goal of reducing smoking by at least 18%. Adult smoking decreased from 30.5% in 2011 to 25.1% in 2016. Youth smoking decreased from 21.9% in 2011 to 13.2% in 2017. However, smokeless tobacco use persists, and new tobacco products like electronic cigarettes and other electronic nicotine delivery systems (ENDS) have emerged on the local market.

Adult smokeless tobacco use (2016): 6.6%
Youth smokeless tobacco use (HS, 2017): 13.5%
Youth e-cigarette use (HS, 2017): 26.5%

GOAL:

Reduce tobacco use by 20% by 2023

Data sources: DPHSS, Guam Behavioral Risk Factor Surveillance System; GDOE, Guam Youth Risk Behavior Surveillance System

OBJECTIVE 1:

By December 2023, amend the Natasha Protection Act and Public Law 30-63 (smokefree public places) to include ENDS.

INDICATORS:

Indicator	2018 Baseline	2023 Target
Current laws amended to include ENDS	Natasha Act and P.L. 30-63 do not include ENDS	Both Natasha Act and P.L. 30-63 will address ENDS; vaping and use of other ENDS will be prohibited in public places law and within 20 feet of entrances
Prevalence of youth e-cigarette use	HS youth: 26.5% (2017 YRBS)	HS youth: 21.2%

STRATEGIC ACTION AND ACTIVITIES:

Actions and activities	Who will lead	When will it be done	Resources needed
Introduce the issue of ENDS and the rationale for incorporating these products under the laws that define smokefree public places when meeting with the 35th Guam Legislature (after November 2018 elections).	Cathy Castro (TCAT)	April 2019	Policy and advocacy support
Partner with media for an educational outreach campaign to foster awareness about ENDS, their health risks and why they need to be included under Guam's smokefree policies.	Liz Guerrero (DPHSS) Linda Flynn (GBHWC)		Communications support
Work with the Legislature to provide information and technical assistance in drafting amended laws.			Policy and advocacy support
Obtain expert testimony and mobilize community support for public hearings.			
Include provisions for enforcement in the amendments.			

OBJECTIVE 2:

By December 2023, increase taxes on all tobacco products, including ENDS, by at least 20%.

INDICATORS:

Indicator	2018 Baseline	2023 Target
Amount of tax levied on tobacco products	$4.00/pack of 20 cigarettes, with corresponding taxes on other tobacco products, but excluding ENDS	$4.80/pack of 20 cigarettes with corresponding increases on other tobacco products, including ENDS

STRATEGIC ACTION AND ACTIVITIES:

Actions and activities	Who will lead	When will it be done	Resources needed
Conduct introductory visits to the 35th Guam Legislature (after November 2018 elections) and introduce the evidence for further raising tobacco taxes, including ENDS, as an NCD prevention and control strategy.	Cathy Castro (TCAT)	April 2019	Policy and advocacy support
Develop information toolkits that document the scientific evidence for the effectiveness of tax increases as a public health intervention. Create the business case for further raising tobacco taxes.	Linda Flynn (GBHWC)		
Work with tobacco control legal experts locally, nationally and regionally to research taxation on ENDS and to identify model tobacco tax laws that could be adapted for Guam.	LaJoy Spears (UOG) Linda Flynn (GBHWC)		
Partner with media and communications experts to develop an educational outreach campaign to foster awareness about tobacco taxation as an NCD “Best buy.”	Liz Guerrero (DPHSS) Linda Flynn (GBHWC)		Communications support
Obtain expert testimony and mobilize community support for public hearings.			

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

I. Overview of the State

Guam is one of seventeen Non-Self-Governing Territories listed by the Special Committee on Decolonization of the United Nations. Located in the western North Pacific Ocean, it houses one of the most strategically important US military installations in the Pacific. Guam also serves as a critical crossroads and distribution center within Micronesia and the rest of Asia-Pacific, because of its air and sea routes. This plays a significant part in the movement of tobacco, alcohol and illicit drugs, which are suicide risk factors, into the island.

Guam is an organized, unincorporated territory of the US with policy relations under the jurisdiction of the Office of Insular Affairs, US Department of the Interior. The Governor and Lieutenant Governor are elected on the same ticket by popular vote, and serve a term of four years. The legislative branch is served by a unicameral Legislature with 15 seats; the members are elected by popular vote to serve two-year terms. Guam also elects one nonvoting delegate to the US House of Representatives to serve a two-year term. The judicial branch was recently revamped to create the Unified Judiciary of Guam, consistent with the Organic Act. Guam has the District Court of Guam (federal) and the Superior Court of Guam (local).

The 2019 total population, based on the 2010 Census projections, is 166,658. Over half (59.03%) are age 25 years or older. The estimated median age is 30.4 years. Males slightly outnumber females, with an overall sex ratio of 1.03; however, for those age 25 years and older, the sex ratio is 1.0. Data on sexual orientation is not available. Guam's population pyramid demonstrates a wide base with a middle bump. Two groups--- (1) infants and children, and (2) adults 25-54 years old--form a significant proportion of the overall population.

Guam's population is multi-ethnic/multi-racial. Chamorros comprise the largest ethnic group, accounting for 37.2% of the total population. Filipinos make up 26.3%, Whites make up 6.8% and other Pacific Islanders comprise 11.5%. The ethnic/racial composition of Guam's population has been shifting over time. The proportion of the population comprised of Chamorros declined from 44.6% in 1980, to 37.2% in 2017. On the other hand, Filipinos comprised only 21.2% of the population in 1980 but currently make up 26.3% of the island's people. The ethnic group with the fastest rate of increase is the Chuukese population; from only 0.1% in 1980, Chuukese currently make up 7% of the population, a 70-fold increase.

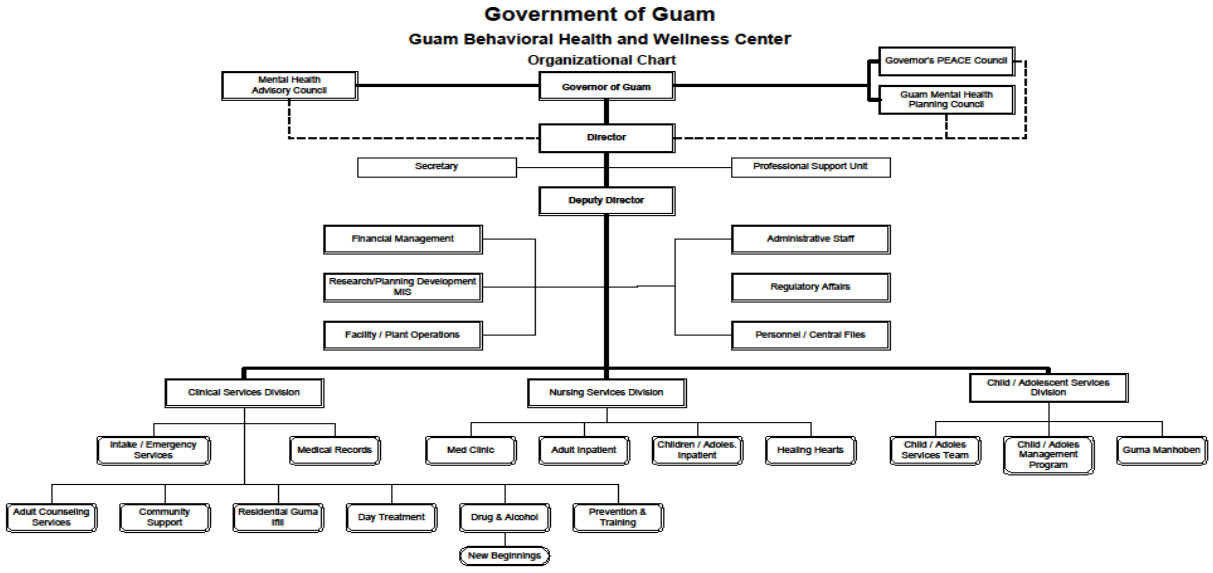
The ethnic diversity is reflected in the languages spoken at home. Twenty percent of the population (over 5 years) speaks a language as frequently as English at home, another 21% speak a language more frequently than English, and 0.5% speaks no English at all. This has a significant implication for effective service delivery, highlighting the need for culturally competent communications and services for close to half of the island's population.

Literacy rate is at 99%. Of those age 25 years and older, 33.8% have graduated from high school, and 15.1% have a Bachelor's degree. Only 7.8% of the population have completed less than 9th grade.

As of December 2014, there were 74,870 people in the civilian labor force, of whom 69,110 were employed. About 8% were unemployed, as compared to 11% in 2012. In 2015, the GDP was estimated at $5.7 billion, with a per capita GDP estimated at $30,500. Twenty-three percent of Guam's people have incomes below the poverty level. Households headed by a single female appear to be closely associated with impoverishment; 38% of the impoverished live in households headed by females, with no husband present. Ethnicity also appears to be associated with income and the risk of impoverishment. Whites, Chamorros, Filipinos and other Asians have higher median incomes than other Pacific islanders. Of the Pacific Island groups, Chuukese have the lowest incomes. Chuukese and other Micronesians are over-represented as recipients of aid; Chuukese filed 51.8% of Medicaid and Medically Indigent Program (MIP) claims in 2014. Over half of Guam's homeless are other Micronesians, predominantly Chuukese, who comprise 38.2% of the homeless.

Guam's economy relies heavily upon military spending and tourism. There were over 1.33 million tourist arrivals in 2014, a slight increase from the previous year. Japan remains Guam's major tourist market, accounting for 61% of visitors. Korea accounts for 23% of the market. The US Military continues to play a significant role in Guam, and recent negotiations for the planned military build-up continue. As of 2014, active military and family members comprised 7.9% of Guam's total population, and veterans make up an additional 7.9%. Currently, the economy is expanding in both its tourism and military sectors. The transfer of the military base on Okinawa to Guam will continue to drive the expansion of the military sector

II. Overview of State Behavioral Health System



a. Organization of Guam Public Behavioral Health System

The Guam Behavioral Health and Wellness Center (GBHWC) is a CARF accredited organization, most recently receiving a Three-Year Accreditation in June 2017. An organization receiving a Three-Year Accreditation has put itself through a rigorous peer review process and has demonstrated to a team of surveyors during an on-site visits its commitment to offering programs and services that are measurable, accountable, and of the highest quality.

The recent CARF survey stated, "GBHWC's leadership demonstrate a strong commitment to providing quality, culturally responsive, evidence-based treatment to the varied and culturally rich population served. This is the organization'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 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.
- Consumers with substance abuse issues receive evidence-based treatment at New Beginnings. Addiction credentialed staff members, assisted by peer counselors, offer continuum of services, including brief interventions, the Driving with Care program for court-referred consumers, and the Matrix Model structured treatment programs. The program helped consumers improve the quality of life and achieve sobriety.
- Provides excellent peer support services and empower consumers throughout the organization, providing outreach, advocacy, and supportive services reaching to communities to address and reduce stigma and enhance access to services.
- The Residential Recovery program provides residential services to greater than 20 individuals that need the care and security of the program. Also, the program developed methods that generate funds for the day-to-day activities and supplies.
- The Prevention and Training Branch served over 3000 individuals for direct services who were trained or participated in prevention programs that provides 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.

GBHWC serves as the single state agency for public mental health services and public substance abuse prevention and treatment services for the U.S. Territory of Guam (Public Law 17-21).

GBHWC is a line agency of the Government of Guam. GBHWC is headed by the Director and Deputy Director is appointed by the Governor and sits on the Governor's cabinet. GBHWC's existence and roles are defined in GCA 10, Chapter 86. It is the role of the Director's Office at GBHWC to execute the roles of the department for the betterment of Guam, its people, and community.

GBHWC has three major divisions: Clinical Services Division (CSD), Child & Adolescent Services Division (CASD), and the Nursing Services Division (NSD).

The core mission of the Clinical Services Division (CSD) is to provide behavioral health services to the people of Guam. In addition, the federal amended permanent injunction focuses primarily on the tremendous need for the provision of such services. It is the primary goal of the Clinical Services Division to increase the number of consumers served, implement new programming, and train those employed to render said services and to be in compliance with the amended permanent injunction. The Clinical Services Division is comprised of seven (7) services which include: Adult Counseling Services Branch, Crisis Hotline Services, Medical Records Services, Drug and Alcohol Services Branch (New Beginnings), Prevention and Training Branch (Prevention and Early Intervention Advisory Committee Empowerment PEACE), Day Treatment Services, and Residential Services. Most adult services are under CSD and direct care staff are assigned to Interdisciplinary Teams that comprise of social workers, counselors, community program aides, psychiatric technician, psychiatrists, and psychologists.

GBHWC is responsible to provide mental health services for clients suffering mental disorders, emotional disturbances, behavioral problems, and familial dysfunction, and drug and alcohol use disorders.

The Drug and Alcohol Branch provides directs services including American Society of Addiction Medicine (ASAM) level 0.5 Brief Intervention/Education, level I Outpatient, and level II Intensive Outpatient and Level 0.7 aftercare program. The Branch also contracts with non-profit providers for ASAM level I Outpatient, II Intensive Outpatient, III.2-D Social Detoxification, and III.5 Residential for adult males and females, as well as adolescents. The Drug & Alcohol also started the Peer Support Program and the Recovery Oriented Systems of Care program with works with individuals in the criminal justice setting.

The Department, under Executive Order No. 2008-25 became the primary agency to manage the Level of Care and Guam Bethesda programs which were transferred from the Department of Integrated Services for Individuals with Disabilities. It also operates an acute psychiatric inpatient facility, provides emergency consultations to related agencies and clinics, offers a 24-hour telephone crisis intervention to all island residents, and provides educational training for mental health and drug prevention and substance abuse programs.

GBHWC Vision – Healthy Island Community.

GBHWC Mission – To provide culturally respectful behavioral health services that support and strengthen the wellbeing of persons served, their families, and the community.

GBHWC's **vision** is **"**We envision an island community that is empowered to choose healthier lifestyle." "That more Caring Communities will be visible throughout the island promoting positive mental health and healthy lifestyle through prevention and education strategies and; that the practice of ensuring delivery of mandated mental health services reflects collaborative engagement and a Standard of Excellence".

The Governor's **Prevention Education and Community Empowerment (PEACE) Council** is tasked to advise the Governor on national and local level programs, policies and practices dealing with mental health promotion and substance abuse prevention.

The **Mental Health Advisory Council** has a statutory requirement to review and approve the plans and programs of GBHWC to include the annual budget and GBHWC's 3-year plan. Just within the past year, four Advisory Council members were appointed and confirmed by the legislature and are meeting to perform their duties.

The **Mental Health Planning Council** has a statutory requirement through a federal statute to conduct mental health planning as a condition for receiving federal mental health block grant. More recently the territory is required to develop a behavioral health planning council that includes representative from the substance abuse and prevention communities. The Mental Health Planning Council Chairperson has a standing agenda in the Mental Health Advisory Council monthly meeting.

b. Guam Demographic Overview

According to the 2010 United States Census, Guam had a population of 159,358, representing an increase of 2.9 percent from the population of 154,805 reported in the 2000 Census. Approximately 34.9% is between 0-14 years of age, 59.09% is between 15-64 years of age, while 6.01% is 65 years and older. Males slightly outnumber females, with a sex ratio of 1.1 males/female. Guam's population is multi-ethnic/multi-racial. Chamorros remain the largest ethnic group, making up 37.3% of the island's population, and representing a 3.6% increase since 2000. Filipinos are the second largest group, comprising 26.3% of the total. The Yapese and Chuukese had the fastest rate of growth---the Yapese population grew by 84.1%, from 686 in 2000 to 1,263 in 2010, while the number of Chuukese grew by 80.3%, from 6,229 in 2000 to 11,230 in 2010. Majority of Guam residents identify themselves as being of one ethnic origin or race, representing an increase of 8.4% since 2000. There were 14,929 persons who chose 2 or more ethnic or racial origins, a decrease of 30.7% since 2000 (Table 2).

Table 2. Ethnic composition of Guam population, 2010 and 2000

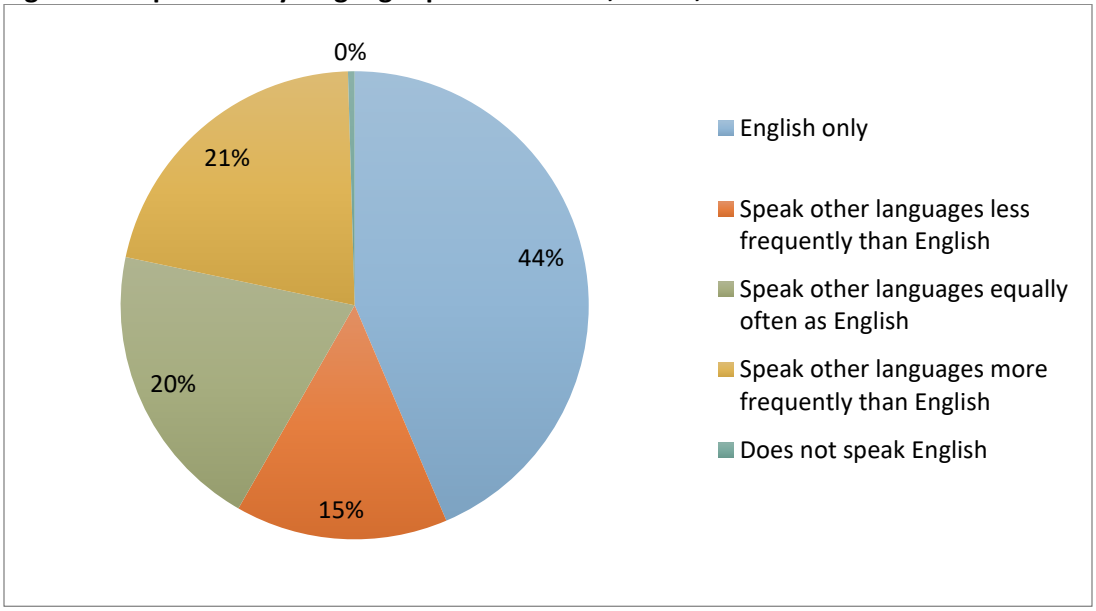
ETHNICITY	2010	2000*
One Ethnic Origin or Race:	144,429	133,252
Native Hawaiian and Other Pacific Islander:	78,582	69,039
Carolinian	242	123
Chamorro	59,381	57,297
Chuukese	11,230	6,229
Kosraean	425	292
Marshallese	315	257
Palauan	2,563	2,141
Pohnpeian	2,248	1,366

Yapese	1,263	686
Other Native Hawaiian and Other Pacific Islander	915	648
Asian:	51,381	50,329
Chinese (except Taiwanese)	2,368	2,707
Filipino	41,944	40,729
Japanese	2,368	2,086
Korean	3,437	3,816
Taiwanese	249	991
Vietnamese	337	10,509
Other Asian	678	1,568
Black or African American	1,540	1,807
Hispanic or Latino	1,201	69,039
White	11,321	123
Other Ethnic Origin or Race	404	57,297
Two or More Ethnic Origins or Races	14,929	21,553
Native Hawaiian and Other Pacific Islander and other groups	11,656	
Chamorro and other groups	9,717	7,946
Asian and other groups	8,574	10,853
Total:	159,358	154,805

Source: US Census Bureau, 2010 Census for Guam as reported by the Bureau of Statistics and Plans, 2012
**Source: US Census Bureau, 2000 Census for Guam as reported by the Bureau of Statistics and Plans, 2005*

The ethnic diversity is reflected in the languages spoken at home. Twenty percent of the population over 5 years of age speak a language as frequently as English at home, another 21% speak a language more frequently than English, and 0.5% speak no English at all. This has a significant implication for effective service delivery, highlighting the need for culturally competent communications and services for close to half of the island's population (Figure 1).

Figure 1. Population by language spoken at home, Guam, 2010



Source: 2010 Census for Guam as reported by the Bureau of Statistics and Plans, 2012

c. Organizational Structure of the Service Delivery System:
With the passage of Public Law 17-21, the Guam Behavioral Health and Wellness Center (formerly the Department of Mental Health and Substance Abuse was created to:

- Provide comprehensive mental health, alcohol and drug programs and services for the people of Guam;
- To continually strive to improve, enhance, and promote the physical and mental well-being of the people of Guam who experience the life-disrupting effects of mental illness, alcoholism and drug abuse or are at risk to suffer those effects and who need such assistance. To provide such assistance in an efficient and effective manner in order to minimize community disruption and strengthen the quality of personal, family and community life;
- To encourage the development of privately-funded community-based programs for mental health, drug and alcohol abuse, in particular those programs that employ qualified local residents;
- As those services become developed and/or available in the Territory, the Government of Guam may gradually phase out of such operations.

With over 203 staff, GBHWC has grown to meet the needs of the people of Guam. GBHWC has its main facility located across the Guam Memorial Hospital, as well as satellite offices in the J&G Commercial Center in Hagatna comprised of Child-Adolescent Services, Drug and Alcohol Treatment, and the Prevention and Training Branch, and an adult mental health transitional residential service in Asan. In addition, privatized services are located in Mangilao (adult mental health permanent supportive residential service); Tamuning (child mental health residential and outpatient services; drop-in services; supported employment; consumer enrichment center); and outsourced drug and alcohol services provided by Sanctuary, OASIS and The Salvation Army. Furthermore, recently providing SBIRT in a primary care setting, particularly the Northern Public Health Center in the village of Dededo, the most populated village on the island.

The Guam Behavioral Health and Wellness Center (GBHWC), hereby submit its FY 2018-2019 SABG Behavioral Health Assessment and Plan grant application to SAMHSA for the Substance Abuse Prevention and Treatment (SAPT) Block Grant. FY 2017 SAPT Block Grant allocations for the Territory of Guam are approximately $1,014,336. The receipt of this grant will significantly contribute to GBHWC's ongoing commitment to provide quality prevention and treatment to those Guam citizens in need of substance abuse treatment and mental health services.

The SAPT Block Grant will be an important driver, funding mechanism, and tool to assist Guam and GBHWC in moving us toward an integrated Behavioral Health System of Care. GBHWC will use Block Grant funds to initiate the plan for change. We will continue to address existing Block Grant requirements while working to create the system change that will be necessary as Health Reform approaches. Specifically, our plan will address SAMHSA-required areas of focus, including:

- Comprehensive community-based services for persons with or at risk of substance use and/or mental health disorders (priority focus on intravenous drug users, and those pregnant and parenting persons with substance use and/or mental disorders);

- Services for persons with tuberculosis and persons with or at risk of HIV/AIDS who are in treatment for substance abuse.
- Workforce Development issues such as increasing the number of certified drug and alcohol counselors, prevention specialists, and peer specialists through pre-employment skills training and programs while continuing training and education for those employed under programs funded by the SAPT Block Grant.

In addition to these required populations, Guam's plan will address services for the following populations:

- Children, youth, adolescents, and youth-in-transition with or at risk for substance abuse and/or mental health problem;
- Those with a substance use and/or mental health problem who are:
  - Homeless or inappropriately housed;
  - Pregnant women with children;
  - Involved with the criminal justice system;
  - Military service members, veterans, or military family members; and/or
- Those embers of traditionally underserved populations, including:
  - Racial/ethnic minorities, particularly the Chuukese population;
  - GLBTQ populations;
  - Persons with disabilities
- Primary prevention services for kids and families who do not require treatment.

SUBSTANCE ABUSE TREATMENT: Drug and Alcohol Branch (D&A) – New Beginnings

The Drug and Alcohol Branch, under the umbrella of the Department's Division of Clinical Services will continue in FY 2020 and FY 2021 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.

GBHWC's D&A 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 withdrawal management and co-occurring disorder clients is being planned with implementation in FY 2020. Clients with no DSM 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 Behavioral 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 Model (DWC). All potential non-profit organizations have been trained in Matrix Model and Driving With Care. The Drug and Alcohol Branch has been a certified Matrix Facility since August 2013. 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 and DWC 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.

In addition, the Branch will continue to Chair the "Community Substance Abuse Planning Development" (CSAPD) Group established in 2005 by the Territory's GBHWC Director. This group is comprised of the SSA, non-profit and profit treatment providers, and other private practitioners. GBHWC chairs the group which meets on a monthly basis. 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 is 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. In addition, the CSAPD is also discussing career ladder for substance abuse treatment counselors and peer specialists or peer recovery coaches. This is to encourage the individuals who have completed treatment and are interested in seeking a career in field of Substance Use treatment.

GBHWC providing direct evidenced-based ambulatory substance treatment services, contracting and monitoring residential and outpatient services with non-profit organizations, and leading the CSAPD group will only continue to provide a seamless and efficient continuum of care for the Territory that results in consumers receiving effective treatment and achieving quality of life for themselves and their families.

Description of substance abuse prevention at all levels:

SUBSTANCE ABUSE PREVENTION: Prevention and Training Branch

The Guam Behavioral Health and Wellness Center (GBHWC) is Guam's single state agency for alcohol and substance abuse prevention and treatment and mental health promotion. GBHWC's Prevention and Training Branch (P&T) is directly responsible for preventive services, works to promote overall health and wellness through the public health model, recognizing that prevention is a lifelong process that requires multi-sectoral partnerships with a broad base of community stakeholders for effective implementation.

The Branch 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 the 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. Prevention is an on-going, lifelong process aimed at promoting healthier lifestyles by reducing the demand for alcohol, tobacco and other drugs in our community through education. Additionally, GBHWC encourages the development of public-private partnerships and collaboration in the development of school-based/community-based programs for mental health and substance abuse prevention and early intervention services. The **Branch's vision…**is an island community empowered and committed to making informed decisions towards a healthier (mental, physical, spiritual) future for ourselves and other on Guam.

The **Branch's mission** is to establish and implement culturally appropriate and sustainable prevention and early intervention policies, programs, and practices that are responsive to the needs of the people of Guam and that are proven to effect positive behavioral health changes. Strategies to be used to accomplish this mission include:

- Using SAMHSA'S Strategic Prevention Framework, a 5-step planning process to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The effectiveness of this process begins with a clear understanding of community needs and depends on the involvement of community members in all stages of the planning process;
- Raise awareness about the effects of alcohol, tobacco, and other drug abuse on Guam;
- Prevent/reduce alcohol, tobacco and other drug use, including underage drinking;
- Promote alcohol-free, tobacco-free and other drug-free lifestyles;
- Reduce the harmful outcomes associated with alcohol, tobacco and other drug use;
- Build Guam's capacity and infrastructure for establishing and sustaining evidence based substance abuse prevention and early intervention programs that are effective.

GBHWC serves diverse ethnic and cultural groups from the region, inclusive of the Asian Pacific region and surrounding Micronesian Islands. Those from the Micronesian Islands often come with limited resources and have difficulty assimilating into the local community's way of life. This is the population that is often over represented in the juvenile justice system and in other governmental systems (i.e. law enforcement, correctional, and public assistance systems).

Health disparities and health equity has been actively undertaken by GBHWC the past couple of years to ensure that Guam's prevention system addresses the needs of the various racial and ethnic minorities on the island. One way it is addressed is through as the on-going trainings to include Culturally and Linguistically Appropriate Services (CLAS) and Health Literacy to government and non-government agencies providing behavioral and primary health services. Additionally, government personnel are required to attend the CLAS training sponsored by the Office of Minority Health of the Department of Public Health and Social Services. The efforts and activities initiated by CLASP is still evolving and much work remains to be done.

Sexual gender minorities are another growing population with our young people and in order to address their needs, GBHWC has formed a strong collaboration and partnership with Guam's Alternative Lifestyle Association (GALA). GALA works closely with Guam's LGBTQ populations in providing much needed services inclusive of substance abuse prevention activities and other social services support. GALA is represented as a member of the

Governor's PEACE Advisory Council and the State Epidemiological Outcomes Workgroup (SEOW). GALA's members have also taken part in many of our Prevention and Training Branch's training and technical assistance activities related to substance abuse and suicide prevention and mental health promotion.

Over the past 21 years, and more recently through GBHWC's receipt of SAMHSA's Partnership for Success (PFS) Grant and the Garrett Lee Smith Memorial Grant funds, educational and training programs utilizing evidence-based curricula in prevention and early intervention have been implemented with youth and family serving agencies in the public and private sector, as well as with community-based organizations, parent and youth groups.

Branch staff consists of Certified Prevention Specialists, and certified trainers, consulting trainers and/or master-level trainers in evidence-based prevention programs: Substance Abuse Prevention Skills Training (SAPST), Ethics in Prevention, Applied Suicide Intervention Skills Training (ASIST), safeTALK for suicide prevention, Connect Suicide Postvention, Suicide Prevention Toolkit for Primary Care providers, Gathering of Native Americans (GONA), and Brief Tobacco Cessation Interventions (BTI). Over the years, Prevention & Training Branch staff expanded its pool of certified trainers in other GBHWC divisions and their sub-grantees/service providers and other community-based organizations, the Guam Memorial Hospital (GMH), the Guam Department of Education (GDOE), , the University of Guam (UOG), the Guam Community College (GCC), and the Guam National Guard (GUNG).

The Prevention and Training Branch applied for and received a SAMHSA's Partnerships for Success (PFS) grant for PEACE issued on September 13, 2013 and again in September 2018. The funds are used to support the implementation of Guam's State Prevention Enhancement (SPE) Comprehensive Strategic Plan (FY2014-2018) in partnership with sub-recipients, the Non-Communicable Disease Consortium, the Governor's PEACE Advisory Council, and Guam's State Epidemiological Outcomes Workgroup (SEOW). The Guam's State Prevention Enhancement (SPE) Comprehensive Strategic Plan addresses SAMHSA's Strategic Initiatives in the prevention of substance abuse and mental illness – with a goal to create prevention prepared communities where individuals, families, schools, workplaces and communities take action to promote emotional health and prevent and reduce mental illness, substance abuse including tobacco and alcohol, and suicide across the lifespan.

The Branch carries out sub-state area prevention planning to determine which populations have the highest incidence and prevalence of substance abuse and related consequences, or who are at greater risk of suicide. Planning and decision-making processes involve representatives on the Governor's appointed PEACE Advisory Council for prevention and early-intervention and the SEOW.

Guam's strategic planning efforts will be data-driven and will reflect an integration of SAMHSA's Strategic Initiatives in the prevention and early intervention of substance abuse. Suicide prevention and mental health promotion – with a goal to create prevention prepared communities where individuals, families, schools, workplaces and communities take action to promote emotional health and prevent and reduce mental illnesses, substance abuse including tobacco, and suicide across the lifespan. Efforts will be made to build Guam's capacity and

workforce that results in strengthening data collection, analysis and reporting systems. Decision-making processes will reflect informed policy development and funding strategies. These efforts include facilitating access to relevant data by service providers and other consumer advocates; thus improving the quality and outcomes of behavioral health care across primary care, specialty care and social service sectors.

Primary prevention and early intervention program goals and objectives fall within the realm of: A) Data Infrastructure, B) Workforce Development, C) Evidence-Based Interventions and C) Collaboration and Partnerships with a focus on establishing data-driven priorities and targeted interventions that are culturally relevant, appropriate and sustainable. Programs and services will be re-aligned and prioritized to ensure that current efforts are enhanced and expanded into preventing mental illness and promoting positive mental health as it relates to substance abuse. SAMHSA's initiatives will be considered for which local programs, policies and practices will be developed and as determined by Guam's documented needs and community readiness.

A state-level Governor appointed Advisory Council for PEACE Strategic Prevention Framework was established to guide and support the work of strategic prevention program planning and implementation, to include the use of substance abuse and mental health data in decision-making processes. PEACE Council members represent the behavioral health, public health and education-related programs and services, the Executive, Legislative and Judicial branches of the Government of Guam, the military and business sectors, special populations – LGBTQ organization, faith-based and community-based organizations including parent/youth-serving organizations.

Guam's State Epidemiological Outcomes Workgroup (SEOW) is considered the definitive authority on substance abuse epidemiology on the island. Its data products are readily acknowledged as comprehensive community resources, and its work has consistently influenced substance abuse policy and program development, prevention resource allocation, services delivery and decision-making at the State government level as well as within individual agencies, institutions, and community organizations. The SEOW's work has been cited and utilized by the Office of the Governor and Lt. Governor, the Guam Legislature, the University of Guam and Guam Community College, the Departments of Public Health and Social Services and Mental Health and Substance Abuse and various other policy leaders and program managers on Guam. The SEOW has contributed significantly to various policies directly related to substance abuse prevention, including Public Law 28-80 (Guam's smoke-free law, 2005), Public Law 30-80 (raising tobacco taxes and earmarking tobacco tax revenues for cancer prevention and health promotion, 2010) and Public Law 30-156 (raising the minimum legal drinking age from 18 to 21 years, 2010). It has also guided prevention program planning and resource allocation in diverse health areas. For instance, the SEOW's Epidemiological Profile is widely quoted in the Guam Comprehensive Cancer Control Plan and is a major reference for the Guam Non-Communicable Disease Control and Prevention strategic plan and the Guam Focus on Life suicide prevention program. It has also been used as a reference by the University of Guam's Cancer Research Center for its U54 research grant application to the National Cancer Institute. The expanded mandate of the SEOW and its ongoing support through the sub-grant will ensure that this valuable community prevention resource will continue to provide the local evidence base for effective substance abuse prevention and mental health promotion in Guam.

Description of how substance abuse prevention services are delivered (SSA and other State agencies)

Suicide Prevention Programs

GBHWC's Prevention and Training Branch grant for Garrett Lee Smith Memorial Act (GLSMA) Youth Suicide Prevention with no cost ended in 07/31/2016. To continue the implementation of Guam's ***Focus on Life - Territorial Plan for Suicide Prevention, Early Intervention, and PostVention***, the Guam's Legislature made a separate special appropriation of funds for FY2017 thru 2019 to support the state's plan to prevent further suicides and attempts. In FY2020, GBHWC included the same level of funding for suicide prevention in its local budget for the first time. GBHWC partners with the, Guam Department of Education, Department of Public Health and Social Services, Guam US Military, Guam National Guard, University of Guam, Guam Community College, Guam Police Department, Guam Fire Department, Guam Memorial Hospital, Guam, Judicial Court System, treatment providers, survivors of suicide and other non-profit organizations.

Tobacco/Nicotine and Alcohol Prevention Control (Underage Drinking), and Synar

In March 2017, Guam's law raised the legal age to use or purchase tobacco/nicotine products from 18 to 21 starting Jan. 1, 2018. Guam's youth smoking rate is the highest in the nation. Smoking rates on Guam have declined in 2017 to 13.2percent among Guam high school students, but still remain higher than the national average for US high school students of 8.8 percent.

GBHWC's Prevention and Training Branch is responsible for implementing the Synar Program ensuring the completion of random, unannounced inspections of any vendor licensed to sell or distribute tobacco/nicotine products and to ensure compliance with laws limiting access to tobacco products to any individual under the age of 21. P&T also provides vendor education of the laws relating to the sale of tobacco/nicotine products.

In addition, the Branch staff serves as key members of the Guam Non-Communicable Disease Consortium led by the Guam Department of Public Health and Social Services. In particular, P&T Branch staff is a member of the NCD Sub-Committees to include the Alcohol Prevention Team (APT) for addressing underage drinking prevention and reducing alcohol abuse among adults; the Tobacco Control Action Team (TCAT) for addressing the prevention of tobacco/nicotine use among youth and adults and providing tobacco cessation services for those who desire to quit tobacco/nicotine use. GBHWC provided input to the development of the latest NCD Plan for Guam and a commitment to sustain partnerships given the correlation between NCDs and substance use and abuse. (*please see Attachment DRAFT_TOBACCO_Guam NCD Strategic Plan_2019-2023)*

GBHWC also administers the Food and Drug Administration (FDA)'s Tobacco Control Enforcement Program. This program conducts un-announced inspections of retail outlets for compliance with no sale of products to minors, requiring presentation of photo identification, and advertising and labeling restrictions of tobacco products.

Prevention services are provided island-wide to individuals of all ages and their families.
Examples of prevention services targeted toward adults are as follows:

- Applied Suicide Intervention Skills Training workshop

- SafeTALK suicide prevention training;
- Connect Suicide Postvention training
- Substance Abuse Prevention Specialist Training (SAPST)
- Substance Abuse Prevention Specialist Training (SAPST) Training of Trainers
- Ethics in Prevention
- Unannounced Tobacco Compliance Inspection Training (Synar)
- Basic Tobacco Intervention Skills Certification Program
- Team Awareness Stress Management
- Health Literacy Training
- Gathering of Native American (GONA)

- Description of regional, county, tribal and local entities:

GBHWC P&T continues to work with the Governor's PEACE Council, a multi-sectoral, state-level group representative of the three branches of government, leaders from the private sector, cultural, faith-based and non-governmental community-based provider organizations. Members reflect the ethnic and cultural make-up of the community and provide direction for PEACE prevention priorities and plans. Additionally, P&T continues to partner and collaborate with respective community organizations in delivering primary prevention and early intervention substance use, suicide and mental health promotion programs. Through the years GBHWC has worked closely with the following organizations and entities in delivering prevention services:

- Youth for Youth Live! Guam (YFYLG) is a year-round comprehensive youth-led prevention program designed to mentor and empower youth to develop, implement, and evaluate youth drug prevention and mental health promotion programs. It One of the longest existing youth-led and youth-serving program is the annual YFYLG Conference which is regional community-based prevention program for over 350 middle and high school students from Guam and other islands in Micronesia. Plenary sessions and workshops that address youth identified social and behavioral health issues to include underage drinking, tobacco/nicotine and suicide prevention as well as bullying, healthy activities and healthy relationships. The conference provides a safe and encouraging environment for the participants where they are valued, respected, unified, validated and empowered to become positive role-models for each other and others.
- Mañe'lu, formerly Big Brothers Big Sisters of Guam, is a local nonprofit that has been educating and empowering children and families to change their lives for the better for over 15 years. Since 2002, Mañe'lu has been enriching the lives of hundreds of children throughout the island by providing excellence in one-to-one mentoring. Over the years they have expanded their programs and services to support the family as a whole through site based youth and family activities and the Micronesian Resource Center One-Stop Shop. In 2017, Mañe'lu became a sub-recipient of GBHWC under PFS FY13 providing evidence-based services such as Positive Action to primary public school students.
- Guam Alternative Lifestyle Association (GALA) is a community-based organization that exists to strengthen the quality of life for gay, lesbian, bisexual and transgendered persons, their families and friends through Support, Education, & Advocacy. GALA upholds a society that embraces social diversity through love and respect for all.GALA

has been a prevention partner for the last decade and provides substance use and suicide prevention trainings and programs for the entire community. GALA is also a member of the Governor's PEACE Council and SEOW.

- Gametime Inc. provides a variety of substance use and suicide prevention services to the island community including the Huddle, Grief Talks (support groups in the community & schools), One-day Sports Camps, as well as Grief Recovery Method services. Gametime's target audience for the Huddle are middle and high school students.
- Sanctuary Incorporated of Guam is a private, non-profit community-based organization that provides critical social services to youth and their families. It was established in 1971 as an alternative to the juvenile justice system for runaway, homeless, neglected, and abused youth. Sanctuary offers comprehensive substance use intervention and treatment services that are voluntary but are contingent upon the consent of both youth and/or parent/legal guardian. Additionally, Sanctuary offers educational group classes on parenting skills and support, youth & adult anger management, tobacco cessation classes, strengthening families program, and conducts numerous youth-centered outreach events.
- Guam Police Department hosts an annual "Fade Away from Violence" two-day sports outreach for dozens of students from various Guam Department of Education middle schools which uses sports as a tool to teach kids about the dangers of drug and alcohol abuse, violence and suicide prevention among many other issues. GBHWC provides support at this event through conducting various substance use and suicide prevention workshops.
- Department of Youth Affairs' (DYA) mission is to improve the quality of life on Guam for all people by the development and implementation of programs and services that promote youth development, decrease juvenile delinquency and status offenses, strengthen the family unit, protect the public from juvenile delinquents, ensure that offenders are held accountable for their actions and are provided with appropriate treatment, and provide restitution to the victims. Additionally, DYA provides primary prevention services to youth in the community through three after-school Prevention Resource Centers, where their annual prevention summer camps are held.Island Girl Power's (IGP) mission is to decrease the occurrence of teen pregnancy, suicide, substance and sexual abuse by empowering our young ladies to make healthy lifestyle choices through encouraging positive self-esteem with mentors and role models, while inspiring cultural and community pride. -
- Guam National Guard's (GNG) Counterdrug unit provides training and technical assistance for prevention coalition development.

Description of how substance abuse addresses needs of diverse racial, ethnic, sexual and gender
GBHWC continues to address the needs of individuals from diverse racial, ethnic, and sexual and gender minorities by working with organizations who serve these populations such as:

- Guam Alternative Lifestyle Association (GALA), a community-based organization that exists to strengthen the quality of life for gay, lesbian, bisexual and transgendered persons, their families and friends through Support, Education, & Advocacy. GALA upholds a society that embraces social diversity through love and respect for all LGBT individuals. GALA has been a prevention partner for the last decade and provides substance use and suicide prevention trainings and programs for the entire community. GALA is also a member of the Governor's PEACE Council.

- Mañe'lu, a local nonprofit that has been educating and empowering children and families to change their lives for the better for over 15 years. Over the years they have expanded their programs and services to support the family as a whole through site based youth and family activities and the Micronesian Resource Center One-Stop Shop. The Micronesian Resource Center One-Stop Shop is a special project of Mañe'lu that provides informational and educational resources to assist Micronesians as they transition to a new life on Guam. Staffed with friendly, multilingual case workers who provide helpful information and refer to various programs and services. The One-Stop Shop seeks to work collaboratively with local government agencies and non-profit organizations to increase awareness of services and address the needs of Micronesians living on Guam. Services include assistance to new arrivals through orientation services, General orientation, information services on public health and public education systems, workforce development training and employment services, , soft-skills training, resume writing & interview skills training, family support initiatives that address cultural and social challenges, youth mentoring, literacy programs, parenting classes, financial literacy classes, domestic violence prevention and health & wellness information.
- Guam Police Department (GPD) in collaboration with other community partners, since 2017 has implemented the annual "Fade Away from Violence" two-day sports outreach for dozens of students from various Guam Department of Education middle schools which uses sports as a tool to teach kids about the dangers of drug and alcohol abuse, violence and suicide prevention among many other issues. GBHWC provides support at this event through conducting various substance use and suicide prevention workshops.
- Guam Department of Education (GDOE) has been a long standing partner particularly Student Support Services Division (SSSD) supports all public schools in the areas of behavioral assessment, counselling, identification and support of students eligible under Section 504, and truancy prevention. In addition, Student Support Services Division provides district-wide guidance with Board Policies and Standard Operating Procedures governing behavior and safety. GDOE is the primary partner for PFS 2018 work with community partners to implement substance use prevention/treatment and mental health programs in the schools. One example of the level of commitment between GDOE and P&T is the cooperative implementation of Hazelden's Lifelines Suicide Prevention Trilogy school-based curriculum in the secondary schools from 2015 thru 2018. GDOE has once again committed to working with P&T to meet the goals and objectives of the PEACE PFS grant and other substance use and suicide prevention efforts.
- Sanctuary Incorporated of Guam is a private, non-profit community-based organization that provides critical social services to youth and their families. It was established in 1971 as an alternative to the juvenile justice system for runaway, homeless, neglected, and abused youth. Sanctuary offers comprehensive substance use intervention and treatment services that are voluntary but are contingent upon the consent of both youth and/or parent/legal guardian. Additionally, Sanctuary offers educational group classes on parenting skills and support, youth & adult anger management, tobacco cessation classes, strengthening families program, and conducts numerous youth-centered outreach events.

Description of the current prevention systems attention to the individuals in need of primary substance abuse prevention:

- Seow is data driven and provides recommendations on audience and effective strategies for programs to reach individuals in need. GBHWC P&T uses SEOW recommendations as a guide in planning, developing and implementing prevention programs with respective agencies and organizations. Individuals in need of prevention services are included in annual primary prevention programs such as the YFYLG conference through school-base registration through the counseling office and notification to youth serving agencies and organizations to include youth identified as at-risk. Other strategies include working with non-government organizations (NGO) to offer village-based prevention programs that include low income housing areas to improve access to primary prevention services.

Identified strengths:

- As of 2019, P&T staff provided evidence-based trainings and technical assistance to over 3,000 individuals that include ASIST, safeTALK, SAPST, CONNECT, Team Awareness Stress Management and Hazelden Lifelines.
- GBHWC's Prevention and Training Branch has established long-term collaborative relationships in addressing substance use and mental health concerns with community partners and government entities.
- The Branch uses SAMHSA's Strategic Prevention Framework, 5-step planning process to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention programs, practices and policies.
- A state-level Governor appointed Advisory Council for PEACE Strategic Prevention Framework was established to guide and support the work of strategic prevention program planning and implementation, to include the use of substance abuse and mental health data in decision-making processes. PEACE Council members represent the behavioral health, public health and education-related programs and services, the Executive, Legislative and Judicial branches of the Government of Guam, the military and business sectors, special populations – LGBTQ organization, faith-based and community-based organizations including parent/youth-serving organizations.
- Guam's State Epidemiological Outcomes Workgroup (SEOW) is considered the definitive authority on substance abuse epidemiology on the island. Its data products are readily acknowledged as comprehensive community resources, and its work has consistently influenced substance abuse policy and program development, prevention resource allocation, services delivery and decision-making at the State government level as well as within individual agencies, institutions, and community organizations. The SEOW's work has been cited and utilized by the Office of the Governor and Lt. Governor, the Guam Legislature, the University of Guam and Guam Community College, the Departments of Public Health and Social Services and Mental Health and Substance Abuse and various other policy leaders and program managers on Guam. The SEOW has contributed significantly to various policies directly related to substance abuse prevention, including Public Law 28-80 (Guam's smoke-free law, 2005), Public Law 30-80 (raising tobacco taxes and earmarking tobacco tax revenues for cancer prevention and health promotion, 2010) and Public Law 30-156 (raising the minimum legal drinking age

from 18 to 21 years, 2010). It has also guided prevention program planning and resource allocation in diverse health areas. For instance, the SEOW's Epidemiological Profile is widely quoted in the Guam Comprehensive Cancer Control Plan and is a major reference for the Guam Non-Communicable Disease Control and Prevention strategic plan and the Guam Focus on Life suicide prevention program. It has also been used as a reference by the University of Guam's Cancer Research Center for its U54 research grant application to the National Cancer Institute. The expanded mandate of the SEOW and its ongoing support through the sub-grant will ensure that this valuable community prevention resource will continue to provide the local evidence base for effective substance abuse prevention and mental health promotion in Guam.

- 32-year relationship and collaboration with Youth for Youth Live! Guam Organization, a year-round positive prevention alternative designed to involve the youth in developing, implementing, and evaluating drug prevention programs for themselves. It is a comprehensive year-round program which includes drug education, personal growth, decision making, and positive peer support for being drug free. Youth for Youth members empower their peers with knowledge and skills to promote healthy, drug-free lifestyles.
- Creation of a coalition known as Culture and Language Access Service Partners (CLASP) made up of many government and non-government agencies. GBHWC is a member of CLASP and is partnering with other agencies including the Guam Community College in organizing trainings for interpreters to be trained in behavioral health matters so that they could provide interpretation and translation services;
- Government of Guam personnel are required to attend the CLAS training sponsored by the Office of Minority Health of the Guam Department Public Health and Social Services;
- Establishment of the Pacific Substance Abuse and Mental Health Certification Board (PSAMHC), under the auspices of the Pacific Behavioral Health Collaborating Council (PBHCC), is a nonprofit regional organization whose purpose is to set and maintain professional certification standards for those practitioners within the substance abuse and mental health field. This serves the profession by defining the practitioner's qualifications at the international level and it provides the individual with a credential that certifies their professional competence. PBHCC has sole jurisdiction over the Certification Board for certifying addiction counselors, co-occurring disorder counselors and substance abuse prevention specialists in the Pacific Region representing six Pacific Jurisdictions: American Samoa, the Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Republic of the Marshall Islands and the Republic of Palau. PBHCC/PSAMHCB is a member board of the International Certification & Reciprocity Consortium- the international body whose function is to provide reciprocity with other member boards and to set appropriate standards. PSAMHCB currently provides certification for the following reciprocal credentials:
    - *Alcohol, Tobacco, & Other Drug Abuse (AODA) Prevention Specialist*
    - *Alcohol, Tobacco, & Other Drug Abuse (AODA) Counselor*
    - *Co-occurring Disorder Professionals & Co-occurring Disorder Professional Diplomate (CCDP)*
    - *Certified Substance Abuse Counselors (CSAC)*
    - *Certified Prevention Specialist (CPS)*

- GBHWC Prevention and Training Branch staff are members of the Non-Communicable Disease Consortium's (NCD) Alcohol Prevention Team (APT) and Tobacco Control Action Team (TCAT) which helps guide substance use and mental health programs in the community. In 2011, the Guam Non-Communicable Disease Consortium was formed, spearheaded by Guam's Department of Public Health and Social Services. The Consortium, which involves members from a variety of backgrounds, including business, government, agriculture, and healthcare, has developed two strategic plans, one in 2011 and one in 2014, to reduce the presence of NCDs on the island. Through policy, advocacy, data surveillance, and outreach, the island brings hope for a healthier, brighter future in the westernmost territory of the United State

Identified Needs:

- Linkage between primary care and behavioral health.
- Hotline and Suicide Intervention Crisis services.
- Creation of a coalition known as Culture and Language Access Service Partners (CLASP) The CLASP program is still evolving and much work remains to be done.
- Grants Management issues and topics inclusive of the Super Circular and the Government of Guam's continued bureaucracy which continues to delay procurement and recruitment of staff.
- Staffing/Recruitment
- Lack of local funds to sustain programs when federal grants expire
- Lack of understanding of the importance of prevention resulting in low Government of Guam priority for funding and personnel

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

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 2020 and FY 2021 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.

Figure 6: Age of Participants

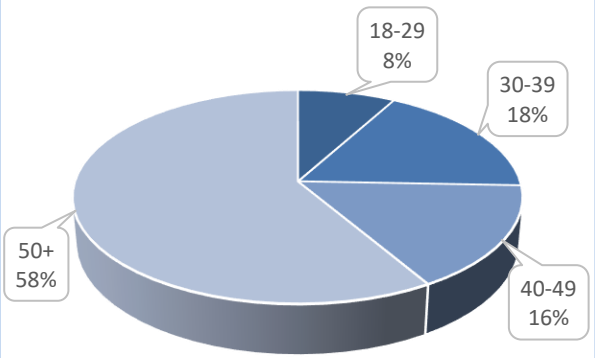


Figure 7: Gender of Participants

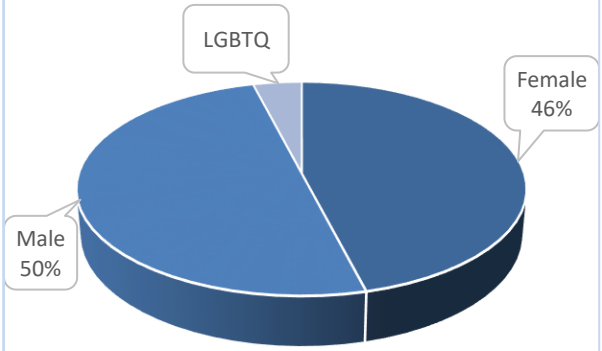
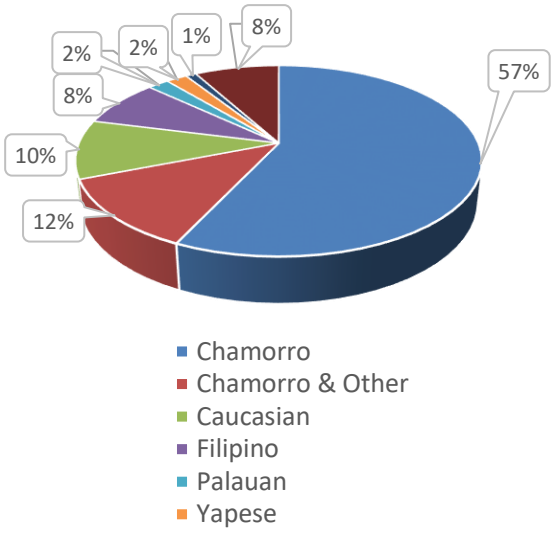


Figure 8: Ethnicity of Participants



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

IDENTIFY UNMET NEEDS AND CRITICAL GAPS WITHIN CURRENT SYSTEM

Description of data sources used to identify primary prevention needs:
In 2005, Guam's SEOW members began by identifying a set of indicators specific to Guam that delineated alcohol, tobacco and other drug consumption patterns and the consequences related to the use of these substances. The criteria for selection of indicators included the following:

- Relevance
- Availability of data
- Validity of data
- Frequency/regularity of data collection
- Consistency in measurement
- If possible, existence of data disaggregated geographically, by age, sex and/or ethnicity/race

The SEOW also compiled a list of existing datasets from which to extract the data for the selected indicators. Indicators from well-established population-based surveillance systems---such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Surveillance System (YRBS)---were given the greatest weight.

Table 11. Data sources

Data Source	Frequency	Agency	Data Type
Behavioral Risk Factor Surveillance System (BRFSS)	annual	DPHSS	Adult tobacco and alcohol use, illicit drug use, depression
Youth Risk Behavior Surveillance System (YRBS)	biannual	Guam Dept. of Education (GDOE)	Youth tobacco, alcohol and drug use; suicidal ideation and attempts; bullying, sexual violence, violence
Modified YRBS	annual	DYA	Youth tobacco, alcohol and illicit drug use
Synar annual tobacco vendors' compliance survey	annual	GBHWC	Vendor compliance to prohibition of tobacco sales to minors
Vital Statistics	annual	DPHSS	Leading Causes of Mortality
Guam Cancer Facts and Figure, Cancer Registry	2008-2012	DPHSS	Cancer prevalence and mortality
Guam Uniform Crime	annual	Guam	Alcohol and drug-related

Report		Police Department	crime
US Probation Office Client Random Drug Testing Statistics	annual	Guam US Probation Office	Adult drug offenders random drug testing results
Suicide Mortality Report	quarterly	Chief Medical Examiner's Office	Suicide deaths and associated data
GALA, Inc. Assessment Report	2014	GALA, Inc.	Tobacco, alcohol and drug use among LGBTQ; suicidal ideation and attempts; physical violence

Guam's State Epidemiological Outcomes Workgroup (SEOW) is considered the definitive authority on substance abuse epidemiology on the island. Its data products are readily acknowledged as comprehensive community resources, and its work has consistently influenced substance abuse policy and program development, prevention resource allocation, services delivery and decision-making at the State government level as well as within individual agencies, institutions, and community organizations. The SEOW's work has been cited and utilized by the Office of the Governor and Lt. Governor, the Guam Legislature, the University of Guam and Guam Community College, the Departments of Public Health and Social Services and Mental Health and Substance Abuse and various other policy leaders and program managers on Guam. The SEOW has contributed significantly to various policies directly related to substance abuse prevention, including Public Law 28-80 (Guam's smoke-free law, 2005), Public Law 30-80 (raising tobacco taxes and earmarking tobacco tax revenues for cancer prevention and health promotion, 2010) and Public Law 30-156 (raising the minimum legal drinking age from 18 to 21 years, 2010). It has also guided prevention program planning and resource allocation in diverse health areas. For instance, the SEOW's Epidemiological Profile is widely quoted in the Guam Comprehensive Cancer Control Plan and is a major reference for the Guam Non-Communicable Disease Control and Prevention strategic plan and the Guam Focus on Life suicide prevention program. It has also been used as a reference by the University of Guam's Cancer Research Center for its U54 research grant application to the National Cancer Institute. The expanded mandate of the SEOW and its ongoing support through the sub-grant will ensure that this valuable community prevention resource will continue to provide the local evidence base for effective substance abuse prevention and mental health promotion in Guam.

The SEOW membership includes the following entities and organizations that meets quarterly:
GUAM STATE EPIDEMIOLOGICAL OUTCOMES WORKGROUP (SEOW)

- Bureau of Statistics and Plans
- Guam Police Department
- Juvenile Drug Court, Superior Court of Guam
- Guam Department of Education
- Health Partners, L.L.C.
- Department of Public Health and Social Services
- Department of Youth Affairs
- Guam Behavioral Health and Wellness Center

- Guam Community College
- Guam's Alternative Lifestyle Association
- Guam Memorial Hospital
- Guam National Guard
- Guam Regional Medical City
- University of Guam Cooperative Extension Services
- University of Guam Cancer Research Center
- Sanctuary, Incorporated

Effective prevention requires a foundation of good data. The SEOW oversees the strategic use of data to inform and guide substance abuse prevention policy and program development on Guam. Guam's SEOW was subsequently established in 2004. Throughout 2005, the SEOW undertook a data inventory, and collated and reviewed data on substance abuse consumption patterns and consequences. The first Guam State Epidemiological Profile (Epi Profile) on substance abuse and consequences was published during the 3rd quarter of 2007. Subsequent updates to the profile were published in 2008 and 2009. The SPF-SIG formally ended in 2010.

In 2008, the Guam Behavioral Health and Wellness Center (GBHWC, formerly known as the Department of Mental Health and Substance Abuse or DMHSA) successfully applied for a SAMHSA GLS youth suicide prevention grant. The three-year grant, entitled Focus on Life, ran from September 2008 to September 2011. One of the grant's objectives was to strengthen and enhance suicide data collection, surveillance and analysis. This was assigned to the SEOW, which released Guam's first Suicide Profile in January 2009. Two updates were published in April 2010 and September 2011. The suicide prevention grant ended on September 2011. In late 2010, Synectics, a SAMHSA contractor, awarded a sub-grant to Guam to sustain the SEOW through 2014. The 4th Epi Profile and 1st Community Profile were published in 2012 followed by the 5th Epi Profile and 2nd Community Profile in 2013. Subsequently, the Partnerships for Success grant provided funding that permits the SEOW's work to continue to the present time and resulted in publishing the 6th and 7th Epi Profiles in 2015 and 2018.

The data products produced by SEOW are readily acknowledged as comprehensive community resources, and its work has consistently influenced substance abuse policy and program development, prevention resource allocation, services delivery and decision-making at the State government level as well as within individual agencies, institutions, and community organizations.

This Profile represents the work done by the various SEOW members in conjunction with the Governor's PEACE Council and the GBHWC Prevention and Training staff. It documents an ongoing process of data collation and surveillance, with an expanded scope that includes not just data on tobacco, alcohol and other drugs of abuse but also suicide and mental health. Through this publication and its continuing work, the SEOW will continue to provide the local evidence base for effective substance abuse prevention

and mental health promotion in Guam.

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

GBHWC's Prevention and Training Branch (P&T) 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 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.

Workforce Development: Prevention and Training branch 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). There are a total of 9 Certified Prevention Specialists (CPS) on Guam. Currently P&T has 6 full time staff but only 3 are certified. One determinant 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. Workforce Development will be strengthened by increasing the number of Certified Prevention Specialists in the P&T Branch to serve the community.

To address this gap, P&T will require staff to be CPS certified and will provide funding opportunities for the CPS certification application and renewals through SAPT. 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 GCC's Human Services Associates Degree Program. Additionally, P&T will continue to collaborate with NPN, PBHCC and Guam Department of Administration in developing a job title and description for Certified Prevention Program Specialists within the Government of Guam.

Data Infrastructure: There are serious data gaps for Guam, and through the years, the SEOW and P&T have continued to work to address these gaps.

• Expanded youth data collection for gap years in YRBS: Out of school youth - To expand the coverage of youth data, the SEOW
facilitated an agreement between GBHWC and the Department of Youth Affairs (DYA) and Sanctuary, Inc. (a private sector provider of youth drug rehabilitation services) to administer a

subset of YRBS questions to all of their clients, representing court-involved youth outside of the school Guam State Epidemiological Profile 18 system. Through this agreement, data on drug consumption is now available for out-of-school high-risk youth. However, no new data for this group was available for the current edition of the Epi Profile. A Memorandum of Understanding (MOU) will be established between GBHWC, DYA and Sanctuary Inc. to consistently collect this data annually.

• LGBTQ population – In 2015, the SEOW incorporated data from the Guam's Alternative Lifestyle Association (GALA), a PEACE Partnerships for Success Partner, into the Profile. However, no new data is available from this population subgroup for the current edition of the Profile. Funding will be allocated to address this need for consistent collection of annual data.

Prevention and Training and SEOW will address these needs by strengthening data infrastructure that captures special populations. P&T will continue to collate and report an epidemiological profile for Guam annually. The SEOW will develop and implement a strategic plan for identifying and capturing data on special populations on Guam. Additionally, GBHWC in collaboration with DYA and Sanctuary Inc., will capture YRBS data annually for the two populations

Substance use Priorities:

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 and to include cultural representatives in the substance use and suicide prevention task-force. 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.

Collaboration and partnerships will continue with non-government organizations (NGOs)in providing prevention strategies and programs. The Prevention and Training Branch will support NGO's 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 (www.peaceguam.org) is kept up to date with relevant prevention materials and information. Media campaigns targeting the prevention of underage drinking and tobacco and suicide prevention will go through focus groups to determine the bes t 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 and tobacco control 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.

Tobacco Access: To address this gap, P&T will continue to work on reducing youth access to tobacco/nicotine by decreasing the number of retail outlets selling tobacco to minors and increasing education and awareness of Guam's tobacco laws among tobacco/nicotine vendors. The strategies will include annually reviewing and updating the listing of new and annual renewals of tobacco/nicotine business licenses as well as continuing annual tobacco vendor education, monitoring, compliance and enforcement.

Alcohol and Tobacco/Nicotine Consequences by Youth and Adults: To address this gap, P&T_will continue to work in decreasing the prevalence of alcohol and tobacco/nicotine consumption in youth and adults through collaborating with NGO's and other partners to provide problem identification and early intervention and referral opportunities and will increase leadership opportunities for youth and young adults influencing positive changes in themselves and the community through education and alternative strategies. SAPT partners and sub-recipients will participate in the Alcohol Prevention Workgroup and Tobacco Control Action Team in Guam's NCD Consortium.

Marijuana Use Among Youth: In April of 2019, the Governor of Guam signed into law the legalization of recreational marijuana (Public Law 35-5). There is no current data collection on youth perception of harm and peer disapproval as of 2019. This gap will be identified and addressed through collection of data through collaboration with the Guam Cannabis Control Board to ensure that data collection is prioritized in the development of rules and regulations. By 2021, state added questions on marijuana youth perception of harm and disapproval will be added to the YRBS. P&T and SEOW will then develop prevention strategies to address data collected youth perception of harm and peer disapproval of marijuana use.

Suicide Prevention and Early Intervention: There were a total of 44 deaths in 2018 resulting in 1 suicide death every 8 days. Suicide is the 6th leading cause of death on Guam. Age-adjusted rate is over 2X higher than the US national rate and >5X higher than AAPIs in the US. Suicide death is the highest among youth and young adults aged 20-29 years; over half of deaths occurred in those under 30 years. In 2018, Chuukese had the highest rates of suicide deaths and were more prevalent among males. (SEOW and CME Office)

GBHWC Prevention and Training branch continues to implement suicide prevention and early intervention strategies. To address this concern, GBHWC will work towards increasing the number of individuals who are aware of suicide prevention services and resources and increase the number of individuals seeking help within GBHWC and its partners. Suicide prevention information will be disseminated through mass media campaigns, resource directories, brochures, website, social media, public service announcements, speaking engagements, and health fairs. By 2021, SAPT funds will be used to support the local initiatives that aim for no suicide deaths among individuals who seek and receive behavioral health services from the GBHWC and its partners. Particularly, supplies and resources will be procured to support locally hosted suicide prevention trainings such as ASIST, safeTALK, Connect Post-Vention and Grief Talks.

Collaboration and Partnerships: There is a need to increase the availability and accessibility of prevention programs that address substance use and mental health promotion. P&T will address this by maintaining an active and functioning PEACE Advisory Council that provides guidance in assessing and implementing the Guam Strategic Plan for Substance Mis-use Prevention and Mental Health Promotion (FY2020-2024). SAPT will fund capacity building activities, training individuals and providing technical assistance to organizations and government agencies on prevention skills, practices, and policies. Additionally, P&T will establish partnerships with youth and special populations-serving agencies to offer prevention strategies as part of their direct services. Further capacity building and sustainability efforts will include the re-establishment of the Alcohol Prevention Workgroup in Guam's NCD Consortium through active participation of SAPT partners and sub-recipients.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's **NBHQF**. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at **http://www.samhsa.gov/data/quality-metrics/block-grant-measures**. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?
   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Quality and Data Collection Readiness

GBHWC's Drug and Alcohol Branch created a unique system (data source) for data collection, analyzing, and reporting. The system collects data for every client admitted to a level of care provided by the Branch or its contracted providers. Providers are required to submit data on a quarterly and annual basis to GBHWC. The types of data being collected include but not limited to demographics, diagnosis, substance choices, referral source, length of stay, number of times in treatment, transportation or translator needed or not, pre-employment skills needed or not, pregnancy status, as well as other data types. The system also collects the substance treatment NOMs data as required by this block grant program. This is one of the two primary data sources the Branch utilizes to support its data driven substance treatment improvement processes.

Through the data sources mentioned, the Branch was able to utilize the information to identify the needs and gaps of the populations being served. For example, we listed earlier in the Background and Structure of the Service Delivery System section of this application that individuals with substance issues and homeless is a Territory priority population. The data sources does indicate that a significant number of individuals were unemployed or remain homeless or without stable housing after completion of core treatment. Therefore, the D&A Treatment Branch will continue supportive efforts to establish long term sobriety/recovery homes or similar to Oxford Houses. The Branch is confident that priority populations and their needs identified was a result of information provided by stated data sources.

In addition, Guam Behavioral Health and Wellness Center recently implemented in July 1, 2015, an electronic behavioral health records system and collects the Treatment Episode Data Set (TEDS), NOMS, and many other substance related treatment data. The name of the electronic records system is "AWARDS" developed and operated by Foothold Technology based out of New York. "AWARDS" also has a billing component. It will allow GBHWC to collect billing information such as type of medical insurance and what substance abuse services are reimbursable. This will allow GBHWC to use this new source of data to identify needs and gaps in services of the populations being served and make new or improved services data driven.

The Prevention and Training Branch utilizes a number of data feeds, systems evaluation, as well as stakeholders' forums, to determine statewide need for services and works with the island-wide need for services. Its data products are readily acknowledged as comprehensive community resources, and its work has consistently influenced substance abuse policy and program development, prevention resource allocation, services delivery and decision-making at the State government level as well as within individual, institutions, and community organizations.

Utilizing the principles of outcomes-based prevention, Guam's State Epidemiological Outcomes Workgroup (SEOW) was established and charged with overseeing the strategic use of data to inform and guide the island's prevention and early intervention efforts. Throughout 2005, Guam's SEOW undertook a data inventory and collated and reviewed data on substance abuse

consumption patterns and consequences. As a result, the island's first Guam Substance Abuse Epidemiological Profile in 2007 (Epi Profile); with subsequent updates in 2008 thru 2016.

The Guam SEOW is the longest-running data work group in Guam. It is considered the definitive authority on substance abuse epidemiology on the island. Its data products are readily acknowledged as comprehensive community resources, and its work has consistently influenced substance abuse policy and program development, prevention resource allocation, services delivery and decision-making at the State government level as well as within individual agencies, institutions, and community organizations.

The 2016 Profile for Guam represents the work done by the various SEOW members in conjunction with the Governor's PEACE Council and the GBHWC Prevention and Training staff. It documents an ongoing process of data collation and surveillance, with an expanded scope that includes not just data on tobacco, alcohol and other drugs of abuse but also suicide and mental health. Through this publication and its continuing work, the SEOW will continue to provide the local evidence base for effective substance abuse prevention and mental health promotion in Guam.

Key Findings for 2016 Profile for Guam:
Substance Abuse

Tobacco

- Tobacco consumption remains higher in Guam than in the US, for both adults and youth. Males smoke more than females; adult female smoking in Guam is similar to male smoking in the US.
- Tobacco use displays marked disparities across socio-economic gradients; the poor and less educated tend to smoke more. Conversely the rich and well educated are more likely to have never smoked.
- Tobacco-related diseases are the major cause of death in Guam today.
- Smokeless tobacco use among adults is nearly double the US rate, and smokeless tobacco use is rising among Guam youth. Micronesians have the highest rates of smokeless tobacco consumption.
- Electronic cigarette use, or "vaping" is high among our youth: One in three (32.2%) of high school students and nearly one in four (23.1%) of middle school students reported current use.
- Tobacco control policies are closely associated with reductions in youth smoking prevalence.

Alcohol

- Current alcohol use is lower in Guam than in the US, but unsafe alcohol use (binge drinking and heavy drinking) among Guam adults surpasses the US rate.
- Current and binge drinking among Guam youth were increasing until alcohol taxes were increased in 2003. A further reduction was noted in 2011, following passage of the law that raised the minimum legal drinking age.
- Alcohol-related arrests comprised 19% of all arrests cleared in 2016. Alcohol was a factor in 17% of all traffic-related deaths in 2016.

Illicit Drugs

- About 12% of adults are current users of marijuana. Current and lifetime marijuana use among Guam students are higher than the US median.
- In 2016, 5.7% of adults reported illicit drug use other than marijuana. About 5% of adults reported taking prescription drugs that were not prescribed for them.
- About 4.5% of Guam high school students report having tried methamphetamines. About 11% reported taking a prescription drug without a doctor's prescription.
- In 2015, about 37% of high school youth reported they had been offered, sold or given an illicit drug on school property.

Suicide

- The age-adjusted 2016 suicide rate in Guam is 36.6 per 100,000, which is markedly higher than the US rate.
- Suicide deaths in Guam occurred predominantly among younger people. From 2008 to 2016, about 56% of all suicides occurred in those under 30 years of age.
- Chuukese and Japanese have the highest ethnicity-specific suicide rate.
- Most suicides in Guam occurred at home; hanging is the predominant method.
- Guam youth have an elevated likelihood of suicidal ideation and attempts than their US counterparts.
- Alcohol use, mental illness and exposure to violence have been linked to suicide deaths.

Mental Illness

- Almost 14% of Guam adults reported a debilitating mental condition or emotional problem in 2016, but only 6% reported receiving treatment for their condition.
- Symptoms of mental illness were more prevalent among Micronesians, those with lower income and lesser education.
- Persistent sadness among Guam high school students is significantly higher than the US median.

In 2005, Guam's SEOW members began by identifying a set of indicators specific to Guam that delineated alcohol, tobacco and other drug consumption patterns and the consequences related to the use of these substances. The criteria for selection of indicators included the following:

- Relevance
- Availability of data
- Validity of data
- Frequency/regularity of data collection
- Consistency in measurement
- If possible, existence of data disaggregated geographically, by age, sex and/or ethnicity/race

The SEOW also compiled a list of existing datasets from which to extract the data for the selected indicators. Indicators from well-established population-based surveillance systems---such as the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Surveillance System (YRBS)---were given the greatest weight.

There are serious data gaps for Guam, and through the years, the SEOW has worked to address these gaps.

- **Adult illicit drug use:** Guam had no data on adult illicit drug use from a population-based survey prior to the SEOW. As a stopgap measure, in 2007 and 2008, GBHWC (formerly DMHSA) commissioned a population-based phone survey of drug use among youth and adults, but this could not be sustained because of the expense. In 2009, the SEOW facilitated a Memorandum of Understanding (MOU) between GBHWC and DPHSS to incorporate selected questions on illicit drug use in the BRFSS. This ongoing MOU (renewed annually since 2010) now provides population-based adult data on illicit drug consumption.
- **Guam ethnicity categories**: Earlier adult tobacco and alcohol data from the BRFSS could not be disaggregated using Guam-specific ethnic categories. The SEOW requested DPHSS to add island-specific ethnic categories as a State-added question in 2008.
- **Expanded youth data**:
- **Out of school youth** - To expand the coverage of youth data, the SEOW will facilitate an agreement between GBHWC and the Department of Youth Affairs (DYA) and Sanctuary, Inc. (a private sector provider of youth drug rehabilitation services) to administer a subset of YRBS questions to all of their clients, representing court-involved youth outside of the school system. **Suicide-related data** - The SEOW undertook a working agreement with the Office of Guam's Chief Medical Examiner to obtain suicide mortality data and with the Guam Memorial Hospital to access suicide-related hospital and Emergency Room admissions data. This year, the SEOW also received data from the National Suicide Hotline on call volumes from Guam.
- **Mental health indicators** – The SEOW has gradually expanded the scope of its data analysis and now includes information on depression, violence, sexual violence and bullying among youth, and depression among adults.
- **LGBTQ population** – SEOW will to expand coverage on data from the Guam's Alternative Lifestyle Association (GALA), a PEACE Partnership for Success Partner, into the Profile. 2014 was the last update on this population.

It is anticipated that over time more behavioral health indicators will be incorporated into the Epi Profile. Currently, selected indicators for the expanded Epi Profile include:

SEOW selected indicators

ALCOHOL	Consumption	Consequences
Indicators	Lifetime use of alcohol by Middle School students Current use of alcohol by High School students Current use of alcohol by 18 and older Current binge drinking by High School students Current binge drinking by 18 and older Current heavy use of alcohol by 18 and older Current binge drinking by LGBTQ Current heavy use of alcohol by LGBTQ Early initiation of alcohol use Drinking and driving among High School students Consumption patterns among court-involved youth Use of alcohol on school property by High School students	Chronic liver disease death rate Suicide death rate Homicide deaths % Fatal motor vehicle crashes that are alcohol-related Violent crime rate Property crime rate Alcohol abuse or dependence Alcohol-related confinement % Alcohol-related participation in treatment programs

TOBACCO	Consumption	Consequences
Indicators	Current smoking by Middle School students Current smoking by High School students Current smoking by 18 and older Current smoking by LGBTQ Current smokeless tobacco use by Middle School students Current smokeless tobacco use by High School students Current smokeless tobacco use by adults Lifetime daily cigarette use by Middle School students Current daily cigarette use by High School students Current daily cigarette use, 18 and older Early initiation of tobacco use % vendors selling to minors Quit attempts in the past year Use of cigarettes and smokeless tobacco	Deaths from lung cancer Deaths from chronic obstructive pulmonary disease (COPD) and emphysema Deaths from cardiovascular and cerebrovascular diseases Tobacco-related cancer prevalence

	products on school property

DRUGS	Consumption	Consequences
Indicators	Lifetime use of marijuana by Middle School students Lifetime and current use of marijuana by High School students Early initiation of marijuana use Lifetime and current use of marijuana by adults Lifetime and current use of marijuana by LGBTQ Lifetime use of cocaine by Middle School students Lifetime and current use of cocaine by High School students Lifetime use of inhalants by Middle School students Lifetime use of inhalants by High School students Lifetime use of methamphetamines or “ice” by Middle School students Lifetime and current use of methamphetamines or “ice” by adults Lifetime and current use of other drugs by adults Lifetime and current use of other drugs by LGBTQ Lifetime use of steroids or other prescription drugs by High School students Illegal drug use on school property Other drug use patterns among court-involved youth % US Probation Office drug testing positive for any drug Drug seizures per year by type and amount of drug	Property crime rate Violent crime rate Drug abuse or dependence Drug-related arrests

SUICIDE	Vital Statistics	Related Data
Indicators	Suicide mortality rate Demographic characteristics of suicide deaths % of suicide deaths involving alcohol use % of suicide deaths involving other drug use	Suicidal ideation among school youth Suicidal ideation among LGBTQ Suicidal attempts among school youth

		Suicidal attempts among LGBTQ % of school youth reporting persistent sadness % of school youth identifying themselves as bi- or homosexual

MENTAL HEALTH	Prevalence
Indicators	Prevalence of depressive symptoms among High School students Prevalence of depressive symptoms among adults % students threatened or injured by a weapon in school in the past 12 months % students in a physical fight in the past 12 months % students forced to have sexual intercourse, lifetime % students subjected to partner violence in the past 12 months % students bullied on school property in the past 12 months % students electronically bullied in the past 12 months % LGBTQ bullied for their sexual preference, lifetime

At present, Guam's SEOW tracks data on substance abuse consumption and consequences and suicide from the following data sources:

Data sources

Data Source	Frequency	Agency	Data Type
Behavioral Risk Factor Surveillance System (BRFSS)	annual	DPHSS	Adult tobacco and alcohol use, illicit drug use, depression
Youth Risk Behavior Surveillance System (YRBS)	biannual	Guam Dept. of Education (GDOE)	Youth tobacco, alcohol and drug use; suicidal ideation and attempts; bullying, sexual violence, violence
Modified YRBS	annual	DYA	Youth tobacco, alcohol and illicit drug use
Synar annual tobacco vendors' compliance survey	annual	GBHWC	Vendor compliance to prohibition of tobacco sales to minors
Vital Statistics	annual	DPHSS	Leading Causes of Mortality
Guam Cancer Facts and Figure, Cancer Registry	2008-2012	DPHSS	Cancer prevalence and mortality
Guam Uniform Crime Report	annual	Guam Police Department	Alcohol and drug-related crime

US Probation Office Client Random Drug Testing Statistics	annual	Guam US Probation Office	Adult drug offenders random drug testing results
Suicide Mortality Report	monthly	Chief Medical Examiner's Office	Suicide deaths and associated data
GALA, Inc. Assessment Report	2014	GALA, Inc.	Tobacco, alcohol and drug use among LGBTQ; suicidal ideation and attempts; physical violence

LESBIAN, GAY, BISEXUAL, TRANSGENDER (LGBT) COMMUNITY

The SEOW identified a data gap regarding substance abuse and mental health data from the local lesbian, gay, bisexual and transgender (LGBT) community in 2012. In 2014, under the Partnership for Success (PFS) grant, Guam's Alternative Lifestyle Association (GALA), Inc. collaborated with the GBHWC PEACE Office to conduct the first GALA Health and Wellness Survey among the local LGBT community.

The survey was comprised of questions borrowed from CDC's BRFSS, PEW Research, the DPHSS Pacific Islands HIV Test form and the Suicidal Behaviors Questionnaire (SBQ). It was reviewed by a community review panel and was granted ethics clearance from the University of Guam's (UOG) Institutional Review Board, Committee on Human Subjects Review.

Survey participants were those who self-identified as lesbian, gay, bisexual and/or transgender over the age of 18, who could provide legal consent for themselves. The data collection period was from August 2014 to December 2014. A convenience, non-probability sampling scheme was employed using a modified version of the Respondent Driven Sampling technique.

A total of 237 surveys were completed. Two surveys were discarded because the respondents self-identified as straight after they completed the survey. In addition, one survey was partially completed but was still included in the data analysis. Survey Results was incorporated in 2015 Guam Epi Profile.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Workforce Development

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Workforce Development in GBHWC's Prevention and Training Branch will be strengthened.

Objective:

1) Increase the number of Certified Prevention Specialists in the P&T Branch to serve the community.

Strategies to attain the objective:

1) Prevention and Training branch will require all staff to be CPS certified
2) Provide funding opportunities for CPS certification application and renewals through SAPT
3) Collaborate with NPN, PBHCC and Guam Department of Administration in developing a job title and description for Certified Prevention Program Specialist within the Government of Guam
4) Continue the collaboration with the Guam Community College (GCC) to further the workforce development in behavioral health care services by offering behavioral health-related courses that meet the requirements for certification and with the issuance of CEU's and/or college credits.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals certified as prevention specialists in GBHWC Prevention and Training Branch

Baseline Measurement: As of FY 2019, there is a total of 1 Certified Prevention Specialists within GBHWC P&T

First-year target/outcome measurement: Increase the number of P&T certified prevention specialist by 50% above the baseline in FY 2020

Second-year target/outcome measurement: Increase the number of P&T certified prevention specialists by 100% above the baseline in FY 2021

Data Source:

Administrative records of the Pacific Behavioral Health Collaborating Council and IC&RC Certification Board

Description of Data:

Records indicating the number of individuals in GBHWC's P&T who are certified.

Data issues/caveats that affect outcome measures::

Lack of interests and/or incentives for prevention service providers to become Prevention Specialists as there are no guaranteed career opportunities for CPS certified professionals on Guam

Priority #: 2

Priority Area: Data Infrastructure

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Strengthened data infrastructure that captures special populations.

Objective:

1) Continue to collate and report an epidemiological profile for Guam annually.
2) SEOW to develop and implement a strategic plan for identifying and capturing data on special populations on Guam
3) GBHWC in collaboration with DYA and Sanctuarty Inc., to capture YRBS data on even years (gap years)

Strategies to attain the objective:

1) Update and Publish Guam's Epidemiological Profile annually
2) P&T to provide support to the SEOW in their strategic planning
3.1) Develop MOU with GBHWC, DYA and Sanctuary Inc. to administer a modified YRBS survey to institutionalize/out of school youth.
3.2) P&T and SEOW will provide training and technical assistance to DYA and Sanctuary Inc. for administering the YRBS

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Guam's annual Epidemiological (Epi) Profile

Baseline Measurement: FY 2018 last publsihed Epi Report

First-year target/outcome measurement: Guam's annual Epidemiological (Epi) Profile FY2020

Second-year target/outcome measurement: Guam's annual Epidemiological (Epi) Profile FY2021

Data Source:

Guam's annual Epidemiological (Epi) Profile

Description of Data:

Epidemiological report on substance use and mental health among youth and adults on Guam

Data issues/caveats that affect outcome measures::

No classified permanent employee to support SEOW's technical needs (research analyst)

Indicator #: 2

Indicator: Number of captured special population groups on Guam

Baseline Measurement: Strategies to monitor their risks and needs have not been comletely established

First-year target/outcome measurement: Updated Health Disparitites Health Impact Statement on Guam that addresses uncaptured special populations

Second-year target/outcome measurement: Implentation of data collection and collation action steps

Data Source:

Prevention and Training SEOW log

Description of Data:

As of FY2019, the Health Disparities Health Impact Statement has only reported on two high-risk/high-need populations on Guam, although other special groups have been identified, no profile has been established for them nor has there been a plan to monitor their risk and needs.

Data issues/caveats that affect outcome measures::

No classified permanent employee to provide support to SEOW and no island-wide data sources where special groups are properly captured.

Indicator #: 3

Indicator: Number of individuals surveyed during the gap years that YRBS does not administer in GDOE

Baseline Measurement: none

First-year target/outcome measurement: MOU with GBHWC, DYA and Sanctuary Inc. FY2020

Second-year target/outcome measurement: All intakes at Sanctuary and DYA will include administration of the YRBS FY2021

Data Source:

P&T and SEOW Log

Description of Data:

YRBS will be conducted to youth who enter DYA and Sanctuary Inc

Data issues/caveats that affect outcome measures::

Personnel and training of administering the YRBS survey

Priority #: 3

Priority Area: Tobacco Access

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Reduced youth access to tobacco/nicotine

Objective:

1) Decrease the number of retail outlets selling tobacco to minors
2) Increased education and awareness of Guam's tobacco laws among tobacco/nicotine vendors

Strategies to attain the objective:

1) Review and update listing of new and annual renewals of tobacco/nicotine business licenses
2) Continue annual tobacco vendor education, monitoring, compliance and enforcement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Synar Compliance - Decrease in the number of retail outlets selling tobacco to minors; maintain over 85% compliance each year as part of its efforts to stop the illegal sales of tobacco to minors

Baseline Measurement: FY 2018 Youth tobacco sales for Guam reported a 12.1% Synar RVR

First-year target/outcome measurement: Maintain RVR rates under 10% by the end of FY2020

Second-year target/outcome measurement: Maintain RVR rates under 10% by the end of FY2021

Data Source:

Annual Synar compliance checks

Description of Data:

Synar Data Collection form

Data issues/caveats that affect outcome measures::

Possible restrategizing of Syanar protocols

Priority #: 4

Priority Area: Alcohol and Tobacco/Nicotine consequences by youth and adults

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Consequences of alcohol and tobacco/nicotine use by youth and adults are reduced

Objective:

Decrease the prevalence of alcohol and tobacco/nicotine consumption in youth and adults

Strategies to attain the objective:

1) Collaborate with NGO's and other partners to provide problem identification and early intervention and referral opportunities
2) Increase leadership opportunities for youth and young adults influencing positive changes in themselves and the community through education and alternatives strategies.
3) Participate in the Alcohol Prevention Workgroup and Tobacco Control Action Team in Guam's NCD Consortium through active participation of SAPT partners and sub-recipients

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Prevalence of binge drinking in youth and adults

Baseline Measurement: Baseline measurements for FY 2016: Adult binge drinking is 20.7% overall prevalence; Youth binge drinking is 13.3% overall prevalence in 2015

First-year target/outcome measurement: Decrease prevalence of binge drinking in youth and adults by 2 percentage points by the end of FY2020

Second-year target/outcome measurement: Decrease prevalence of binge drinking in youth and adults by another 2 percentage points by the end of FY2021

Data Source:

Well-established population-based surveillance systems such as the Behavioral Risk Factor Surveillance System (BRFSS) - Adults; and the Youth Risk Behavior Surveillance System (YRBS)- Youth.

Description of Data:

Both data sources track alcohol and tobacco consumption in youth and adults, respectively

Data issues/caveats that affect outcome measures::

• YRBS is collected every two years.
· YRBS is only conducted in Guam’s public schools
· Other survey conducted based on the availability of funding.

Indicator #: 2

Indicator: Prevalence of current smoking in youth and adults

Baseline Measurement: Adult Current Smoking is 21.9% overall prevalence in 2018; Youth Current Smoking is 13.2% overall prevalence in 2017.

First-year target/outcome measurement: Decrease prevalence of current tobacco use in youth and adults by 2 percentage points by the end of FY2020

Second-year target/outcome measurement: Decrease prevalence of current tobacco use in youth and adults by another 2 percentage points by the end of FY2021

Data Source:

Youth Risk Behavior Survey (YRBS) for Youth and Behavioral Risk Factor Surveillance System (BRFSS) for Adult.

Description of Data:

Both data sources track tobacco consumption in youth and adults, respectively.

Data issues/caveats that affect outcome measures::

· YRBS is collected every two years.
· YRBS is only conducted in Guam's public schools
· Other survey conducted based on the availability of funding.

Priority #: 5

Priority Area: Marijuana use among youth

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Current trends on marijuana use and perception among youth will be identified and addressed

Objective:

Increase the perception of harm and peer disapproval of marijuana use among youth

Strategies to attain the objective:

1) P&T and SEOW to collect data on the perception of harm and peer disapproval of marijuana use among youth
2) P&T and SEOW to develop prevention strategies to address data collected on the perception of harm and peer disapproval of marijuana use among youth

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Perceived risk of harm of marijuana use among youth

Baseline Measurement: none

First-year target/outcome measurement: Identify baseline data for the perception of harm of marijuana use among youth FY2020

Second-year target/outcome measurement: Decrease the perception of harm of marijuana use among youth by 20% FY2021

Data Source:

P&T SEOW FY2020 and YRBS FY2021

Description of Data:

State added questions will be added to the YRBS

Data issues/caveats that affect outcome measures::

Gap years and obtaining Guam Department of Education's approval for state added questions

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Indicator #: 2

Indicator: Perceived peer disapproval of marijuana use among youth

Baseline Measurement: none

First-year target/outcome measurement: Identify baseline data for the perception of peer disapproval of marijuana use among youth FY2020

Second-year target/outcome measurement: Increased perceived peer disapproval by 20% in FY 2021

Data Source:

P&T Log FY2020 and YRBS FY2021

Description of Data:

State added questions for perceived peer disapproval will be added to the YRBS survey FY2021

Data issues/caveats that affect outcome measures::

Approval form Guam Department of Education for state added questions

Priority #: 6

Priority Area: Suicide Prevention and Early Intervention

Priority Type: SAP

Population(s): PP

Goal of the priority area:

No suicide deaths will occur among individuals who seek and receive behavioral health services from GBHWC and its partners

Objective:

1) Increase number of individuals who are aware of suicide prevention services and resources
2) Increase number of individuals seeking help within GBHWC and its partners

Strategies to attain the objective:

1) Information Dissemination through mass media campaigns, resource directory, brochures, website, social media, public service announcements, speaking engagements, and health fairs.
2) Provide support for locally hosted suicide prevention trainings that include supplies and resources.
3) Improve suicide-related data collection and analysis and reporting to the SEOW

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals reached by information dissimination strategies

Baseline Measurement:

First-year target/outcome measurement: Increase individulas reached by 10% in FY2020

Second-year target/outcome measurement: Increase individuals reached by 10% in FY2021

Data Source:

P&T's Master File Log

Description of Data:

1) Number of individuals who received prevention materials and resources via in-person events
2) Number of impressions made from the media campaign

Data issues/caveats that affect outcome measures::

Campaign impressions are not accurate measures of increased awareness and motivation to take action.

Indicator #: 2

Indicator: Number of individuals who received services from GBHWC and its partners

Baseline Measurement: GBHWC FY2018 is 3,467 and Isa Pyschological Services FY2018 is 442

First-year target/outcome measurement: Increase number of individuals who received services from GBHWC and its partners by 10% for FY2020

Second-year target/outcome measurement: Increase number of individuals who received services from GBHWC and its partners by 10% for FY2021

Data Source:

GBHWC and Isa Psychological Services' intake log

Description of Data:

Number of unique individuals served by GBHWC and Isa Psychological Services per year

Data issues/caveats that affect outcome measures::

P&T's challenged with identifying strategies implemented and the number of individuals served

Priority #: 7

Priority Area: Collaboration and Partnerships

Priority Type: SAP

Population(s): PP

Goal of the priority area:

That prevention programs are provided by NGO's, government agencies and other community organizations.

Objective:

1) Maintain an active and functioning PEACE Advisory Council that provides guidance in assessing and implementing the Guam Strategic Plan for Substance Mis-use Prevention and Mental Health Promotion (FY2020-2024)
2) Increase prevention programs provided by NGO's, government agencies and community organizations

Strategies to attain the objective:

1.1) PEACE Council and Prevention and Training staff will conduct prevention resource mapping of prevention programs provided throughout Guam
1.2) P&T staff and PEACE Council will review the annual SEOW Epidemiological Profile for Guam to identify gaps and needs in prevention resources
1.3) PEACE Council will submit annual report to the Governor of Guam to identify and address prevention strengths and needs and recommendations to improve Guam's prevention system.
2.1) Build Guam's prevention capacity by offering training to individuals and providing technical assistance to organizations and government agencies on prevention skills, practices, and policies.
2.2) Establish partnerships with government agencies to support the implementation of prevention strategies
2.3) Provide funding opportunities to NGO's to deliver prevention strategies and programs
2.4) Re-establish the Alcohol Prevention Workgroup in Guam's NCD Consortium through active participation of SAPT partners and sub-recipients

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Governor's PEACE Advisory Council participation rate

Baseline Measurement: 0 due to new governement adminsitration in 2019

First-year target/outcome measurement: At least 60% of members consistently attend council meetings

Second-year target/outcome measurement: At least 90% of members consistently attend council meetings

Data Source:

Minutes of Meetings

Description of Data:

1) At least 60% of the PEACE Council members consistently attend the 4 council meetings in FY2020

2)At least 90% of PEACE Council members consistently attend the 4 council meetings in FY2021

Data issues/caveats that affect outcome measures::

Appointees are not considered members until official swear-in

PEACe Council has to meet quorum to proceed with the meeting

Indicator #: 2

Indicator: Number of products submitted to Governor

Baseline Measurement: 0 due to new governement adminsitration in 2019

First-year target/outcome measurement: Governor's PEACE Council Annual Report FY2020

Second-year target/outcome measurement: Governor's PEACE Council Annual Report FY2021

Data Source:

Record log of memo submitted via GBHWC Director and PEACE Council Chair to Governor's Office

Description of Data:

Governor's PEACE Council Annual Report FY2020 and 2021which will include resource prevention map and gap analysis, strengths and needs and recommendations for prevention system improvement.

Data issues/caveats that affect outcome measures::

PEACE Council will have to identify a workgroup among its members to work with P&T staff in developing technical aspects of products.

Indicator #: 3

Indicator: Number of organizations that serve high-need/high-risk population represented in training

Baseline Measurement: 70 organizations represented in training in FY2018

First-year target/outcome measurement: Increase number of public and private organizations respresented by the individuals trained by P&T

Second-year target/outcome measurement: Increase number of agreements with agencies and organizations to commit employee participation in P&T trainings

Data Source:

1. P&T training log
2. Record of agreements between the agencies and organizations

Description of Data:

1) Training to be provided may include but not limited to: (Applied Suicide Intervention Skills Training), safeTALK, Introduction to Substance Mis-use, Substance Use Prevention Skills Training, Ethics in Prevention, Connect Post-Vention, Intro to Culturally and Linguistically Appropriate Services, SBIRT, Brief Tobacco Intervention, Strategic Health Communication, Epidemiology 101, Prevention Program Evaluation and Monitoring, Intro to SPF, MHFA Youth and Adult, Team Awareness Stress Management
2) Agencies and organizations will include multi-sector representation from Non-Government Organizations (faith-based, LGBTQ, Cultural, veterans), Youth-Serving organizations, Substance Use and Mental Health Care, military and organizations serving the identified high-risk/high-need populations for Guam

Data issues/caveats that affect outcome measures::

1) External factors with potential partners to include : administration priorities and other relative costs

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Indicator #: 4

Indicator: Number of organizations providing prevention strategies/services

Baseline Measurement: 3 NGO's in FY2019

First-year target/outcome measurement: Maintain at least 6 NGO's providing prevention services in 2020

Second-year target/outcome measurement: Maintain at least 6 NGO's providing prevention services in 2021

Data Source:

P&T record of the organization's progress reports and P&T's Master File Log of all population reach of prevention strategies provided

Description of Data:

1) NGO's will provide services addressing the CSAP's 6 Primary Prevention Strategies (Information Dissemination, Alternatives, Problem Identification and Referral, Community-based process and environmental strategies)

Data issues/caveats that affect outcome measures::

1) P&T Staff have to set protocols for data collection, entry and analysis for technical assistance to sub-recipients for consistency

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Indicator #: 5

Indicator: Number of organizations involved in Alcohol Prevention Workgroup (APW) of Guam NCD Consortium

Baseline Measurement: 2 organizations in FY2019

First-year target/outcome measurement: 6 organizations represented in APW in FY2020

Second-year target/outcome measurement: 6 organizations represented in APW in FY2021

Data Source:

Annual NCD progress report and sign-in sheets

Description of Data:

The 6 SAPT sub-recipients will be represented and involved in the implementation of APW's strategic plan

Data issues/caveats that affect outcome measures::

As of 2019, the NCD Consortium is overseen by the Department of Public Health and Social Services and 2 out of the 12 per anum meetings were held.

Priority #: 8

Priority Area: Workforce Development

Priority Type: SAT

Population(s): SMI, SED, PWWDC, PWID

Goal of the priority area:

Additional 20 Guam Providers/Clinicians with acquired minimum competencies to provide treatment for Substance Use and Mental health disorders

Objective:

a) Secure 10 participants each year for the certification program.
b) Participants will gain knowledge in the certification process and the 4 domains.
c) Certified staff will provide supervision hours (300 hours)
d) Complete 288 contact hours

Strategies to attain the objective:

a) Recruit participants from treatment centers, and educational systems.
b) Provide monthly training that covers the drug and alcohol counseling 4 domains
c) Certified staff to provide supervision
d) Provide monthly training for needed contact hours for certification

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of certified M/SUD clinicians on Guam

Baseline Measurement: 4 Candidates currently working on certification requriements

First-year target/outcome measurement: 50% of certification requirements completed

Second-year target/outcome measurement: 100% of certification requirements completed

Data Source:

Certification Administrator

Description of Data:

Number of candidates taking the certification exam

Data issues/caveats that affect outcome measures::

Due to the complexity of the certification requirements, a year or 2 may not be enough time to complete it all.

Priority #: 9

Priority Area: Workforce Development

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PP, PWID, EIS/HIV, TB

Goal of the priority area:

5 certified Co-occurring disorder professionals to provide treatment to individuals in the M/SUD programs and in the Level III.7 inpatient unit

Objective:

a) Recruit M/SUD clinicians for the certification
b) Complete education contact hours
c) Complete Supervision hours
d) Take IC&RC or NAADAC exam for Cooccurring clinicians

Strategies to attain the objective:

a) Advertise for recruitment
b) Coordinate training program
c) Coordinate clinical supervision at the Level III.7 inpatient unit.
d) Provide exam for certification

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: 5 Individuals certified in Co-occurring Disorders

Baseline Measurement: None at this time

First-year target/outcome measurement: 50% of certification requirements completed

Second-year target/outcome measurement: 100% of certification requirements completed

Data Source:

Certification Administrator

Description of Data:

Data on thew number of individuals taking the certification exam for Co-occurring disorders

Data issues/caveats that affect outcome measures::

Not many individuals are interested in this certification

Priority #: 10

Priority Area: Trauma and Recovery Services

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

Integrate evidence-based model for trauma in M/SUD program

Objective:

Provide Men Do Recovery curriculum in all M/SUD programs

Strategies to attain the objective:

a) Training for this evidence-base model to all m/SUD treatment program on Guam
b) Implement the Men Do Recover curriculum

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number consumers

Baseline Measurement: None at this time

First-year target/outcome measurement: 20 consumers to receive Men Do Recover curriculum

Second-year target/outcome measurement: 20 more consumers to receive Men Do Recover curriculum

Data Source:

Electronic Behavioral Health Record

Description of Data:

EBHR will indicate all individuals who attended and completed Men Do Recovery Curriculum

Data issues/caveats that affect outcome measures::

This program will be provided on a voluntary basis and not all consumers will receive this treatment.

Priority #: 11

Priority Area: Workforce Development

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

All M/SUD providers to be Trauma Informed providers

Objective:

a) Provide Trauma Informed Care Training
b) At least 20 treatment providers trained on Trauma Informed Care and will provide with care in all M/SUD facilities.

Strategies to attain the objective:

a) Coordinate Trauma Informed Care training for all M/SUD clinicians and staff
b) Collaborate and seek Technical Assistance for this project

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Trauma Informed Clinicians on Guam

Baseline Measurement: None at this time

First-year target/outcome measurement: 20 clinicians to attend Trauma Informed Care Training

Second-year target/outcome measurement: 20 more clinicians to attend Trauma Informed Care Training

Data Source:

Registration for trauma informed care training

Description of Data:

Number of individuals for each M/SUD agency to attend the Trauma Informed Care trainings

Data issues/caveats that affect outcome measures::

NONE

Priority #: 12

Priority Area: Collaboration and Partnerships

Priority Type: SAT

Population(s): PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

Available AIDS/HIV and STI Early Intervention/Education, testing and treatment services

Objective:

Consumers in all M/SUD treatment facilities will receive AIDS/HIV and STI education
Consumers in all M/SID treatment facilities will receive early intervention and testing for AIDS/HIV and STI
Consumers in all M/SUD treatment facilities will receive AIDS/HIV/STI treatment services

Strategies to attain the objective:

SSA will collaborate and continue partnership with the local Department of Public Health and Social Services to provide Early Intervention, testing and treatment services for AIDS/HIV/STI.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of M/SUD consumers to receive AIDS/HIV/STI

Baseline Measurement: FY 2018 approximately 843 consumers received, education and testing for AIDS/HIV/STI

First-year target/outcome measurement: FY 2019 for 1000 consumers to receive education , testing, and treatment for AIDS/HIV/STI

Second-year target/outcome measurement: FY 2020 for 1200 consumers to receive education , testing, and treatment for AIDS/HIV/STI

Data Source:

Providers to provide data on the number of consumers who received education , testing, and treatment for AIDS/HIV/STI

Description of Data:

Data field to be added to the data set for each provider to count on their data collection. This will provide a more accurate number of consumers receiving this service.

Data issues/caveats that affect outcome measures::

This service is voluntary and therefore not all consumers will receive this service.

Priority #: 13

Priority Area: Collaboration and Partnerships

Priority Type: SAT

Population(s): PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

TB clearance for all M/SUD Consumers on Guam

Objective:

Provide PPD testing for all M/SUD consumers on Guam

Strategies to attain the objective:

Collaborate with Department of Public Health and Social Services and local clinics to provide PPD testing for all M/SUD consumers

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: All M/SUD consumers to receive TB clearance prior to entering treatment

Baseline Measurement: 50% of all consumers will receive PPD testing prior to entering treatment

First-year target/outcome measurement: 80% of all consumers will receive PPD testing prior to entering treatment

Second-year target/outcome measurement: 100% of all consumers will receive PPD testing prior to entering treatment

Data Source:

Data collection at screening and intake

Description of Data:

All consumers are asked and it is part of the data set collected at screening and at intake

Data issues/caveats that affect outcome measures::

None

Priority #: 14

Priority Area: Recovery Support Services-Housing

Priority Type: SAT

Population(s): PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

Available recovery supportive housing

Objective:

Provide Recovery Housing or a sober living home for consumers in need of housing in order to maintain their recovery

Strategies to attain the objective:

Collaborate and partnership with the Guam Housing & Urban Renewal to attain housing to start a sober living home.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Available housing or individuals in recovery

Baseline Measurement: None at this time

First-year target/outcome measurement: 6 individuals in recovery to gain housing

Second-year target/outcome measurement: 12 individuals in recovery to gain housing

Data Source:

Collected through EBHR

Description of Data:

Each consumer receiving housing through and M/SUD program will be indicated in the EBHR

Data issues/caveats that affect outcome measures::

None

Priority #: 15

Priority Area: Collaboration and Partnerships

Priority Type: SAT

Population(s): PWWDC, PP, ESMI, PWID

Goal of the priority area:

Available Prenatal and primary care services for pregnant women and women with children.

Objective:

Pregnant women and women with children to have access to primary care and prenatal services when entering treatment

Strategies to attain the objective:

Collaborate with Department of Public Health and Social Services and local medical clinics to provide health care at the onset of M/SUD treatment.

Assist women and consumers to apply for health benefits at the onset of treatment

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase access to prenatal and primary care services for pregnant women and women with children

Baseline Measurement: 26 women provided access to primary care and prenatal services.

First-year target/outcome measurement: 40 pregnant women and women with children access to primary care and prenatal services.

Second-year target/outcome measurement: 40 pregnant women and women with children access to primary care and prenatal services.

Data Source:

D

Description of Data:

Data collected on EBHR at screening and intake

Data issues/caveats that affect outcome measures::

Data will be collected on EBHR and data will be collect prior tp discharge to indicate that the women had access to health care services while in treatment.

Priority #: 16

Priority Area: Access to treatment

Priority Type: SAT

Population(s): SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

Provide SBIRT at primary care facilities, Emergency rooms and at outreach events.

Objective:

Provide training on SBIRT for all non-clinical staff to provde SBIRT at Department of Health & Social Services, Department of Education, in emergency rooms and medical clinics and at all outreach events

Strategies to attain the objective:

Train non clinical staff on SBIRT
Staff outreach events and homeless counts where they will be able to provide SBIRT
Create MOA with local medical clinics and emergency rooms to be able to be called to provide peer support and SBIRT

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase number of individuals trained to provide SBIRT

Baseline Measurement: 6 trainined in SBIRT

First-year target/outcome measurement: 20 trained in SBIRT

Second-year target/outcome measurement: 20 more trained in SBIRT

Data Source:

Registration of SBIRT trainings

Description of Data:

data collect on the number of those trained in SBIRT and the data collected by SBIRT team

Data issues/caveats that affect outcome measures::

None

Priority #: 17

Priority Area: Collaboration and Partnerships

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

Reduce recidivism and the number of those re-incarcerated at Department of Corrections

Objective:

Continue to work closely with therapeutic courts and the department of corrections on ongoing projects
Collaborate to solidify partnerships with therapeutic courts and the department of corrections

Strategies to attain the objective:

SSA to attend planning meetings for court programs and DOC programs
Develop plans for treatment and other recovery support services for those being released from DOC

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Decrease recidivism and jail time

Baseline Measurement: None at this time

First-year target/outcome measurement: Decrease recidivism by 20%

Second-year target/outcome measurement: Decrease recidivism by 30%

Data Source:

Data collected by Department of Corrections on admission

Description of Data:

Department of corrections will provide data on their admission rate and compare to the individuals released form DOC

Data issues/caveats that affect outcome measures::

May not be an accurate number

Priority #: 18

Priority Area: Nutrition and Wellness

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, ESMI, PWID, EIS/HIV, TB

Goal of the priority area:

Quality of life for everyone including good physical health, eating healthy and exercise

Objective:

Educate onf nutrition
Ability to look for healthier snacks
Exercise Right
Manage food budget
Access to fitness center of wellness programs

Strategies to attain the objective:

Work with and collaborate with Department of Public Health & Social Services for nutrition education
Provide a trainer or access to a fitness gym for consumers

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase wellness in recovery

Baseline Measurement: None at this time

First-year target/outcome measurement: 40% will benefit from the wellness program

Second-year target/outcome measurement: 50% will benefit from the wellness program

Data Source:

Data collection

Description of Data:

Data will be collected from surveys in the wellness program and documented in the data set

Data issues/caveats that affect outcome measures::

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$96,316		$0	$0	$1,003,683	$0	$0
a. Pregnant Women and Women with Dependent Children**	$96,316		$0	$0	$1,003,683	$0	$0
b. All Other	$0		$0	$0	$0	$0	$0
2. Primary Prevention	$489,902		$0	$0	$263,840	$0	$0
a. Substance Abuse Primary Prevention	$489,902		$0	$0	$0	$0	$0
b. Mental Health Primary Prevention							
3. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$122,475		$0	$0	$0	$0	$0
10. Total	**$1,198,595**	**$0**	**$0**	**$0**	**$1,267,523**	**$0**	**$0**

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	50	6
2. Women with Dependent Children	100	45
3. Individuals with a co-occurring M/SUD	500	120
4. Persons who inject drugs	100	20
5. Persons experiencing homelessness	150	50

Please provide an explanation for any data cells for which the state does not have a data source.

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Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	$843,166
2 . Primary Substance Abuse Prevention	$224,844
3 . Early Intervention Services for HIV**	$0
4 . Tuberculosis Services	$0
5 . Administration (SSA Level Only)	$56,211
6. Total	**$1,124,221**

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
	Universal	

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
7. Section 1926 Tobacco	Universal	$7,500
	Selective	
	Indicated	
	Unspecified	
	Total	**$7,500**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$7,500**
Total SABG Award*		**$1,124,221**
Planned Primary Prevention Percentage		**0.67 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	$41,337
Universal Indirect	$142,829
Selective	$25,339
Indicated	$15,339
Column Total	**$224,844**
Total SABG Award*	**$1,124,221**
Planned Primary Prevention Percentage	**20.00 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☐
Military Families	☑
LGBTQ	☑
American Indians/Alaska Natives	☐
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☑
Asian	☐
Rural	☐
Underserved Racial and Ethnic Minorities	☑

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FY 2020 A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	$8,557	$19,118	
2. Infrastructure Support	$8,557	$19,118	
3. Partnerships, community outreach, and needs assessment	$56,355	$66,916	
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement	$14,002	$21,189	
6. Research and Evaluation	$17,021	$29,469	
7. Training and Education	$1,929	$13,192	
8. Total	**$106,421**	**$169,002**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

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Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

[23] Research Review of Health Promotion Programs for People with SMI, 2012, **http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper**; About SAMHSA's Wellness Efforts, **https://www.samhsa.gov/wellness-initiative**; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, **https://www.samhsa.gov/health-care-health-systems-integration**; Schizophrenia as a health disparity, **http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml**

[24] Comorbidity: Addiction and other mental illnesses, **http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses** Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; **http://www.samhsa.gov/co-occurring/**

[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **http://www.samhsa.gov/health-disparities/strategic-initiatives**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **http://telehealthpolicy.us/medicaid**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**; National Behavioral Health Quality Framework, Draft, August 2013, **http://samhsa.gov/data/NBHQF**

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

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.

Our treatment program provides a fully integrative evidence based set of substance use disorder treatment and mental health services to individuals with co-occurring alcohol drug addiction and mental health conditions. We offer a comprehensive set of services to consumer that include: clinical services, case management navigation services, and other ancillary services. We offer individual therapy services aimed at addressing substance/alcohol dependence, decreasing symptoms related to interpersonal struggles with loved ones, family systems, as well as their mental health conditions. New Beginnings focuses on providing a safe space for consumers to explore personal experiences in therapy and develop coping skills for overall functioning. The treatment team will collaborate with all parties involved in the care of the consumer and work to accommodate any necessary treatment needs. Our primary goal is to help our consumers gain insight and understanding of their symptoms, what may have caused these symptoms, and how to manage and address these symptoms. We want to support our consumers in discovering their choice for change. We want to know what happened and how we can help them in their recovery process and overall obtainment of a higher quality of life.

In addition to the treatment each consumer has case management services. In case management services each consumer develops their own treatment. Consumers are also assigned to a Peer Recovery Support staff who assists the consumer in navigating a variety of needed services, to include primary health care. The consumer is navigated to through the Department of Public Health & Social Services to apply for health benefits and to make the necessary primary care appointments.

Department of Public Health and Social Services also hold Semi-annual health fairs that include vaccinations and testing for

diabetes, and hypertension on sight. Consumers from the SSA and contracted providers are invited to these health fairs.

SSA and its Contractors continues to refer clients to Dept. of Public Health for PPD testing and completion of TB clearance, and for pregnant women prenatal services.

SSA continues to collaborate with Dept. of Public Health & Social Services (DPHSS) and WestCare Pacific Islands, where AIDS/HIV/STDs Unit staff will provide education/brief intervention services, and testing.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Our treatment program provides a fully integrative evidence based set of substance use disorder treatment and mental health services to individuals with co-occurring alcohol drug addiction and mental health conditions. We offer a comprehensive set of services to consumer that include: clinical services, case management navigation services, and other ancillary services. We offer individual therapy services aimed at addressing substance/alcohol dependence, decreasing symptoms related to interpersonal struggles with loved ones, family systems, as well as their mental health conditions. New Beginnings focuses on providing a safe space for consumers to explore personal experiences in therapy and develop coping skills for overall functioning. The treatment team will collaborate with all parties involved in the care of the consumer and work to accommodate any necessary treatment needs. Our primary goal is to help our consumers gain insight and understanding of their symptoms, what may have caused these symptoms, and how to manage and address these symptoms. We want to support our consumers in discovering their choice for change. We want to know what happened and how we can help them in their recovery process and overall obtainment of a higher quality of life.

We are committed to treating each consumer with a person-centered focus according to the following guidelines: Recognizing the signs and symptoms of addiction in consumers and understanding their impact on the consumer, family, and the community. Providing an atmosphere of recovery in a safe and supportive environment. Culturally sensitive staff members who are mindful of consumers' individual needs and encourage recovery through multi-dimensional therapies. Acknowledging the importance of personal motivation and promoting active consumer engagement in all aspects of treatment.

Collaborating with consumer to discover their unique challenges through the assessment process and supporting the development of personal strengths in service planning. Empowering consumers through their choice of individual care and creating a space of trust through consistent daily structure. Incorporating the knowledge about addiction, and mental health conditions into our evidence-supported practices.

SSA also provides 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.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ◉ No

b) and Medicaid? ○ Yes ◉ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

Quality Improvement officer.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ◉ Yes ○ No

iii) hypertension ◉ Yes ○ No

iv) high cholesterol ◉ Yes ○ No

v) diabetes ◉ Yes ○ No

c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based ◉ Yes ○ No

contractual relationships that advance coordination of care?

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? (●) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Guam Behavioral Health and Wellness Center in collaboration with Public Health and Social Services have provided consumer awareness about parity laws however, at a minimum and not in coordinated and consistent efforts. The SSA recognizes the need to increase awareness and education about parity, however in conjunction with the Department of Public Health and Social Services, the Governor's Health Advisor, and other pertinent government agencies.
GBHWC may request for technical assistance on this area.

10. Does the state have any activities related to this section that you would like to highlight?

NONE

Please indicate areas of technical assistance needed related to this section

SSA request for technical assistance on the area related to the implementation and enforcement of parity provisions.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	○ Yes ○ No
b) Ethnicity	○ Yes ○ No
c) Gender	○ Yes ○ No
d) Sexual orientation	○ Yes ○ No
e) Gender identity	○ Yes ○ No
f) Age	○ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ○ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ○ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ○ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ○ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ○ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

SSA currently has a Compliance Officer who is working on Risk Management within the programs and federal grants.

Please indicate areas of technical assistance needed related to this section

The SSA will need some technical assistance for the Corporate Compliance Officer.

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Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state?s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? ○ Yes ○ No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) ○ Yes ○ No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☐ Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- ☐ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)
- ☑ Older adults (age 55 and above)
- ☑ Cultural/ethnic minorities
- ☑ Sexual/gender minorities
- ☐ Rural communities
- ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [ ] Archival indicators (Please list)

- [ ] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [x] Others (please list)

Guam's SEOW collects outcome data through National (BRFSS, YRBSS) and state added reports and required by NOMs (Guam Global Youth Tobacco Survey, Guam Vital Statistics, Guam Police Department, Guam Memorial Hospital Data, Guam Community Health Assessment, reports from the Guam Statistical Yearbook, and the Suicide Mortality Report. These findings are reported and updated annually in the Guam Epidemiological Profile.

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (●) Yes ( ) No

If yes, (please explain)

The Governor's PEACE Council and the Guam's State Epidemiological Outcomes Workgroup (SEOW) has been retained to guide and advise the Office of the Governor and the Office of the Lt. Governor in strategic prevention framework processes that involve assessment, capacity building, planning, implementation and evaluation steps to ensure that substance abuse prevention, mental health promotion and suicide prevention work is data-driven, culturally relevant, effective and sustainable. Executive Order No. 2011-03 was signed January 31, 2011 by Governor Edward J.B. Calvo and Lt. Governor Raymond S. Tenorio. This Council will help to guide and advise GBHWC staff and PEACE partners, as they facilitate opportunities to strengthen Guam's capacity to create a healthier island community following a strategic prevention framework (SPF) process for establishing evidence-based programs, practices and policies that build upon the strengths and resources of the people of Guam. Needs assessment data collected and analyzed by Guam's SEOW is presented to the Governor's PEACE Advisory Council to drive and guide the work of the Prevention and Training Branch. Guidance provided by the PEACE Council include recommendations on effective programs, policies, and practices that address priorities identified by SEOW as well as recommendations on resource allocation for these priorities. GBHWC provides leadership in obtaining state and federal funding to support comprehensive prevention services on Guam. GBHWC's P&T Branch provides direct community-based prevention services that incorporate CSAP's six primary prevention strategies – (1) information dissemination, (2) problem identification and referral, (3) education, (4) alternatives, (5) community-based process, and (6) environmental strategies. The P&T Branch monitors GBHWC's prevention systems and processes as part of an ongoing quality control assessment of the Department's prevention service delivery. In addition, the P&T Branch maintains the GBHWC's prevention website (www.peaceguam.org), conducts information dissemination and mass media campaigns, manages the various prevention grants of the GBHWC, and provides community-based and stakeholder training and technical assistance. Current resources for prevention programs include the Government of Guam "state" legislative appropriations and the SAMHSA Substance Abuse Prevention and Treatment (SAPT) Block Grant funds.

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

The Prevention and Training Branch staff are Certified Prevention Specialists, and certified as trainers, consulting trainers and/or master-level trainers in evidence-based prevention programs: SAPTS, ASIST, safeTALK for suicide prevention, Connect suicide postvention, Brief Tobacco Cessation Interventions, etc. provided to community-based coalitions, PFS sub-recipients, and the community at large. TA is also available via SAMHSA.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

Developing the substance abuse prevention workforce in Guam is a high priority. In 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA), through a landmark collaborative effort with the Pacific Behavioral Health Collaborating Council (PBHCC), initiated a workforce development project aimed at building a cadre of qualified trainers for the Pacific Region. Since that time, this collaborative effort has not only provided significant training and workforce-related outcomes, it has also increased the ability of the PBHCC to develop and manage a range of projects across the Pacific thus having a regional impact.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ( ) Yes (●) No

If yes, please describe mechanism used

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

Guam State Prevention and Enhancement (SPE) Comprehensive Strategic Plan 2014-2018 and Guam State plan for Suicide intervention and Early Intervention 2015-2020 are attached.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☑ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☑ Timelines
- **c)** ☑ Roles and responsibilities
- **d)** ☑ Process indicators
- **e)** ☑ Outcome indicators
- **f)** ☑ Cultural competence component
- **g)** ☑ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ( ) Yes (●) No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

Governor's Prevention Education and Community Empowerment (PEACE) Advisory Council are appointed member representatives from the executive, legislative and judicial branches of government, the private sector and community-based prevention advocates charged with the development of policies, programs and practices to address Guam's substance abuse and suicide problems, and to include planning, implementing, and evaluating comprehensive evidenced-based prevention strategies that result in positive environment changes.

Guam currently does not have an active evidence-based workgroup. However, the Prevention and Training Branch staff continue

to actively support its stated mission to implement promising practices and evidence-based prevention and early intervention practices, policies and programs in schools, workplaces and other community-based settings for the island of Guam. The Branch utilizes SAMHSA's Identifying and Selecting Evidence-Based Interventions as the guidance for determining appropriate strategies to be implemented with prevention funds.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☑ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

1) www.peaceguam.org website
2) Annual updates of Guam Epidemiological Profiles on Substance Abuse and Suicide
3) Educational Fact Sheets on Alcohol, Tobacco and Other Drugs, and Mental Health
4) Guam Public Policies Relative to Alcohol, Tobacco and Other Drugs
6) Alcohol, tobacco and marijuana Prevention Campaigns
7) Suicide Prevention Campaigns

b) Education:

1) Youth for Youth Leadership Program
2) Substance Abuse Prevention Skills Training (SAPST)
3) Suicide Prevention and Intervention Training
4) Connect Post-Vention
5) Culture and Linguistically Appropriate Services (CLAS) Training
6) Health Literacy
7) Screening Brief Intervention, Referral and Treatment (SBIRT)

8) safeTALK Training
9) Applied Intervention Skills Training (ASIST)
10) Grief Talk
10) Brief Tobacco Intervention (BTI)
11) Ethics in Prevention
12) Team Awareness Stress Management
13) Data Collection and Evaluation

c) Alternatives:

1) ROTARACT
2) Annual Youth for Youth Live! Annual Conference
3) Too Cool to Do Drugs
4) Summer Youth Prevention Programs
5) Youth Sports Events
6) Fade Away from Violence
7) Harvest Christian Academy Mental Health Club
8) Haya Foundation

d) Problem Identification and Referral:

1) Team Awareness
2) Applied Suicide Intervention Skills Training (ASIST)
3) Brief Tobacco Intervention (BTI)
4) Screening Brief Intervention, Referral and Treatment (SBIRT)
5) Grief Talk

e) Community-Based Processes:

1) PEACE Advisory Council Meetings
2) SEOW Meetings
3) Monthly Non-Communicable Disease (NCD) Consortium
4) Task Force, Alcohol Prevention Workgroup and Tobacco Control Action Team
5) GBHWC Mental Health Planning Council
6) Red Ribbon Campaign
7) Cannabis Public Awareness Subcommittee

f) Environmental:

1) Tobacco Vendor Education
2) Tobacco Synar Inspections
3) NCD T-CAT Compliance Team

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

P&T Branch staff re-evaluates our prevention systems and processes as part of ongoing quality control assessment of the Department. GBHWC will continue to work in collaboration with other partnering agencies – majority of which are already represented on the Governor's PEACE Council – to develop and implement the SAPT BG and PEACE Partnerships for Success. The Prevention and Training Branch, inclusive of all prevention programs and strategies implemented, is currently guided by the PEACE Council - a multi-sectoral, state-level representative of the three branches of government and other leaders from the private sector, cultural, faith-based and non-governmental community-based provider organizations. This Council composition reflects the ethnic and cultural make-up of the community at large. The Council and community were instrumental in the development of Guam's State Prevention Enhancement (SPE) Comprehensive Strategic Plan (2014-2018) which outlines the Prevention and Training Branch's goals and objectives for prevention on Guam. Programs, strategies, and interventions that are implemented and are funded by SAPT BG must adhere to this strategic prevention plan.
Staff of the Prevention and Training Branch will devote 100% of their time to working with program activities under the SAPT Block Grant and Partnerships for Success Grant. Altogether, staff members possess a combined total of over 65 years of prevention work experience and are invaluable to Guam's ATOD and suicide prevention and early intervention teamwork. In-kind services will include coordinating T/TA services throughout the life of each grant. These staff members are responsible for the implementation of prevention services on Guam focusing on the goals and objectives respective of each grant while ensuring that all work accomplished abides by the prevention strategic plan. Also, the Branch has an assigned Administrative Officer that manages the Branch's financial and procurement tasks to determine if costs and services are allowable and eligible; and to verify funding compliance. Program planning and monitoring clearly identify what specific programs and strategies are funded by the SAPT BG

versus other funding streams. SABG funded programs are separate from the Partnerships for Success program; however, where appropriate, all prevention staff and PFS partners are
included in training and technical assistance events funded through Partnerships for Success as a key opportunity for prevention workforce development and capacity building.

Does the state have any activities related to this section that you would like to highlight?

The identified programs, policies and/or practices deliverables under the above six strategies are to be supported by SAPT block grant funds in FY 2018 and FY 2019, as well as other potential resources which may be leveraged to address data-driven priorities that enhance and expand into prevention mental illness and promoting positive mental health as it relates to substance use and abuse.

Please indicate areas of technical assistance needed related to this section. None at this time, but will defer.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

Guam State Prevention and Enhancement (SPE) Comprehensive Strategic Plan 2014-2018 and Guam State plan for Suicide intervention and Early Intervention 2015-2020 are attached.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [ ] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [ ] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [ ] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **g)** [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** [x] Numbers served
- **b)** [ ] Implementation fidelity
- **c)** [x] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] Demographic information
- **g)** [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [x] Heavy use
- [x] Binge use

☑ Perception of harm

c) ☑ Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☑ Other (please describe):

State added questions into the BRFSS systematically collects data on adult alcohol, tobacco, and illicit drug use as well as mental health status on Guam. 29 added indicators on Alcohol indicators, Tobacco indicators, Illicit Drug indicators, Prescription Drug Use indicators, Perception of Workplace Policy indicator, Family Communication Around Drug Use indicator, Betel Nut indicators, Sexual Orientation and Gender Identity indicators, and Mental Health and Stigma indicators. State added questions for youth marijuana perception of harm and peer disapproval will be recommended by the SEOW to be included in YRBS.

Footnotes:

Prevention Education And Community Empowerment

PEACE

Guam State Prevention Enhancement (SPE)
Comprehensive Strategic Plan

2014-2018

The Conch shell symbolizes our awakening from the deep slumber of unawareness and urges us to accomplish our and others' welfare.

ACKNOWLEDGEMENTS

OF THE GATHERING OF PACIFIC ISLANDERS FOR PEACE (GOPEACE) PARTICIPANTS, CONTRIBUTORS AND OTHER COMMUNITY STAKEHOLDERS IN THE DEVELOPMENT OF GUAM'S 5-YEAR STRATEGIC PREVENTION AND EARLY INTERVENTION PLAN FOR PEACE

Over a span of more than twelve months, monthly stakeholder meetings were held which culminated with the August 2013 Gathering of Pacific Islanders for PEACE (referred to as GOPEACE); a 2-day event with over 200 youth and adult participants.

On behalf of the Governor's PEACE Council and the Guam State Epidemiological Outcomes Workgroup, the Prevention and Training Branch of the Guam Behavioral Health and Wellness Center (formerly known as the Department of Mental Health and Substance Abuse) thanks the individuals, public and private organizations and coalitions on Guam who gave their personal and professional time, courageously shared their personal stories and experiences, and helped to develop Guam's 5-Year Plan for PEACE (Prevention Education and Community Empowerment). Additional thanks are expressed to Kauffman and Associates, Inc. and the Native Aspirations Project. Each made special contributions with providing valuable insight for the focus areas in the PEACE mini-action plans and strengthened Guam's vision for PEACE in 2018 with defined 5-year Plan strategies and actions that embrace the rich cultures, values and strengths of Pacific Islanders who call Guam, home.

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EXECUTIVE SUMMARY

In 2003, Guam initiated a planning process for the development of the island's first comprehensive strategic plan for substance abuse prevention and early intervention that sets the path for creating a healthier Guam. The PEACE Strategic Prevention Framework-State Incentive Grant (SPF/SIG), Guam Comprehensive Strategic Plan (2006-2009) was written, implemented and evaluated. The initial PEACE goals set were to: prevent the onset and reduce the progression of substance abuse (alcohol and tobacco), including childhood and underage drinking; reduce substance abuse-related problems in the communities; and build prevention capacity and infrastructure at the "state and community" level.

Guam's State Prevention Enhancement (SPE) Plan development for PEACE (2014-2018) follows with additional U.S. national goals and other data-driven priorities determined locally, that are relevant to the island of Guam:

1. Prevent or reduce consequences of underage drinking and adult problem drinking;
2. Prevent suicides and attempted suicides among populations at risk, including military families and LGBTQ youth;
3. Reduce prescription drug misuse and abuse;
4. Prevent substance abuse and mental illness (promote positive mental health);
5. Develop and enhance policy and funding to support needed services for behavioral health system improvements on Guam; and
6. Enhance behavioral health workforce development initiatives.

From the onset of strategic prevention planning, Guam's stated vision for PEACE is ***an island community empowered and committed to making informed decisions and choices towards a healthier (mental, physical, spiritual) future for themselves and others on Guam.*** Its stated mission is *to establish and implement culturally appropriate and sustainable prevention and early intervention policies, programs and practices that are responsive to the needs of the people of Guam and that are proven to effect positive behavioral health changes*.

The Prevention and Training Branch staff of the Guam Behavioral health and Wellness Center has stayed true to its stated mission. PEACE is a community-based plan development process that engages and empowers public and private sector stakeholders, consumers and peer specialists of behavioral health services, youth and adult community volunteers, the Governor-appointed PEACE Council members and Guam's State Epidemiological Outcomes Workgroup (SEOW) members to **be part of the change**. These PEACE partners make informed, data-driven decisions following an effective five-step strategic prevention framework process (Assessment, Capacity Building, Planning, Implementation, and Evaluation) for setting priorities that are respectful of cultural values and practices, and result in sustainable policies, programs and practices that are relevant to the people of Guam.

I. OVERVIEW OF PLANNING

Introduction to PEACE

Established by Guam Public Law 17-21, the Department of Mental Health and Substance Abuse (renamed Guam Behavioral Health and Wellness Center by Guam Public Law 32-024) is Guam's single state agency and is responsible for mental health promotion and service provision,

and substance abuse prevention and control. The Center's Prevention and Training Branch, under the Division of Clinical Services, directly oversees the prevention arm and works in collaboration with other partner agencies and community-based organizations to assess, develop and implement prevention policies, programs and practices. Prevention initiatives on Guam receive strong support and guidance from the Governor's PEACE Council.

Governor's Executive Order No. 2011-03 (Appendix A) retained the Governor's PEACE (Prevention Education And Community Empowerment) Council with appointed member representatives from the executive, legislative and judicial branches of government, the private sector and community-based *prevention advocates charged with the development of policies, programs and practices to address Guam's substance abuse and suicide problems, and to include planning, implementing and evaluating comprehensive evidence-based prevention strategies that result in positive environment changes.*

The Planning Process

Throughout the state prevention enhancement development process for Guam's 2014-2018 PEACE Five-Year Strategic Plan, the Governor's Council served as the primary "state prevention enhancement" Consortium. Council members provided guidance and advisement to ensure that substance abuse prevention, mental health promotion and suicide prevention work is data-driven, culturally relevant, effective and sustainable. Guam's PEACE Council/SPE Consortium along with members of the State Epidemiological Outcomes Workgroup (SEOW) and the established Non-Communicable Disease Consortium led by the Department of Public Health & Social Services were first contributors in this Plan development process. They recommended complementary and measurable goals, objectives and activities that they believed to reflect relevant and responsive approaches for and with the community, that truly empower the island's people; thereby building upon the strengths and resources of the people of Guam.

The 2013 Gathering of Pacific Islands for PEACE (GOPEACE) event brought together increased and new representation of the different Pacific Island cultures and groups present on Guam. Over 200 youth and adults joined GOPEACE and united to *be part of the change* as one community for a healthier ***One Nation.*** Participants ranged between 15 and 75 years of age from various ethnic groups (Chamorro, Chuukese, Filipino, Marshallese, Palauan, Pohnpeian and Yapese) in the Western Pacific Region who live on one of Guam's nineteen village districts. There were an almost equal number of males and females in attendance. The participants represented various organizations, including government agencies, non-profit organizations, faith-based organizations, law enforcement and the judiciary, military, higher education institutions, advocacy groups, and the community at large. Participants were not only service providers but also consumers and other recipients of services, peer mentors, as well as policy makers, youth leaders, clergy, and concerned family members.

This two-day gathering encouraged everyone to be part of a journey towards community healing and empowerment. Participants rolled up their sleeves and worked as community partners to address the major concerns the people of Guam face. Personal stories and legends were told about the lives of the Pacific Island peoples and about the things that are valued and held close to their hearts. Individual and community trauma, pain, struggles, survival and most especially hope and healing were personal experiences first acknowledged; a vital step necessary towards improving the quality of life for individuals, families and the island community as a whole.

As one faith-based leader from the Palauan community expressed, *"Suicide and substance abuse affects many lives and it may be about us that we speak about, or our loved ones. As traumatic and life changing as these issues may be, we as Pacific Islanders have proven to be amazingly resilient. Our islands are prone to be in the path of many natural disasters that we have endured for many years, yet we are able to survive those storms. We can survive storms within because we are crafted to be survivors. It is essential for us to* ***listen*** *and* ***observe*** *what is going on with our families and in our communities. We must make a conscious effort to* ***think*** *about how our personal lives are impacted and what we* ***feel*** *when our cultural values are put to the test.*"

With training and technical assistance provided by the Native Aspirations Project, led by Kauffman and Associates, GBHWC's prevention and training branch staff were trained as facilitators of the Gathering of Native Americans (GONA) curriculum. With the design of this two-day Gathering of Pacific Islanders (GOPI) using the GONA principles, Guam's GOPI was the beginning of collective affirmation, that ***we are worthy*** as individuals, as a people, and as a community. It is only then when we have the courage to tell our stories that we begin to feel a **sense of belonging**; feel like we have something of **value to offer**; feel like it is **safe to shar**e what is in our hearts and in our thoughts, without judgment. We are able to **depend on one another**, and thus we could **generously give** of ourselves.

Through the GOPI experience, participants felt a strong sense of community; they felt more confident that they will go back into their homes, their villages, and their whole island community with a fresher perspective, a heart of courage, and the ability to make a difference.

Assessing Our Environment

Guam's Epidemiological Profile on Substance Use and Suicide – The Foundation for Data-Driven Priorities

Guam is the largest and southernmost island in the Mariana Islands archipelago. Located in the western North Pacific Ocean, it houses one of the most strategically important installations in the Pacific for the U.S. military. Guam also serves as a critical crossroad and distribution center within Micronesia and the rest of the Pacific, as well as Asia, because of its air links. This plays a significant part in the movement of tobacco, alcohol and illicit drugs.

The 2010 Guam census indicates that as of April 1, 2010, Guam's population totaled 159,358, representing an increase of 2.9% from the 2000 Census counts. Guam's population is multi-ethnic/multi-racial. According to the 2010 Guam Statistical Yearbook, the indigenous Chamorro people comprise approximately 37 percent of the population, followed by Filipinos (26.3%), other Pacific Islanders (12.0%), Whites (7.1%), other Asians (5.9%) and African Americans (1%). The groups with the fastest rate of increase are the Yapese and Chuukese populations -- the Yapese population grew by 84.1%, from 686 in 2000 to 1,263 in 2010, while the Chuukese population grew by 80.3%, from 6,229 in 2000 to 11,230 in 2010. The ethnic composition of the population in large part determines the languages spoken at home. At present, 43.6% of Guam's households speak English inclusively. Of the remainder, 41.3% speak another language either as frequently as or more frequently than English. Another 0.5% speak

no English at all. This has a significant implication for effective service delivery, highlighting the need for culturally and linguistically competent communications and services for close to half of the island's population.

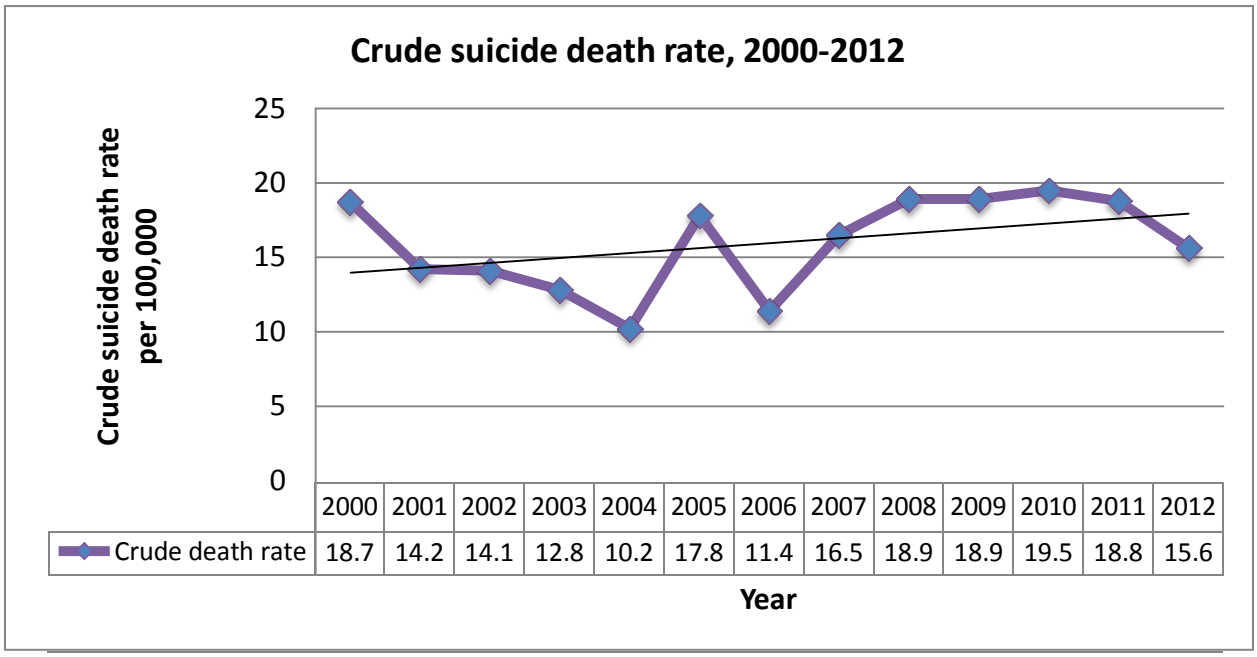
In 2004, Guam's State Epidemiological Outcomes Workgroup (SEOW) was established. SEOW was charged with overseeing the strategic use of data to inform and guide substance abuse prevention policy and program development on Guam. SEOW initiated a data inventory and collated and reviewed data on substance abuse consumption patterns and consequences. The first Guam State Epidemiological Profile (Epi Profile) on substance abuse and consequence was published in 2007, with subsequent annual updates in 2008 thru 2012.

Currently, Guam's SEOW is considered the definitive authority on substance abuse epidemiology on the island. Its data products are readily acknowledged as comprehensive community resources, and its work has consistently influenced substance abuse policy and decision-making for program development, prevention resource allocation, and services delivery.

Guam's PEACE Plan recognizes the importance of data surveillance and monitoring and data-driven decision-making for setting targeted priorities, allocating resources and building and sustaining local capacity for prevention. It also acknowledges that while local data represents the realities of conditions of substance abuse and poor mental health on the island, it does not draw attention to the cultural practices and strengths of individuals, families and the broader community of Guam which will be an important and necessary aspect of effective, strategic planning for Pacific Islanders.

Prevention Infographics (Appendices B-G) highlighting the following excerpts from Guam's 2012 Epidemiological Profile have been developed and widely distributed in the community. Each number in the profile represents a person whose life has been negatively impacted. This person comes from a family who has also been affected and is a neighbor to other community members in a village on Guam.

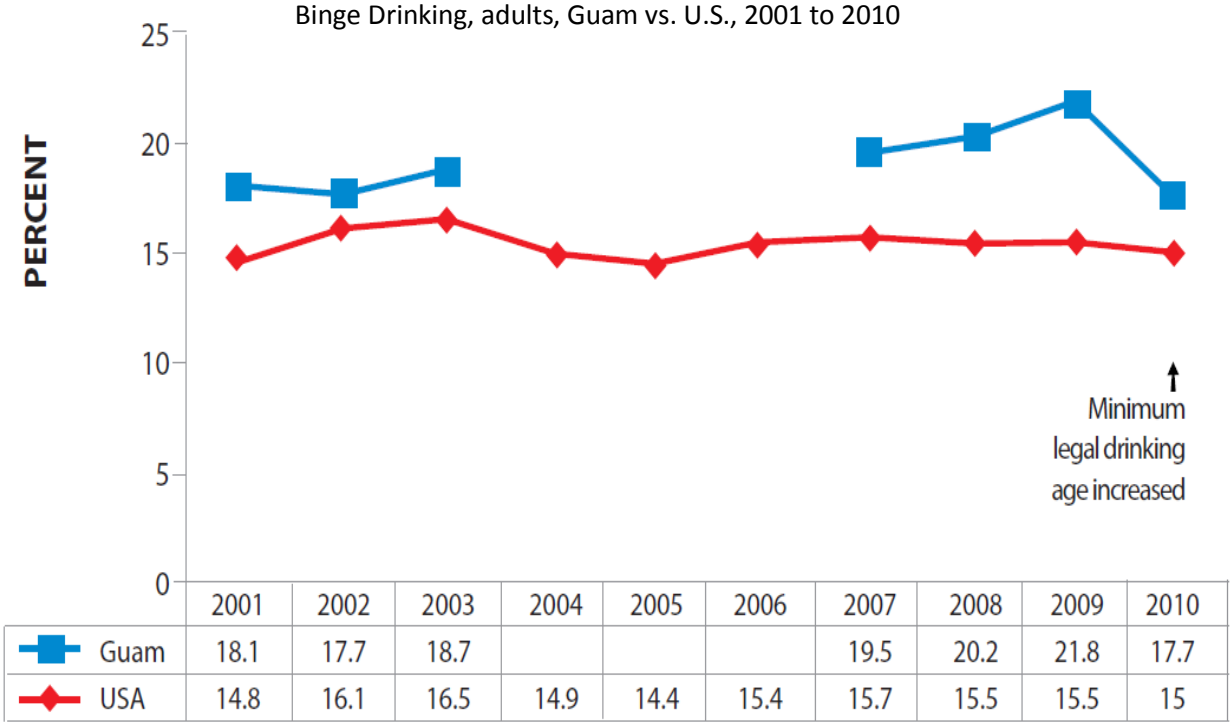
Suicide remains prevalent on Guam, with an average of 1 suicide death occurring every 2 weeks. Guam has a suicide death rate of 15.6 per 100,000 inhabitants. This is the first significant decrease in 6 years.



Suicide deaths are highest among youth and young adults, with 57.5% of all suicide deaths occurring in those under the age of 30 years. Micronesian Islanders, particularly Chuukese and Chamorros are significantly over-represented in suicide deaths.

Alcohol is implicated in almost one-fourth (24%) of suicide deaths in 2012. Almost 1 in 5 adults and 1 in 7 youth are binge drinkers in Guam. Binge drinking among Guam men is about 3 times higher than women in Guam.

Binge Drinking, adults, Guam vs. U.S., 2001 to 2010

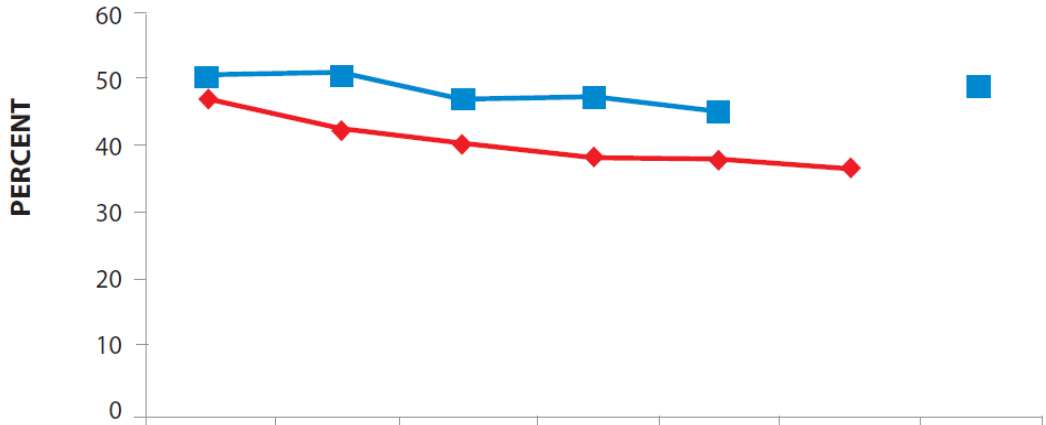


	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Guam	18.1	17.7	18.7				19.5	20.2	21.8	17.7
USA	14.8	16.1	16.5	14.9	14.4	15.4	15.7	15.5	15.5	15

Binge drinking is highest among younger adults (<45 years). Among youth, girls are drinking as much as boys and Chamorro youth have the highest rates of alcohol consumption.

1 in 5 adults have tried using marijuana and 17% are current users. Among youth, nearly 1 in 3 are current users of marijuana. Lifetime and current marijuana use are higher among Guam's youth than among U.S. youth in general.

Lifetime marijuana use, high school, Guam vs. US, 1999-2011

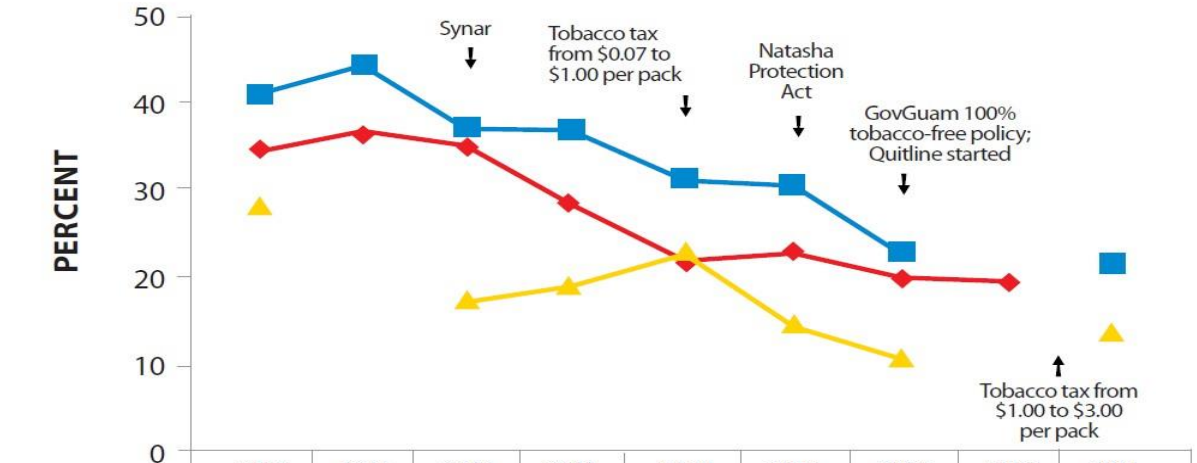


	1999	2001	2003	2005	2007	2009	2011
Guam HS	50.9	50.6	46.9	47.3	45.5		48.8
USA HS	47.2	42.4	40.2	38.4	38.1	36.8	

Among adults, males are more likely to use marijuana. Among high school students, marijuana users are more likely to be male and Chamorro.

About 1 in 3 adults in Guam is a smoker. Among youth, 1 in 5 smokes. Guam's smoking rate is higher than most US States and Territories; this has remained unchanged since 2001.

Current smoking, high school and middle school, Guam vs. US, 1995-2011

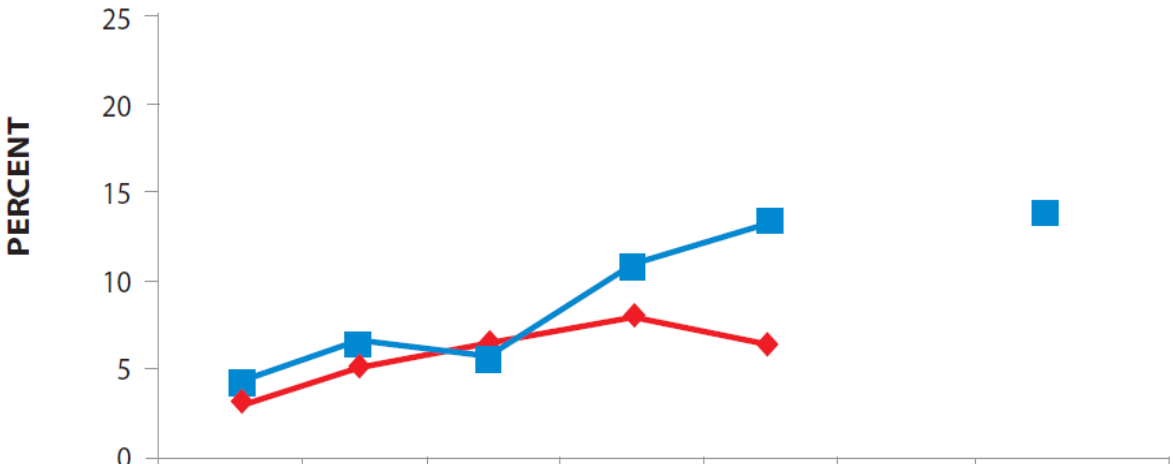


	1995	1997	1999	2001	2003	2005	2007	2009	2011
Guam HS	41.1	44.7	37.3	37.1	31.67	30.8	23.1		21.9
USA HS	34.8	36.4	34.8	28.5	21.9	23	20	19.5	
Guam MS	28.4		17.6	19.3	23.3	14.8	11		13.9

Among adults, men smoke more than women. Among youth, girls smoke as much as the boys. Women in Guam smoke more than men in the U.S. Smoking is reported more frequently among the poor and the less educated. Chamorros have the highest smoking rate, followed by other Micronesians.

Smokeless tobacco use is rising for both adults and youth. The practice of chewing tobacco with betel nut is gradually increasing in Guam.

Smokeless tobacco use, high school vs. middle school, Guam, 1999-2011



	1999	2001	2003	2005	2007	2009	2011
HS	4	6.3	5.6	10.6	13.4		14
MS	3.2	5	6.3	7.9	6.3		

Current smokeless tobacco use among adults increased from 4.2% in 2009 to 6.9% in 2010. Among high school students, smokeless tobacco use increased from 6.3% in 2001 to 14% in 2011.

Assets and Resources

The greatest prevention resource that exists on Guam is the people of the island with the diverse cultures, values and practices that are the strengths from which positive changes can be experienced and sustained. It was evident during the 2013 GOPEACE event that Chamorros, Chuukese and other Pacific Islanders, youth and adults, community volunteers and leaders from the three branches of government can respectfully and with a purpose come together to be part of the change in prevention planning for 2018. This GOPEACE community and partners represented the NCD (Non-Communicable Disease) Consortium, Governor's PEACE Council, Guam's SEOW, Youth for Youth LIVE! Guam, Just Say No Dance Crew, GALA (Guam's Alternative Lifestyle Association), Department of Education, Guam Legislature, Guam Memorial Hospital, Guam State Rehabilitation Council, Guam Youth Congress, Oasis Empowerment Center, Salvation Army, St. Paul Christian Center, Guam Community College, University of Guam, Island Girl Power, Ayuda Foundation, Southern Christian Academy, Department of Youth Affairs, Department of Public Health and Social Services, Victims

Advocate Reaching Out (VARO), Sanctuary, Inc., Guam Police Department, Guam Customs and Quarantine, Self Advocates in Action (SINA), Department of Veteran Affairs, Christian Life Center, Protection and Advocacy for Individuals with Mental Illness (PAIMI), Judiciary of Guam, Health Services of the Pacific, Taotao Lagu, FSM Church Leaders Association of Guam, Bento Chef, Mayors' Council of Guam, Guam National Guard – Counterdrug Program, Pohnpeian Youth, LifeWorks Guam, DISID (Department for Integrated Services for Individuals with Disabilities), Guma' Mami, Inc., American Cancer Society, Archdiocese of Agana, Board of Education, Campus Crusade for Christ, Center for Family Development, Catholic Social Services/Community Habilitation Program, Department of Parks and Recreation, Goodness Zero Down, Greenlight Media Productions, Guam Center for Independent Living, and Guam Behavioral Health and Wellness Center - Prevention and Training Branch and Drug and Alcohol Treatment Branch – staff and consumers.

II. SHARED VISION FOR PEACE ON GUAM IN 2018

> …help island community stakeholders "to discover, own, and explore their personal roles and responsibilities" in the development of the five-year strategic plan to address suicide prevention, substance abuse, and other behavioral health issues within the Guam community.

Consistent with Guam's stated vision for PEACE, Guam's strategic plan community stakeholders' involvement produced more focus on this vision; bringing GOPEACE's shared vision into focus, the following enhanced vision was identified for what Guam will *look like*, *be like* and *feel like* in 2018:

"*We see an island community empowered and committed to making informed decisions towards a healthier (mental, physical, spiritual) future for ourselves and others on Guam; accepting of our diverse cultures, embracing our spirituality and ancient wisdom, empowered by Kina 'Ole and the active support of our leaders and government systems to provide a safe and sustainable environment for all of Guam."* Kina 'Ole is a belief of the Hawaiian people that means doing the right thing, for the right reason, with the right attitude, to the right person, with the right intention the very first time. This was shared during GOPEACE which the participants related with.

This enhanced shared vision statement blends the major themes that emerged from the stakeholders engagement process that involved the participation of many sectors of the Guam community. The participants, when asked what they want Guam to look like, be like and feel like by 2018, sharpened their shared vision to the following major categories:

- **Health and Wellness:** *There will be quality choices for health and wellness care that are affordable and accessible.*
- **Safety:** *There will be personal and public safety and involvement, island wide.*
- **Culture and Spirituality:** *There will be a higher level of awareness, sensitivity and acceptance of the various cultures on Guam and the spirituality that is our foundation.*
- **Infrastructure and Leadership:** *Our leadership will be engaged providing needed laws or policies to support our vision. We will have strong partnerships and collaboration and a vibrant and prosperous economy.*

- **Education and Empowerment:** *Education will empower our people. Our people will enjoy healthy lifestyles and healthy relationships because of their education and understanding of their place and importance to this community.*
- **Environmental Stewardship**: *Guam will be a sustainable environment and our community will embrace our role as stewards to protect and cherish this beautiful island*.

III. UNDERSTANDING GUAM'S CHALLENGES AND OBSTACLES

The beauty of GOPEACE's vision for Guam in 2018 begs the question, *'what prevents us from achieving this wonderful vision?* Every strategic plan must be tempered in reality by taking an open, honest and candid assessment of the challenges that exist and the obstacles or contradictions being experienced. Guam's PEACE planning team sees this as one of the most crucial steps that must be addressed as part of the necessary action steps for developing a solid, achievable plan. In doing so, the PEACE planning team asked the GOPEACE community of stakeholders to help answer this question: "*What are the obstacles or challenges that stand in our way and prevent us from achieving our shared vision for Guam?"* Their responses reveal the depth of understanding that the solutions to our challenges must come from the wisdom and resources of our own community.

A brief summary of those major or root causes behind known and perceived challenges are provided below:

Monthly outreach activities throughout all nineteen village districts are needed to initiate and/or strengthen contact with families and community leaders to raise awareness about existing behavioral health care and primary health care programs and services available if they need them. Meetings, trainings and other gatherings held brought directly into each village will make accessibility and participation in these planned events more realistic. Stakeholders expressed missed opportunities to attend events that are hosted outside of their village residence, for lack of transportation, hesitancy to meet with individuals who are unfamiliar to them and who may not be from the same residential area, or are from a different ethnic group and who may not speak their language.

Community trainings offered on substance abuse and suicide prevention and postvention, anger management, stress management, and mental health promotion, for example, must include members from each distinct major ethnic group on Guam who are minimally represented. Additionally, Chamorro, Chuukese, Pohnpeian, Palauan, and other Pacific and Asian Language-speaking leaders in the villages who serve these and other Micronesian people must be trained as trainers. These leaders and other persons of influence who not only speak English, but also their native tongue will more likely be received by people from within their cultural groups because of their personal and cultural relationships. Community training includes participants who speak Chuukese or other Pacific languages and are asked to assist with translating or interpreting in their language what is taught in English. Rather than relying on the assistance of co-participants to do this, training trainers from these various ethnic groups and organizations who serve them would minimize language barriers and increase involvement and skills in behavioral health trainings.

Increase educational print and electronic media campaign products using respected and influential community members from the different Pacific Island groups who set an example as individuals and families who make deliberate and purposeful choices to improve their lives. Most educational products are in English only and placement of these products that are developed to inform and invite interest and participation are in lower trafficked areas by various ethnic groups for which services and programs are intended.

Island leaders and decision-makers are entrusted with being committed partners to lead the way in embracing and carrying forth the community's vision for PEACE, reinforcing partnerships and commitments, building on the grassroots movement to **be part of the change** and being accountable to the vision the community wants to achieve.

IV. IDENTIFYING GUAM'S STRATEGIC PILLARS FOR SUCCESS

GOPEACE community stakeholders generated proposed strategies and action steps that would help with overcoming identified barriers and challenges. These strategic pillars for achieving success with PEACE efforts are:

- **Empowered Youth**: *Engage and empower our youth: Providing a safe and healthy future for our youth;*
- **Effective Communication:** *Implement a social media and communications plan that is inclusive and culturally responsive;*
- **Strong Leadership**: *Demonstrating strong leadership through integrity, transparency, and follow-through;*
- **Grassroots Engagement:** *Foster community involvement through meaningful outreach, inclusion and engagement with all communities*;
- **A Safe and Healthy Environment:** *Securing a sustainable, healthy environment for Guam*

V. DISCUSSION OF GUAM'S CAPACITY TO ADDRESS STRATEGIC PILLARS FOR PEACE

Partnerships among public, private, non-profit organizations and volunteers continue to be strengthened particularly among existing consortiums. Collaborative work among members of the Governor's PEACE Council/SPE Consortium and the Guam Non-Communicable Disease Consortium resulted in the development of complementary, strategic action steps for: 1) assessing Guam's resources; 2) building local capacity; 3) comprehensive and targeted planning to empower individuals and communities to adopt healthy lifestyles through proper nutrition, increased physical activity, promotion of good mental health, and prevention of risk behaviors such as with the use and abuse of alcohol and tobacco; 4) developing mini action plans and steps for implementing identified goals and objectives to include researching current health related policies and assessing local capacity in the behavioral health and primary care field; and 5) evaluating all roadmap processes undertaken among PEACE and NCD consortium members and implementation outcomes.

During the monthly meetings of the PEACE Council/SPE Consortium and community stakeholders, a community participatory research process was conducted, whereby meeting participants engaged in four-part planning discussions to assess existing resources, identify data gaps, determine targeted priorities and list strategic action steps that would move towards the realization of Guam's PEACE Enhancement goals.

To bridge the prevention infrastructure with the mental health system of care, Guam's SPE for PEACE initiated systematic linkages between Guam's substance abuse and mental health infrastructure, highlighting the connection between tobacco use, alcohol abuse, mental illness and suicide risk. Through monthly community stakeholders meetings held, participants discussed what they knew and understood about current systems and services, as well as available resources and gaps for meeting the demand for behavioral health services throughout the continuum of care; prevention, early intervention, referrals, treatment and follow-up. In each

meeting, stakeholders contributed **initial recommendations** upon review of the following SPE Mini Action Plan narratives:

1) Data Collection, Analysis and Reporting (Appendix H) – There exists data gaps with information collected from the military community, youth in private schools and LGBTQ population. Action steps to address this need include recruitment of key representatives to serve on SEOW and establishment of formal agreements for developing uniformity in instruments and processes that will be used for data collection, analysis and reporting. The outcome of this partnership will result in enriched updates of Gu am's S ubst ance Abuse E pidemiol ogical P r ofile and A Profile of Suicide on Guam that would be mutually beneficial among data contributors and for data-driven decision making and setting targeted priorities.

The PEACE Council representatives for faith-based organizations support the identified need for conducting the YRBS in private catholic schools. Although the challenge regarding military data remains, efforts are underway to link with the Guam National Guard, where young men and women of Chamorro and Micronesian descent have enlisted for military service. A representative from the Guam National Guard has joined and participates in SEOW planning sessions. Additionally, Guam officially organized a team who participated in the 2013 SAMHSA-sponsored Policy Academy for Service Members, Veterans, and their Families (SMVF). The draft SMVF Plan for Guam (Appendix L) is also referenced in the work of PEACE.

The input and recommendations provided during this meeting with stakeholders to enhance Guam's data system are reflected in this Action Plan. Stakeholders are in agreement that at present, the infrastructure linkages between substance abuse and mental health are tenuous, and project/program-specific. Strategic reorientation of the existing prevention infrastructure to connect and align with the island's mental health and substance abuse treatment infrastructures need to be addressed. This will permit better coordination of data collection, analysis and reporting for the entire spectrum of behavioral health care. More effective evaluation strategies will be developed to include this broad-based, holistic perspective.

2) Coordination of Services (Appendix I) **–** There are numerous Guam prevention resources, programs and activities for promoting healthier lifestyles, substance abuse and suicide prevention, early intervention and referrals for treatment. SPE planning stakeholders acknowledged Guam's PEACE priorities, reviewed available services and resources, and identified areas that needed to be strengthened in order to improve services coordination and to address perceived barriers to coordinating, collaborating and leveraging needed prevention resources. The recommended priorities for coordinating services better will be focused on *mental health of the Guam-based military personnel and their families, followed by mental health promotion among Guam's youth and the LGBTQ community.*

To address identified gaps in the coordination of prevention services on Guam, PEACE will strengthen and maintain ongoing communications in order to expand community partnerships in prevention and to ensure responsiveness and effectiveness with serving high need groups. Additional community partners who can successfully engage and connect with the military community and influence Chamorro and other Micronesian youth and young adults, and the LGBTQ community will be invited to join the PEACE Council and SEOW. They will be able to voice specific needs of the entities they represent; participation will strengthen resource and funding coordination and allocation to assist with prevention capacity building within these high need groups.

Coordinated planning and implementation of services is to be enhanced by leveraging personnel services and expertise for workforce development, infrastructure capacity building and development of local resources. Workplace policies and programs that are responsive to employees' identified needs with respect to mental health promotion and substance abuse prevention, early intervention and referrals for treatment will be developed.

Collaboration with local, regional, national and international organizations who share similar goals and objectives for healthier Pacific peoples and communities will continue (i.e. PEACE Council, Non-Communicable Disease Consortium (NCD), Service Members, Veterans and Families (SMVF) Planning Committee, Pacific Behavioral Health Collaborating Council (PBHCC), Pacific Islands Health Officers Association (PIHOA), Pacific Islands Mental Health Network (PIMHNet), Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL), National Asian Americans Against Substance Abuse (NAPAFASA), National Prevention Network (NPN), CADCA and the World Health Organization (WHO), including funding streams and programs that are directed at communities, coalitions and public/private sector organizations relative to substance abuse and its consequences.

3) Technical Assistance and Training (Appendix J) – As the existing prevention infrastructure is strategically reoriented to connect and align with the island's mental health and substance abuse treatment infrastructures, T/TA coordination of mental health promotion, substance abuse prevention and early intervention services, as part of the entire spectrum of behavioral health care will improve. With an eye toward accountability and improvement, T/TA strategies will be developed, refined and put in place to more effectively encompass measurements of effectiveness in this broad-based, holistic perspective. When possible, the PEACE Council leverages funding and personnel support across its member organizations, highlights the potential use of tobacco tax revenues earmarked for Guam's Healthy Futures Fund and pursues grant opportunities to support PEACE efforts.

To address identified gaps in Guam's technical assistance and training system, PEACE will expand community partnerships (i.e. Chamorro and other Micronesian youth and young adults, LGBTQ and the military) in prevention to ensure responsiveness and effectiveness with serving high need groups.

Local prevention policies that call for the use of the Strategic Prevention Framework 5-step process (Assessment, Capacity Building, Planning, Implementation and Evaluation) will result in the desired prevention outcomes for the people of Guam. The island's data-driven priorities and community needs will be clearly understood and justified. Services providers will be empowered with knowledge, skills and resources, and effective prevention and early intervention policies, programs, and practices will be implemented.

Given the limitation of funding and resources, duplication of efforts or working in silos will be minimized. T/TA services will be enhanced through the leveraging of personnel services, workforce development, infrastructure capacity building and development of local resources. Workplace policies and programs that are responsive to employees' identified needs with respect to mental health promotion and substance abuse prevention, early intervention and referrals for treatment will be developed. Training of trainer programs, certification of prevention specialists and employee assistance program managers in an identified evidence-based workplace program will be institutionalized.

4) Performance Evaluation (Appendix K) **-** In an attempt to gauge the effectiveness of the PEACE input planning process, a self-report survey was developed to generate perceptions and insights from stakeholders for a two-month period, from August to September 2012.

Twenty-seven (27) stakeholders completed this evaluation tool. The study results indicated that PEACE stakeholders are committed constituents who have the island's best interest in their minds and hearts. A majority of these respondents who took part in the PEACE community stakeholder sessions would volunteer to refine and strengthen the written action plans, if certain barriers (such as workload and time constraints) did not exist. Their primary goal is to see the development of a 5-Year Comprehensive State Prevention Plan for PEACE that incorporates constituent and community input, and builds on evidence-based programs, practices, and policies that are already in Guam's prevention system. They were certain that Guam's PEACE Plan will serve as a significant and critical guide for these constituents in their respective agencies as they serve Guam's youth, adults, and other special populations.

Through their survey participation, the stakeholders expressed their commitment to prevention work, which included discussion on the significance of prevention planning evaluation. It was therefore necessary for participants to review current data collection systems and survey instruments used by government entities and non-profit sectors on Guam. As shown in Appendix M, the specific areas identified where robust evaluation is taking place are among youth and adult programs, with notable gaps in special populations, like the military, LGBTQ, and service providers. A category of "Other" to encompass traumatized, homeless, PTSD, and "shadow people" was also discussed as part of the gap identification process in relation to program evaluation. Consequently, a comprehensive evaluation process was considered with emphasis on these characteristics: systematic, integrated, and holistic. All the stakeholders were in agreement that the overall intent of evaluation is to determine program efficiency (i.e., process evaluation) and effectiveness (i.e., outcome/impact evaluation) of specific programs on Guam that address substance abuse and mental health promotion. The sharing of best practices in evaluation was agreed upon as a critical movement away from silo-entrenched evaluation practices on the same priority areas engaged in by both government and non-profit sectors of the prevention care network on island. The group envisioned the development of a statewide data center that would serve as the repository of all evaluation activities that would move all stakeholders closer toward greater accountability and improvement of all prevention-related programs on Guam under their purview.

Also out of this discussion, a comprehensive evaluation framework emerged as a critical need. This mini plan describes the following framework evaluation components that are needed (to provide a consistent, systematized, cyclical approach for planning and conducting evaluation processes in Guam's prevention system of care and services):

1. The methods used for conducting the evaluation;
2. The process for collecting, managing, and analyzing data that is reliable and trustworthy;
3. The process for interpreting data and disseminating information; and
4. The process of performance improvement as a result of evaluation findings.

Evaluation of Guam's 2014-2018 PEACE Five-Year Strategic Plan will use both *formative* and *summative* evaluation processes in order to determine the success in achieving the Strategic Plan's stated goals and objectives and that will generate quantitative and qualitative data for analysis.

Significant groundwork has been accomplished to improve Guam's ability to gather and report on federally required performance measures. Much of the credit goes to Guam's current SEOW leadership, as it has developed and fostered relationships with various gatekeepers in

order to facilitate data management procedures, to include data collection, analysis, reporting, and dissemination. For instance, GBHWC has technical agreements with the Department of Youth Affairs and Sanctuary, Inc. that provide for the adoption of standardized questions from the Youth Risk Behavior Survey into the screening battery in these organizations. As a prime example of data partnerships, this arrangement allows for meaningful comparisons in consumption and risk factor data between in-school and court-involved youth. To address identified data gaps, existing surveillance systems on Guam have been used to collect National Outcome Measures (NOMs) not previously collected. For example, a Memorandum of Understanding has been entered into by GBHWC and the Department of Public Health and Social Services to utilize Guam's Behavioral Risk Factor Surveillance System (BRFSS) to collect adult required NOMs.

Indeed, efficient and meaningful prevention practice derives its strength from the use of credible data. Guam's SEOW has spearheaded the enhancement of Guam's data infrastructure since 2007 through its institutionalization of a data-driven process that has streamlined the collection, analysis and sharing of critical data to key stakeholders. SEOW, as described in its Charter, aims to unify and integrate the data infrastructure systems on Guam, building on what currently exists. The updated data sets contained in the published versions of the Guam's Substance Abuse Epidemiological Profile (September 2012) and A Profile of Suicide on Guam (August 2012) serve as the baseline data for all the priority areas identified in the PEACE Enhancement grant.

The formative or process evaluation component of the PEACE Plan will measure program integrity or fidelity, adjust program practice, as deemed necessary, and evaluate the implementation plan. The plan also uses process evaluation to assist in the interpretation of the outcome data by identifying the strengths and weaknesses of the program, providing information on intensity and dosage of services, identifying programmatic factors associated with program recipient outcomes, and identifying individual participant factors resulting in differential outcomes. Process evaluation includes the following descriptive elements:

1. Achievement of implementation goals and objectives;
2. Description of target population (demographics and other relevant characteristics);
3. Integrity, fidelity and adherence in the implementation and utilization of the selected evidence-based practices; and
4. Participant perceptions of overall program quality, program staff, and service delivery.

This evaluation framework systematizes data collection strategies and tools to gather relevant data that will ensure that evaluation processes will weave through all prevention activities, as outlined in the Data Collection, Analysis and Reporting Action Plan. The process evaluation component documents and monitors the prevention process by assessing the work of the GBHWC Prevention and Training Branch staff, the Governor's PEACE Council and SEOW in achieving Guam's prevention goals and objectives. It also measures the extent to which the State Prevention Enhancement funding and related activities stimulate positive infrastructure and system changes and improve the effectiveness of prevention services delivery in the community.

Performance improvement is a critical component to ensure that Guam's PEACE Plan is being implemented as intended, providing quality services, and attaining expected outcomes. This entire mini action plan utilizes a structured **Plan-Do-Study-Act** or PDSA strategy (Deming, 1993) and the following processes:

1. Identify and describe the deviation or unexpected outcome;

2. Generate a fishbone diagram to define all possible causes;
3. Collect data to correctly identify the cause related to the problem and pinpoint the area for intervention; and
4. Implement a corrective action to address the gap; and
5. Collect monitoring data to determine the effectiveness of the corrective action.

In addition, the process evaluation documents the procedures used to carry out the services, the problems encountered as well as the respective solutions. It also analyzes the degree to which the original design was followed.

Measuring the impact of a program's effectiveness requires the analysis of quantitative or qualitative data, or a combination of both, where appropriate. Depending on the research design, a variety of methods and tools that may be used to assess outcome effectiveness include surveys, document review, pretest-posttest measures, key informant interviewing and focus groups, among others. Through the use of appropriate instruments, and training necessary to utilize them, outcome-based evaluation under each of the mini plans addresses the success of the PEACE Plan in attaining its desired outcomes.

The effectiveness of a coordinated system of prevention activities and services in increasing knowledge and awareness among youth and adults in the consequences of alcohol, tobacco and other drug use and abuse, suicide prevention, workforce training, as well as the development of legislative policies affecting these issues and most importantly, the evidence, through quantitative and qualitative data indicators that support these improvements, remain to be the overarching goal of the PEACE Plan.

Yearly evaluation reports will be developed and disseminated to all State and community stakeholders. Furthermore, an annual Gathering of Pacific Islanders for PEACE (GOPEACE) Conference will be held in order to highlight and showcase significant progress made in terms of formative and summative evaluation of prevention-related programs island-wide. The analysis of measures and indicators described above will also be included in the annual Guam Substance Abuse Epidemiological Profile to make modifications, or support changes occurring in alcohol consumption and consequences, as well as the active promotion of mental health on Guam.

VI. THE LATTE FOUNDATION FOR SUCCESSFUL COMMUNITY PREVENTION EFFORTS

The new look of Guam's Logic Model for PEACE reflects the Latte Stone, a symbol of the indigenous Chamorro culture that reflects a rich cultural heritage in the Pacific whose strength and pride centers on the foundation of accepted responsibility for taking caring of one another. The Chamorro culture, like most other Pacific Island cultures builds upon the concept of "*we-esteem"* and not *"self-esteem"*, whereby individuals, families and the broader community works and lives interdependently and not independently. All belong to this One Nation of Pacific peoples who give generously in support of one another as part of daily living and by providing resources and help especially during times of need and crisis.

THE LATTE FOUNDATION FOR SUCCESSFUL COMMUNITY PREVENTION EFFORTS

Safety
Health and Wellness
Education and Empowerment
Infrastructure and Leadership
Environmental Stewardship
Culture and Spirituality

GRASSROOTS ENGAGEMENT
1) Produce/Disseminate resources to key grassroots members/leaders;
2) Increase representation of ethnic, civic, and cultural groups in PEACE; and
3) Strengthen formal partnerships throughout PEACE to collaborate, implement and sustain prevention programs that utilize Pacific Island cultural values and strengths as protective factors.

EMPOWER YOUTH
1) Strengthen/enforce policies regarding official youth representation;
2) Increase youth on Guam certified as trainers in behavioral health-related prevention trainings;
3) Develop prevention media campaign materials with youth for youth;
4) Increase diversity of youth participation in youth leadership programs; and
5) Increase opportunities for student internships in prevention programs/ pre-employment education.

SAFE & HEALTHY ENVIRONMENT
1) Research and establish PEACE partnerships with public and private entities charged with environmental issues.

EFFECTIVE COMMUNICATION
1) Establish a working group for media plan development with various cultural background representation;
2) Maintain and enhance social media resources;
3) Adhere to CLAS standards; and
4) Develop an annual master calendar for improved coordination of services and advanced participant planning.

STRONG LEADERSHIP
1) Provide opportunities for trainings in effective leadership and mentoring;
2) Strengthen/Establish traditional leaders in community initiatives;
3) Develop village leaders' skills on the use of Guam's data to inform/educate community;
4) Provide opportunities to network with leaders in community development;
5) Establish policies that support funding for evidence based prevention and early intervention programs;
6) Evaluate policies to strengthen support of Guam's best practices and evidence based strategies for substance abuse prevention and suicide; and
7) Establish policies that support T/TA among behavioral health, prevention and primary care professionals, para-professionals, program mentors, and coaches.

Empower Youth + Effective Communication + Strong Leadership + Grassroots Engagement + Safe and Healthy Environment

PILLARS FOR SUCCESS

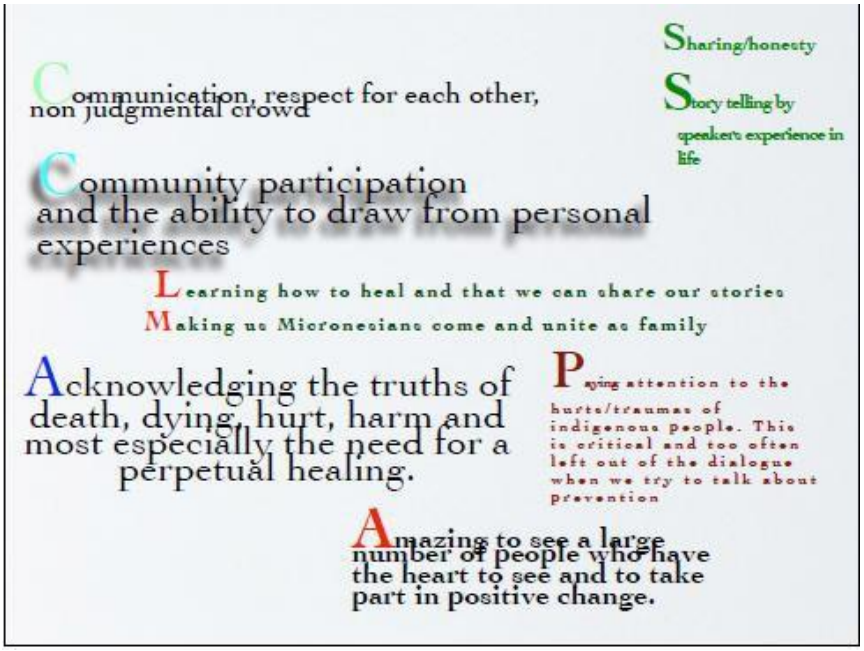
Staff + Funding + Time + Resources + Data/Research Findings + Equipment + Technology + Expertise + Knowledge + Cultural Relevancy + Respect + Care + Passion

WHAT WE PUT IN

Assumptions

1. Improved knowledge and skills leads to change in values which lead to positive behavior change;
2. Community members are valuable resources and have the ability to make positive change; and
3. Who we are; what we've learned and experienced; and the strengths we use and teach in our cultures, work.

VII. PILLARS FOR PEACE PLAN IMPLEMENTATION



During Guam's August 2013 Gathering of Pacific Islanders for PEACE, two hundred youth and adults actively participated in facilitated discussions about what the **meaning** of PEACE (Prevention Education and Community Empowerment) is to them, what their **vision** for Guam in 2018 was, and what they felt were important and necessary **strategies and actions** that must be included in Guam's 5-Year Comprehensive PEACE Plan in order to achieve their shared Vision for Guam in 2018. Key planning areas upon which GOPEACE stakeholders focused on for enhancing Guam's prevention and early intervention services include attention to: Culture, Safety, Health, Infrastructure, Education and the Environment. The majority felt strongly that PEACE efforts needed to help build a foundation of awareness and acceptance of the diverse groups of Pacific Islanders who live among the indigenous Chamorro people of Guam. Their common principles and cultural values of respect and spirituality as peoples of the Pacific are the strengths upon which important relationships and partnerships will be built for PEACE. GOPEACE participants also felt strongly that a safer, clean and healthier ecosystem was critical to fostering and sustaining positive behavioral health among the people of Guam. A holistic approach for improving Guam's infrastructure, human services system and public safety is needed and thereby requires true collaboration and active participation from spiritual and cultural leaders, elected government officials, primary and behavioral health care providers, agriculture and aquaculture resources, educational institutions, law enforcement, private businesses, youth, parents and families.

Specific 5-Year PEACE Plan strategies and action steps were proposed as follows:

1. **Empowered Youth**: Engage and empower our youth - providing a safe and healthy future for our youth.

The youth identified education excellence as a foundation step towards success in their lives. With formal education, opportunities would be more realistically available to help them achieve personal, family and community goals; to be part of the change that includes perpetuating the cultural values, beliefs, strengths and practices among the Pacific Island cultures.

Strategies	Action Steps	Projected Timelines
Strengthen and enforce local policies regarding official youth representation on official Government of Guam Boards,	Research existing local policies and youth representation. Promote inclusion of youth and diversity	Year One – 1st and 2nd Quarters

Councils and Committees, as well as government-funded organizations that serve youths' interests.	in their representation from ethnic groups, military, and LGBT; including the promotion of active participation of youth from high risk backgrounds, those that have been involved in the Juvenile Justice System and youth in recovery. Generate recommendations and nominations of individuals for official submission	
Increase number of youth on Guam certified as trainers in behavioral health-related prevention trainings.	Identify youth who meet the age criteria to become certified trainers in prevention courses such as Substance Abuse Prevention Skills Training (SAPST), Applied Suicide Intervention Skills Training (ASIST), safeTALK (Tell, Ask, Listen, Know), Gathering of Native Americans (GONA), Connect – Suicide Post-Vention Training, Mental Health First Aid (MHFA). Develop formal Agreements between GBHWC and youth or youth organization indicating commitment to receive training certification and to conduct training for their peers as needed.	Year One – 3rd and 4th Quarters
Develop prevention media campaign materials (print and electronic) with youth, for youth.	Identify youth mentors and role models in prevention who are potentially influential with their peers and who represent cultural and ethnic diversity. Conduct focus groups and other activities involving youth who will help develop media concepts, designs, product development and distribution plan.	Year One - 3rd and 4th Quarters
Increase diversity of youth representation and participation in youth leadership programs and events.	Develop and strengthen partnerships by including organizations who serve youth such as Youth for Youth Live Guam, Just Say No Dance Crew, Sanctuary, Inc., Guam Alternative Lifestyle Association (GALA), public and private schools, faith-based organizations. Recruit youth who are underserved and who may be at greater risk for self-harm and substance use/abuse (including youth in recovery and those involved in the Juvenile Justice System) to participate in	Year One –2nd Quarter and ongoing

	island wide prevention programs and services that offer knowledge, training, resources and support.	
Increase opportunities for student internships in prevention programs as well as pre-employment education and training in the behavioral health field and other career fields of interest.	Promote "stay-in-school" messages to encourage students to complete high school graduation requirements. Encourage applicants for Prevention Fellowship Programs such as what is offered by SAMHSA/CSAP. Promote student registration for established behavioral health courses at the Guam Community College.	Year One – 3rd and 4th Quarters

2. **Effective Communication:** Implement a social media and communications plan that is inclusive and culturally responsive.

Community stakeholders find media campaign messages more relatable and effective when a personal story is told and by a person who is familiar and respected from their community, and in their primary language and form of communication.		
Strategies	**Action Steps**	**Projected Timelines**
Establish a working group for media campaign plan development with 12-15 individuals who represent youth and adults from various cultural backgrounds and professions.	Invite members from known cultural groups and organizations to include GOPEACE participants. Orient group members to PEACE work and resources that have been developed such as the Epidemiological Profiles on Substance Abuse and Suicide and Info graphics. Develop framework and prevention focus for media campaign theme, audio and visual products, targeted populations and communities and dissemination. Develop a process for soliciting and receiving community feedback.	Year One- 1st and 2nd Quarters
Maintain and enhance social media and marketing resources for PEACE.	Assess current utilization rates of www.peaceguam.org website. Increase the number of informative website links to other community resources such as the NCD consortium and	Year One- 2nd Quarter and ongoing

	committees that promote overall health and wellness.	
Adhere to CLAS (cultural and linguistically appropriate services) standards in all media campaign materials development.	Assess special needs of individuals who may be involved in PEACE events who are visually, hearing or physically impaired and require special accommodations or training resources (such as ASIST workbooks in Braille). Obtain needed resources and technical support for the conduct of trainings and/or the effective delivery of prevention services.	Year One – 1st and 2nd Quarters
Develop an annual master calendar for training and other prevention-related events for improved coordination of T/TA services and advanced participant planning.	Solicit information from public and private organizations on planned trainings that may be of interest to PEACE. Include relevant trainings on a PEACE Master Training Calendar and make available on www.peaceguam.org or distribute via e-mail and post hardcopies in key community spots.	Year One - 1st and 2nd Quarters

3. **Strong Leadership**: Demonstrating strong leadership through integrity, transparency, and follow-through.

The 2013 GOPEACE was attended by a significant number of *natural born* leaders who represent people from their ethnic and cultural groups, civic/social and faith-based organizations, school and village communities, youth and parent organizations, and persons in recovery who now mentor and inspire others. Leaders among Pacific Islander groups are respected, trusted and counted on to voice concerns of those who may be underserved, underrepresented and/or misrepresented.

Strategies	**Action Steps**	**Projected Timelines**
Provide opportunities for trainings in effective leadership and mentoring in behavioral health.	Identify and recruit natural leaders from within the Chamorro, Chuukese, Filipino, and other Pacific Islander and Asian communities, and consumers in recovery and/or being served by established health and human services such as GBHWC, DISID and Guam Legal Services. Identify and conduct evidenced-based leadership training programs that is culturally based and that will enhance CLAS adherence and competence.	Year One - 2nd and 3rd Quarters

	Facilitate village-based Gathering of Pacific Islanders events utilizing the GONA curriculum.	
Strengthen and/or establish policies and programs that acknowledge, support and utilize traditional and grassroots leaders in community development initiatives that address social issues.	Identify community leaders and champions who can be prepared to lead in community-driven initiatives. Review identified community needs, challenges and obstacles that have been raised during 2013 GOPEACE event. Prioritize community needs and align with existing resources. Assess public policies and programs that exist for the purpose of meeting a specific community need. Develop specific strategies that address identified challenges and obstacles and list recommendations for improving services (i.e. public transportation and access to services). Provide advocacy trainings for raising awareness about social issues and effectively educating policy makers from the grassroots' perspective and experience. Include in government Boards, Councils and Commissions official stakeholder representation from ethnic groups.	Year Two - 1st and 2nd Quarters
Develop confidence and competence among leaders in each village on the use of Guam's data to inform and educate people in the grassroots community.	Identify key village representatives who are interested in learning about Guam's Epidemiological Profiles and the use of substance use and suicide data to inform and guide in decision-making processes. Conduct semi-annual meetings with village representatives to discuss data-driven, community-driven strategies for prevention and early intervention. Develop strategies for distributing PEACE Info graphics to keep the general public aware of local data and the current state of affairs. Include in annual Gathering of Pacific Islanders for PEACE conferences sessions	Year One – 4th Quarter and Year Two – 1st Quarter

	on Guam's Epidemiological Profile Updates.	
Provide opportunities to network and learn from and access local, regional and national organizations and leaders in community development.	Establish and maintain CADCA (Community Anti-Drug Coalitions of America) Membership and attendance in annual conferences. Establish and maintain APPEAL (Asian Pacific Partnerships for Empowerment, Advocacy and Leadership). Solicit membership support and scholarships for leadership training and technical assistance. Maintain working relationship with the Native Aspirations Project for the continued use of the GONA Curriculum and for further training and technical assistance as needed. Attend national conferences and meetings, and participate in relevant webinars. Conduct Annual Gathering of Pacific Islanders (GOPI).	Year One - 2nd Quarter and ongoing
Establish public policy that supports and appropriates funding for the implementation of evidenced-based prevention and early intervention programs for substance abuse and suicide (e.g. GONA, ASIST, safeTALK, Connect, Suicide Prevention Toolkit, Responsible Beverage Servers Training).	Identify laws that direct funding and resources to support prevention Expand and strengthen Guam policies that sustain leveraging of resources and integration of prevention efforts across agencies Draft proposed policies that direct prevention funding to organizations who are oriented to the SPF 5-step process.	Year One – 4th Quarter and ongoing
Evaluate and change public policies to strengthen support of Guam's best practices and evidence-based strategies for prevention and early intervention programs and services for substance abuse and suicide.	Identify laws that that support evidence-based strategies for prevention and early intervention programs, policies and practices. Expand and strengthen laws that sustain positive outcomes as it relates to local research and funding.	Year One – 4th Quarter and ongoing
Establish public and	Assess and utilize local expertise in	Year One - 2nd and 3rd

organizational policies that support on-going training and technical assistance among behavioral health, prevention and primary care professionals, para-professionals, program mentors and coaches.	behavioral health and primary care practices on Guam. Identify and prioritize inter-disciplinary and multi-sectoral trainings and opportunities for peer mentoring. Establish training programs for certification of prevention specialists and Employee Assistance Program managers in an identified evidence-based workplace program that will be institutionalized. Establish written formal agreements between the Government of Guam and entities trained as trainers to conduct and provide T/TA	Quarters

4. **Grassroots Engagement:** Foster community involvement through meaningful outreach, inclusion and engagement with all communities.

There has been significant presence and publicity of PEACE information and resources distributed in the media. GOPEACE community members stand ready to assist with the dissemination of media campaign products, program notices and educational materials to ensure that members of their cultural group, village community and diverse networks are informed. A more strategic and direct approach will be taken to effectively deliver these resources into the hands of the grassroots community leaders and members and to increase attendance at PEACE events.

Strategies	**Action Steps**	**Projected Timelines**
Produce and disseminate electronic and print resources to key grassroots community members and leaders.	Recruit key GOPEACE participants to serve as points of contact to receive and distribute PEACE resources in their villages and cultural networks.	Year One - 1st and 2nd Quarters
Increase representation and diversity of ethnic, civic and cultural groups in PEACE trainings and meetings.	Provide incentives and meaningful educational rewards for community members' attendance. Develop training materials and evaluation processes that would enhance participation, skills development and sustained partnerships. Increase access to public transportation.	Ongoing
Strengthen formal partnerships and written Agreements	Explore partnerships with agencies, organizations and network that share	Year One - 2nd Quarter and ongoing

throughout the PEACE network to collaborate, implement and sustain prevention programs, policies and practices that are true protective factors among Pacific Island cultural values and strengths used in prevention.	PEACE's vision and are capable of engaging Chamorro and other Micronesian youth and young adults, LGBTQ and the military. Establish written Agreements or membership with identified community-based groups and organizations, public and private agencies Execute written agreements for joint projects and activities.	

5. **A Safe and Healthy Environment:** Securing a sustainable, healthy environment for Guam

GOPEACE participants feel strongly that in order to have good mental, physical and spiritual health, the island ecosystem (land, water, air) in which the people of Guam live and must thrive on, must be healthy as well. There is a direct relationship between the environment and an individual's and community's health. The island's natural resources must be protected and safe and to accomplish this, each resident must accept individual responsibility and stewardship for maintaining and sustaining positive environmental actions that impact on behavioral health.

Strategies	**Action Steps**	**Projected Timelines**
Research and establish PEACE partnerships with public and private entities charged with environmental issues (e.g. Guam Environmental Protection Agency, Department of Agriculture, University of Guam, the Department of Public Health and Social Services, Department of Parks & Recreation, Department of Land Management, Fish and Wildlife, and others).	Identify common strategies for promoting environmentally conscious campaign messages that raise awareness for personal, environmental and behavioral health. Provide training opportunities for PEACE constituent learning about environmental strategies that can be incorporated into procurement of environment friendly PEACE program resources (i.e. reducing, reusing and recycling waste). Develop joint media campaign strategies and products that influence community stewardship for a healthier island community and promotes environmental stewardship that encourages individuals to think more critically of how our behaviors are affecting our environment.	Year One - 4th Quarter and ongoing

VIII. APPENDICES

OFFICE OF THE GOVERNOR
HAGÅTÑA, GUAM 96910
U. S. A.

EXECUTIVE ORDER NO. 2011-03

RELATIVE TO AMENDING EXECUTIVE ORDER NO. 2003-29 WHICH CREATED THE GOVERNOR'S PEACE (PREVENTION AND EARLY INTERVENTION ADVISORY COMMUNITY EMPOWERMENT) COUNCIL

WHEREAS, the Governor's PEACE Council was created in 2003 and whose appointed members represent the executive, legislative and judicial branches of government, the private sector and community-based prevention advocates charged with the development of policies, programs and practices to address Guam's substance abuse and suicide problems, and to include planning, implementing and evaluating comprehensive evidence-based prevention strategies that result in positive environmental changes; and

WHEREAS, Guam's State Epidemiological Workgroup (SEW), is represented on the Governor's PEACE Council and leads in the collection, analysis, reporting and strategic use of Guam's data to inform and guide decision-making processes for the allocation of funding and resources to promote positive mental health and prevent substance abuse and suicide among targeted priorities; and

WHEREAS, this SEW body of key data gatekeepers will be now known as Guam's State Epidemiological Outcomes Workgroup (SEOW) whose areas of responsibilities are to manage Guam's mental health and substance abuse related data collectively and collaboratively and to facilitate annual Profile updates and data sharing with program and policy leaders and managers in government and the private sector; and

WHEREAS, the PEACE Council endorsed the publications of the Guam Substance Abuse Epidemiological Profile and the Profile of Suicide on Guam (and subsequent updates) which serve as a tool for strategic and comprehensive planning among state and community level mental health and substance abuse prevention and treatment partners; and

WHEREAS, the Governor's PEACE Council and the Guam's State Epidemiological Outcomes Workgroup (SEOW) will be retained with the appointment of key organizational members who will serve to guide and advise the Offices of the Governor and Lt. Governor in strategic prevention framework processes that involve assessment, capacity building, planning, implementation and evaluation steps to ensure that substance abuse prevention, mental health promotion and suicide prevention work is data-driven, culturally relevant, effective and sustainable; and

WHEREAS, our island community recognizes the need to improve the quality of Jjfe for the people of Guam, as reflected in a vision of good physical and mental health, long life, and the assurance that basic needs for primary health care and behavioral health services for Guam's residents are met; and

WHEREAS, the Governor 's PEACE Council will work collaboratively with the Department of Mental Health and Substance Abuse (DMHSA) and the Department of Public Health and Social Services (DPHSS) to jointly and strategically develop and/or strengthen, comprehensive state plans for mental health promotion and the prevention of substance abuse, suicide, ill health and deaths resulting from non-communicable diseases, via behavioral health and primary health care service systems and withln community-based settings on Guam; and

WHEREAS, the Governor's PEACE Council will help to guide and advise DMHSA staff as they facilitate opportunities to strengthen Guam's capacity to create a healthler island community following a strategic prevention framework (SPF) process for planning, implementing and evaluating culturally relevant, evidence-based programs, practices and policies that build upon the strengths and resources of the people of Guam.

NOW, THEREFORE, I, EDWARD J.B. CALVO, *I Maga 'LOhen Guahmt,* Governor of Guam, by virtue of the authority vested in me by the Organic Act of Guam, as amended , do hereby order that:

1. PEACE now stands for Prevention Education And Community Empowerment and that the PEACE Council shall consist of state and community-level members (not to exceed 25) representing the following:

    a) Youths between the ages of 15 and 21 (Representing established youth organizations)
    b) Parents (Representing established parent organizations)
    c) Healthcare Providers
    d) Private Businesses (Not Involved in the Alcohol or Tobacco Industry)
    e) Media Company (Involved in Promoting Good Health)
    t) Faith-Based Organization
    g) Civic or Volunteer Organizations
    h) Military Sector
    i) State Epidemiological Outcomes Workgroup (SEOW)
    j) Guam Department of Education
    k) Department of Youth Affairs
    I) Emergency First Responders (e.g., Guam Police Dept. and/or Guam Fire Dept.)
    m) Department of Mental Health & Substance Abuse
    n) Department of Public Health & Social Services
    o) Guam Memorial Hospital
    p) Mayors' Council of Guam
    q) Superior Court of Guam
    r) U.S. District Court of Guam- U.S. Probation Office
    s) *I Liheslaturan Guahan,* Committee on Health and Human Services

2. Each PEACE Council member shaH be appointed by the Governor of Guam and shall serve for a period of up to four years, unless removed sooner by the Governor of Guam, and until the Governor of Guam either formally renews hls or her term or replaces him or her with a new, qualified member; and

3. The PEACE Council shall elect a Chairperson and Co-Chairperson from among its members and shaH meet bi-monthly to review and revise its By-laws as necessary and to support the State Epidemiological Outcomes Workgroup in meeting its stated goals and objectives; and

4. The Department of Mental Health and Substance Abuse shaH remain the lead Government of Guam entity for substance abuse and suicide prevention with the administration of SAMHSA grants and to include the Garrett Lee Smith Memorial Act - Youth Suicide Prevention Grant and the State Epidemjological Outcomes Workgroup Sub-grants and their implementation.

SIGNED AND PROMULGATED at Hagatiia, Guam thls _II_ day of **January, 2011.**

EDWARD J. B. CALVO
I Maga'lahen Guahan
Governor of Guam

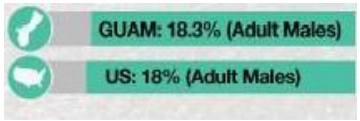
COUNTERSIGNED:

RAYMOND S. TENORIO
I Segundu na Maga'l ten Guahan
Lieutenant Governor of Guam

ALCOHOL

Binge drinking is similar among adults in Guam and the US.

SOCNCe: SRFSS, *2011*



WHO *IS* ABUSING ALCOHOL?

ADULTS

- 1 in 5 adults in *Guam* is *a* binge drinker.

Heavy drinking is highest among Chamorros and Courosians.
Binge drinking is highest among *Chamorros* and other Micronesians.

YOUTH

- 1 in 7 youth in *Guam* is *a* binge drinker.
- Girls *are drinking as much as* boys.

WHAT IS THE PRICE, AND WHO PAYS IT?

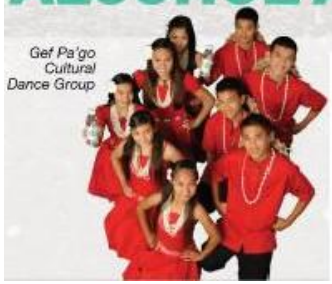
6: 3 *of the top* 5 *causes of* cancer *death are alcohol-related.*

Other Micronesians *have almost* 9 times *the US rate of* dying *from* liver cancer, *while Chamorros have over double the US rate.*

Close to 70% *of all* DUI arrests *occured among* Guamanians and *Pacific* Islanders. *These groups also have the highest* binge drinking *rates.*

About 1 in 4 suicides involve *alcohol abuse.*

WHAT WORKS TO REDUCE ALCOHOL ABUSE?



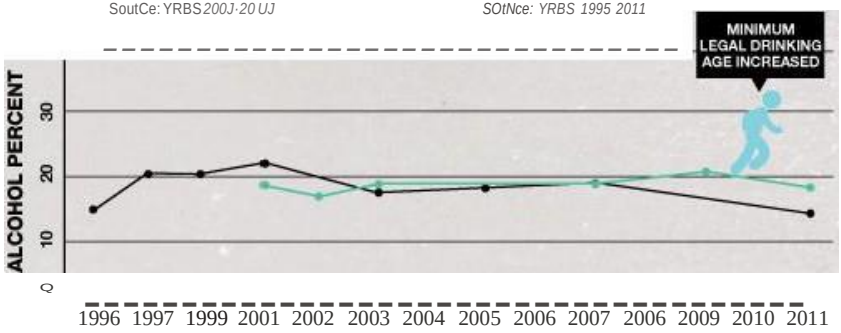
- Strictly enforce *the* minimum *legal drinking age law.*
- Raise taxes *further on alcohol products.*
- Promote alcohol-tree norms, *like the One* Nation *campaign*

HOW CAN YOU REDUCE AI.C@HOL ABUSE?

- *In 2010, Guam passed laws to* raise t.he minimum legal drinking age *and to restrict the hours of* sale of alcoholic products.
- *In 2011, for the first* time *in several years,* binge-drinking *among adults* and *youth* decreased in Guam.
- Evidence-based policies *can result* in immediate *and* measurable decreases *in alcohol abuse.*

Binge Drinking, High S<hool
SoutCe: YRBS *200J-20 UJ*

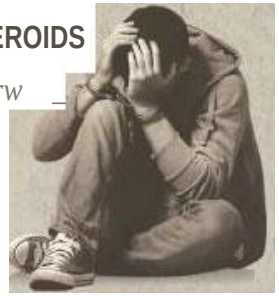
Binge Drinki g, *Adults*
SOtNce: *YRBS 1995 2011*



BINGE DRINKittG IN GUA

ILLICIT DRUGS

MARJJUANA, METHAMPHETAMINE, AND STEROIDS



Lifetime and current **marijuana** *u5e* are *highe? amorw* Guam$*you h* th011*among [,JSyouth ingeneraL*

Source: ABS 1977

LIFETIME MARIJUANA USE

WHO rs USING ILLICIT DRUGS?

ADULTS

MA JUANA

- **1 in 3 adults** *have* tried using *marijuana*
- **Males, Y,OUng adults and Chamorros** *are more likely to* use *marquana*

METHAMPHETAMINE

- **About 6%** *reported having* used *methamphetamines* in *their lifetime.*

Users were more likely to be **MALE, Chamorro, 25-44** *years old* **lass educated,** and to *have* **lower intome.**

YOUTH

MA JUANA

- **Nearly 1 in 3** *youth are* current *users of marijuana*
- *Marijuana users are* more *likely te* **male** ***and*** **Chamorro.**

METHAMPHETAMINE

- About **3%** *of high* school students *have* used *methamphetamines* in *their lifetime*

STEROIDS

- *About 3.4% of high school youth have used steroids without* adoaor's *prescription in their lifetime.*

WHAT IS THE PRICE, AND WHO PAYS IT?

Illicit drug use is implicated in 7% of **suicide** *deaths.*

Illicit drug use contributes to **crime.**

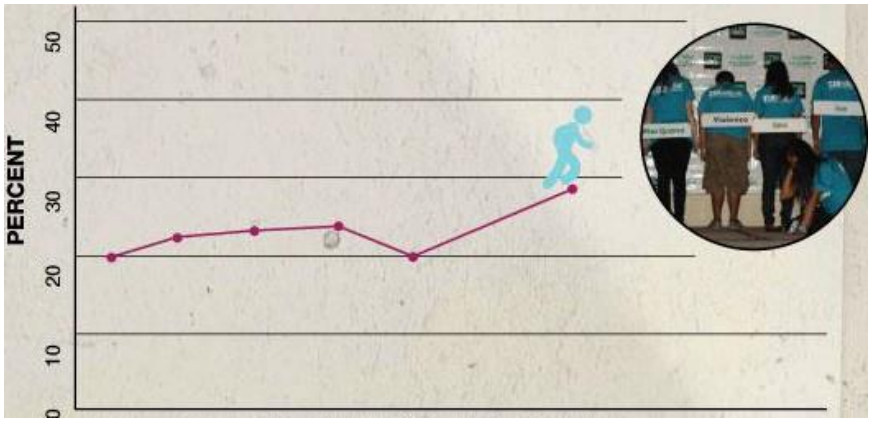
HOW CAN YOU REDUCE ILLICIT DRUG USE?

- *Research shows that* **demand redudion and treatment strategies** *ore effective in preventing and reduciTW* illicit *drug use.*

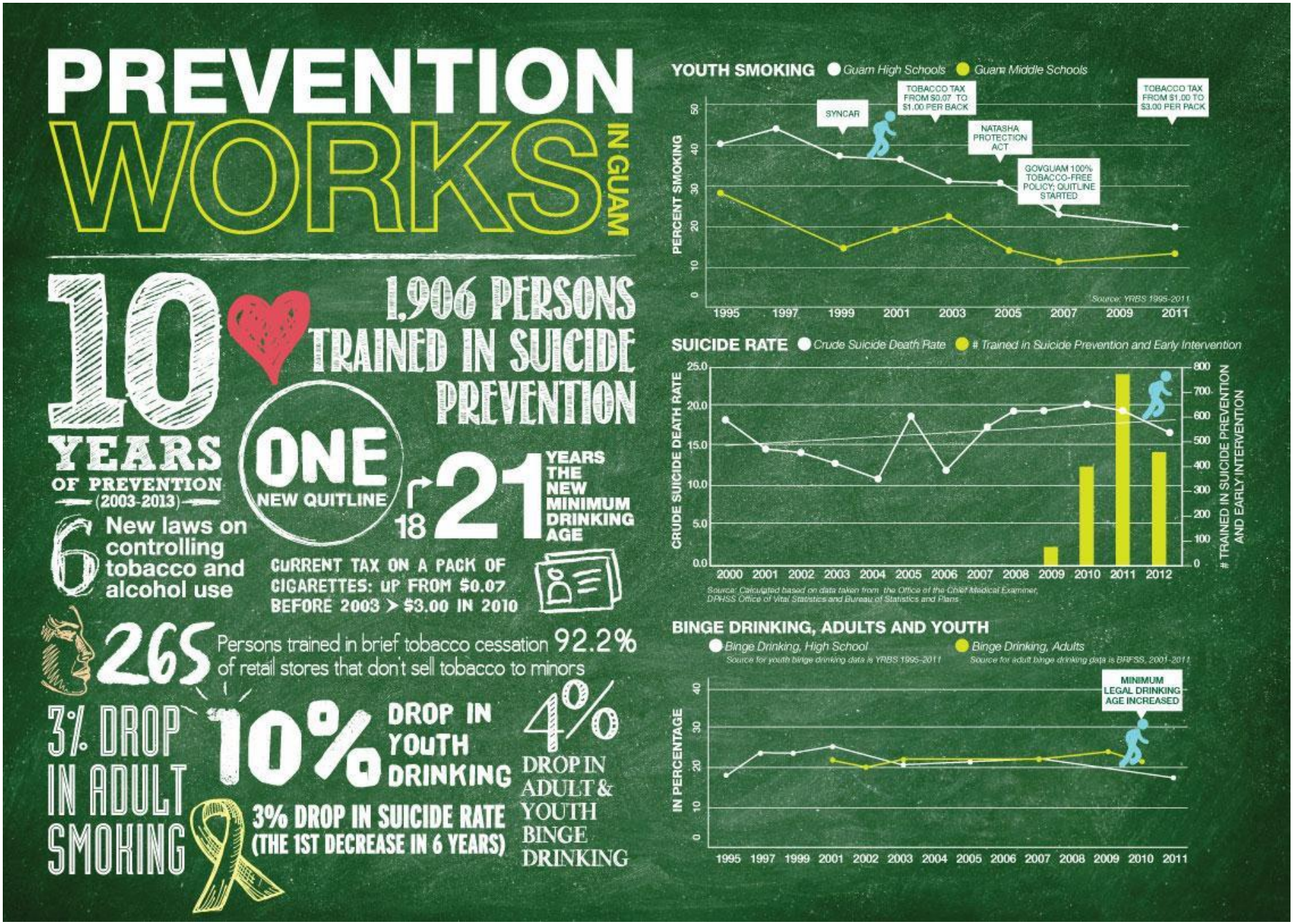
WHAT DO WE NEED TO DO To REDUCE THE BURDEN FROM ILLICIT DRUG USE?

- *,[nvest in* **science-based prevention programs** *that taW? trisks and protective factors.*
- **Expand treatment and recovery services.**

CURRENT Jo1ARIJUANA USE AMONG GUAM YOUTH



Source: YRBS 1995-2011


PREVENTION WORKS IN GUAM
10 YEARS OF PREVENTION (2003-2013)
1,906 PERSONS TRAINED IN SUICIDE PREVENTION
ONE NEW QUITLINE
18 21 YEARS THE NEW MINIMUM DRINKING AGE
6 New laws on controlling tobacco and alcohol use
CURRENT TAX ON A PACK OF CIGARETTES: UP FROM $0.07 BEFORE 2003 > $3.00 IN 2010
265 Persons trained in brief tobacco cessation
92.2% of retail stores that don't sell tobacco to minors
3% DROP IN ADULT SMOKING
10% DROP IN YOUTH DRINKING
3% DROP IN SUICIDE RATE (THE 1ST DECREASE IN 6 YEARS)
4% DROP IN ADULT & YOUTH BINGE DRINKING
YOUTH SMOKING
Guam High Schools
Guam Middle Schools
SYNCAR
TOBACCO TAX FROM $0.07 TO $1.00 PER BACK
NATASHA PROTECTION ACT
GOVGUAM 100% TOBACCO-FREE POLICY; QUITLINE STARTED
TOBACCO TAX FROM $1.00 TO $3.00 PER PACK
PERCENT SMOKING
Source: YRBS 1995-2011
SUICIDE RATE
Crude Suicide Death Rate
Trained in Suicide Prevention and Early Intervention
CRUDE SUICIDE DEATH RATE
TRAINED IN SUICIDE PREVENTION AND EARLY INTERVENTION
Source: Calculated based on data taken from the Office of the Chief Medical Examiner, DPHSS Office of Vital Statistics and Bureau of Statistics and Plans
BINGE DRINKING, ADULTS AND YOUTH
Binge Drinking, High School
Source for youth binge drinking data is YRBS 1995-2011
Binge Drinking, Adults
Source for adult binge drinking data is BRFSS, 2001-2011
MINIMUM LEGAL DRINKING AGE INCREASED
IN PERCENTAGE

Dtl'IT a l , GUAM VS. US, 2011

Guam's smoking rate is gher *than most US States and Territories; this has remained unchanged since2001.*

&v<a!'. *DAFSS ,2CII*

GUAM30.5%

1 US 19%

TOBACCO SM KIN G

WHAT WORKS TO REDUCE SMOKING?

- **Raise taxes** on tobacco products
- **Prohibit** *tobacco* **sales** *to* **minors (SYNAR)**
- *Make all* **public** *places* **smoke-free**
- *Promote* **cessation** *programs.*

WHO SMOKES?

ADULTS

1 in 3 **adults** in *Guam is a* smoker.

Men *smoke more than women,* but **women in Guam** *smoke as* much *as men in the US.*

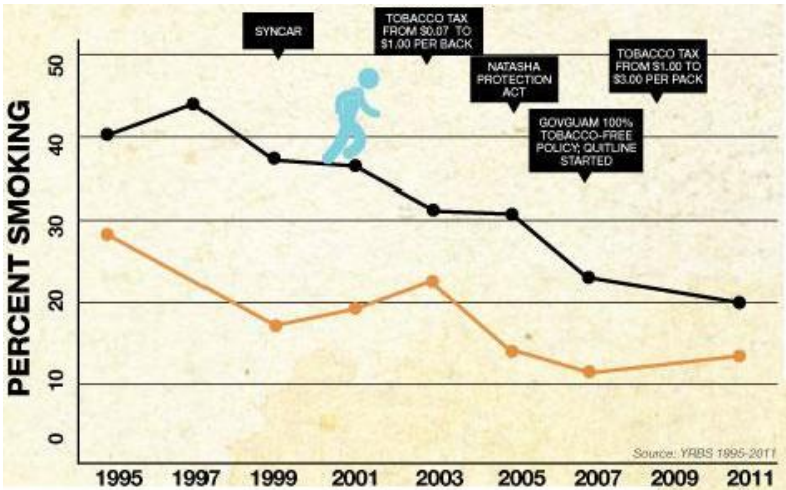
YOUTH

1 in 5 youth in Guam *is a smoker.*

Girls *smoke as much as* boys.

$<lt.YE8S.201'

YOUTH *9!101\.IHG PREVAI.b.nl;:I* AND TOBACCO CONTROL LAW IN GUAM



WHATIS THE PRICE, *AND* WHO PAYS IT?

t.:L\ *Tobacco* kills at *least 1* person on *Guam every day.*
The **top 3 causes of death** *are all tobacco* related.

Lung and oral cancers, most *of which are caused by tobacco, are highest among* **Chamorros** *and* **other Micronesians.**

'UJ **Lung cancer** *is the* top *cause of cancer death for both men and women.*

SOUND **TOBACCO CONTROL POLICIES** *DECREASE YOUTH SMOKING IN GUAM.*

Toll Free Tobacco Quitline: 1800·QUIT *NOW (784 8669)*

Smokeless tobacco use is rising *for both adults and youth The practice of chewing* tobacco *with betel nut* is *gradually* increasing in *Guam*

TOBACCO SM KELESS

WHO usEs SMOKELESS TOBACCO *PRODUCTS?*

ADULTS

- Males *are* more *likely to chew* or *use other* smoheless *tobacco products.* Chamorros *and* other Micronesians *have the highest* use *rates.*
- *Current users were* younger and had lower educational attainmenl .
- *Current smokeless tobacco* use *among adults* increased *from* 4.2%. *In 2009* to 6.9% in *2010.*

YO+U

- *Among high school students, smokeless tobacco use increased from* 6.3% *in 2001* to 14% in20ll.

WJ-I.AT JS THE PRICE

AJJD WH0 D'YS -

Oral cancer *r-a tes are* 4 times *highertormales.*

Oral cancer is 2X as *high in* Chamorros *and* 3X as *high inother* Micronesians ascomparedtothe *general US populanon.*

WHAT WORKS TO REVERSE SMOKELESS TOBACCO USE?

- Raise taxes *on smokeless tobacco products .*
- Promote cessation *through* cessation counseli718 *and the Guam Quidine.*
- *Expand the Natasha* Protection _, *Act to* make all public places tobacco-free.
- *Include* betel nut in tax increases.

SMOKELESS TOBACCO USE AMONG GUAM STUDENTS

e *HighSchool* *eMidclleschool*

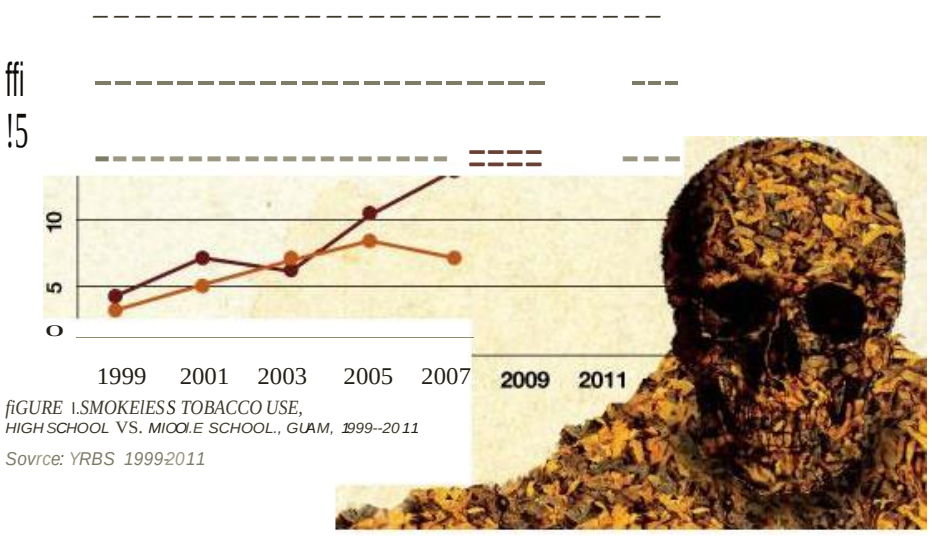


fiGURE I.SMOKEIESS TOBACCO USE, HIGH SCHOOL VS. MIOOLE SCHOOL., GUAM, 1999--2011

Sovrce: YRBS 1999-2011

SUICIDE

WHO *DIES* ON *GUAM?*

- 1 suicide *death* every 2 weeks.
- *60%* of suicide deaths are *under* the age of 30 *years.*
- Most suicide deaths are in *Chuukese* and Chamorros.

1 in 3 *suicide deaths left evidence of their* intent.

- *Recognize* suicide warning signs.
- Immediately *refer* persons at risk to prevention resources.

HOW CAN YOU REDUCE SUICIDE?

Address *risk factors* for suicide:

- Sexual violence
- Substance Abuse
- Depression
- Sexual Identity

1 in 4 suicide deaths involves alcohol 7% involve other drugs. Prevent alcohol and drug abuse.

WHAT *WORKS* TO *REDUCE* THE *BURDEN* FROM *SUICIDE?*

- Prevent and control *alcohol* and *illicit drug use.*
- Screen and treat mental illness and depression.
- Train health care personnel and other emergency responders to do *brief* intervention and to *refer all* attempted suicides *of* Suicide to *GBHWC* and other mental health providers.
- Empower youth to develop healthy relationship skills.
- Promote family involvement, *physical* and *sexual*
- Build *capacity* to identify persons at risk for suicide and to connect those at-risk to professional resources.

CRUDE SUICIDE DEATH RATE
NUMBERS TRAINED IN SUICIDE PREVENTION AND EARLY INTERVENTION

SUICIDE IN GUAM, *2000-2012*

Guam's suicide rate declined in 2011, following the passage of the law raising the minimum legal drinking age in 2010, and coinciding with the increased number of community members trained in brief suicide interventions.

WHERE TO GET HELP:
NATIONAL CRISIS HOTLINE: 1-800-273-TALK (8255)
GBHWC CRISIS HOTLINE: 1 (671) 647-8833
www.dmhsa.guam.gov

Guam PEACE Enhancement
Data Collection, Analysis and Reporting Action Plan

The purpose of Guam's PEACE Enhancement project is to strengthen Guam's prevention infrastructure and systems of care for individuals at risk of developing mental illness and engaging in substance abuse. Data gaps have been identified that will be addressed in order to strategically align PEACE enhancement planning, implementation and evaluation efforts successfully with current data, updated targeted priorities and relevant interventions.

On February 15 and 29, 2012, Guam's community and state-level stakeholders representative of Guam's State Epidemiological Outcomes Workgroup (SEOW) and state prevention specialists convened to discuss Guam's funded proposal and intended outcomes for PEACE State Prevention Enhancement planning. Twelve key stakeholders joined in a community participatory research process, whereby meeting participants engaged in a four-part planning discussions to assess existing resources, identify data gaps, determine targeted priorities and list strategic action steps that would move towards the realization of Guam's PEACE Enhancement goals, to:

1. Prevent or reduce consequences of underage drinking and adult problem drinking;
2. Prevent suicides and attempted suicides among populations at risk, including military families and LGBTQ youth;
3. Reduce prescription drug misuse and abuse;
4. Enhance state workforce development; and
5. Develop and enhance Government of Guam policy and funding to support needed services for mental health and substance abuse system improvements.

To bridge the prevention infrastructure with the mental health system of care, Guam's SPE for PEACE will establish systematic linkages between Guam's substance abuse and mental health infrastructure that will highlight the correlation between tobacco use, alcohol abuse, mental illness and suicide risk. Participants reviewed current data collection systems and survey instruments used on Guam and data and targeted priorities as reported in Guam's Substance Abuse Epidemiological Profile and A Profile of Suicide on Guam. Stakeholders proceeded to identify the following data gaps and perceived barriers to obtaining data that they believe are lacking: Youth in Private Schools, LGBTQ and the Military Community. The PEACE Council representatives for faith-based organizations support the identified need for conducting the YRBS in private catholic schools. Although the challenge regarding military data remains, efforts are underway to link with the Guam National Guard, where young men and women of Chamorro and Micronesian descent have enlisted for military service. A representative from the Guam National Guard now sits in the SEOW and participated in SEOW planning sessions.

The input and recommendations provided during this meeting with stakeholders to enhance Guam's data system are reflected in this Action Plan. Stakeholders are in agreement that at present, the infrastructure linkages between substance abuse and mental health are tenuous and are project/program-specific and that strategic reorientation of the existing prevention infrastructure to connect and align with the island's mental health and substance abuse treatment infrastructures need to be addressed. This will permit better coordination of prevention services with mental health promotion, substance abuse prevention and early

intervention, to allow for the entire spectrum of behavioral health care. More effective evaluation strategies will be developed to encompass this broad-based, holistic perspective.

Military wide statistics indicate that some active duty personnel are prone to alcohol problems and have elevated levels of suicide risk; nearly 50% of deployed military personnel have post deployment adjustment problems which warrant assessment and variable levels of care intensity. A significant proportion of military forces in Guam is comprised of Chamorro and other Micronesian young adults, who are the identified high risk groups for prevention. The military community on Guam is a critical stakeholder with limited presence at the table for prevention.

Good data underlies efficient prevention practice. Guam has made considerable strides in enhancing its data infrastructure for prevention under the SPF-SIG by establishing the SEOW, institutionalizing the data-driven process and streamlining the collection, analysis and dissemination of critical data to key stakeholders. However, data challenges persist. For instance, currently the SEOW has no access to military data or data from providers in the private sector. Rapid turnover in technical staff disrupts the continuity of membership in the SEOW and requires constant re-orientation of new members to the SPF process. Data enhancements, such as through on-line interactive databases, are needed.

Epidemiological work needs to be sustained and efforts to secure local resources and funding will ensure that relevant PEACE Enhancement work continues to be data-driven. The emphasis on data remains at the core of the prevention infrastructure on Guam, which in the long-range plan, will lead toward the adoption and sustained implementation of evidence-based programs (EBPs). This will in turn pave the way for better identification of well-suited and culturally-relevant evaluation strategies that will measure the impact of these programs. Accountability and improvement remain as the two major goals of evaluation for this grant.

At the completion of the community stakeholders meeting and discussions using the community participatory research process the following Goals, Objectives, Actions and Measurements have been initially identified for strengthening existing data collection, analysis and reporting instruments and processes and addressing targeted priority populations and prevention topic area gaps:

Goal 1: **To update annually Guam's Profile on mental health and substance abuse, including data on private school youth, the military population and other underserved community groups such as people who identify as LGBTQ.**						
Objective 1.1: To collect current data on alcohol and other drug use and suicide risks among middle and high school students in Guam's private schools, military personnel and families and LGBTQ population.						
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Action Step	**1.1:** Recruit member representatives of the military community and treatment providers of mental health and substance abuse to serve on Guam's State Epidemiological Outcomes Workgroup (SEOW).	X				
	1.2: Establish written formal Agreements between the Government of Guam and each of the identified entities (e.g. private schools, military sector, LGBTQ organization) from which data is needed and currently not included in Guam's Epidemiological Profile.	X				
	1.3: Identify funds to train data personnel and prepare resources for the annual/bi-annual conduct of relevant surveys to include YRBS costs for state-added questions as determined by the State Epidemiological Outcomes Workgroup (SEOW).	X				
	1.4: Execute written Agreements between the government of Guam and each participating entity that describes the scope of work, areas of responsibility by parties, expected outcomes and required deliverables, and costs for conducting relevant data surveys.	X	X			
	1.5: Include private school, military and LGBTQ data in the official updates of Guam's Profile on substance abuse and mental health.	X	X			
	1.6: Begin incorporating data from qualitative and mixed methods research to augment epidemiological and surveillance data in the annual Guam Epi Profile update.	X	X			
Goal 2: Secure sustainable funding for maintaining State Epidemiological Outcomes Workgroup services annually.						
Objective 2.1: Establishment of Government of Guam policy that prioritizes and directs funding for needed mental health and substance abuse services that demonstrate data-driven evidence of effectiveness.						
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Action Step	**2.1:** Disseminate critical substance abuse and mental health data to key government and private sector leaders, to raise awareness about PEACE efforts and secure support for evidence-based policy development and resource allocation.	X	X	X	X	X

Guam PEACE Enhancement
Coordination of Services Action Plan

The purpose of Guam's PEACE Enhancement project is to strengthen Guam's prevention infrastructure and systems of care for individuals at risk of developing mental illness and engaging in substance abuse. Gaps have been identified that will be addressed in order to strategically align PEACE enhancement planning, implementation and evaluation efforts successfully with current data, updated targeted priorities and relevant interventions.

On February 10, 2012, Guam's community and state-level stakeholders representative of Guam's PEACE Council and state prevention specialists convened to discuss Guam's funded proposal and intended outcomes for PEACE State Prevention Enhancement planning. Twenty-three key additional stakeholders contributed to this community participatory research process on September 13, 2012. Participants engaged in a four-part planning process to assess existing resources and identify gaps, determine targeted priorities and list strategic action steps relative to developing a Coordination of Services Action Plan for Guam. Additionally, meetings were held with key partners such as members of the Non-Communicable Disease Consortium during monthly meetings for which PEACE representatives also serve. Combined stakeholder input provided for this Plan would help to realize Guam's PEACE Enhancement goals, to:

1. Prevent or reduce consequences of underage drinking and adult problem drinking;
2. Prevent suicides and attempted suicides among populations at risk, including military families and LGBTQ youth;
3. Reduce prescription drug misuse and abuse;
4. Enhance state workforce development; and
5. Develop and enhance Government of Guam policy and funding to support needed services for mental health and substance abuse system improvements.

To bridge the prevention infrastructure with the mental health system of care, Guam's SPE planning for PEACE will be guided by the State Prevention Framework processes. PEACE will continue to strengthen systematic linkages between Guam's substance abuse and mental health infrastructure and will establish a comprehensive system for the coordination of relevant behavioral health care services that meet the needs of prevention and primary health care services providers and the community. Stakeholders acknowledged Guam's PEACE priorities, reviewed available services and resources, and identified areas that needed to be strengthened for improved services coordination as well as perceived barriers to coordinating, collaborating and leveraging needed prevention resources. The priorities for coordinating services better will be focused on *mental health of the (local) military personnel and their families, followed by mental health promotion among Guam's youth and the LGBTQ community.*

The input and recommendations provided during these meetings with stakeholders are reflected in this Action Plan. As noted in the two Action Plans for Data Collection, Analysis and Reporting and Technical Assistance and Training, the infrastructure linkages between substance abuse and mental health are tenuous and are project/program-specific. The existing prevention infrastructure needs to be strategically reoriented to connect and align with the island's mental health and substance abuse treatment infrastructures. This will permit better coordination of mental health promotion, substance abuse prevention and early intervention services, as part of the continuum of behavioral health care. With an

eye toward accountability and improvement, evaluation strategies will be developed, refined and put in place to more effectively encompass measurements of effectiveness in this broad-based, holistic perspective. When possible, the PEACE Council leverages funding and personnel support across its member organizations, highlights the potential use of tobacco tax revenues earmarked for Guam's Healthy Futures Fund and pursues grant opportunities to support PEACE efforts.

To address identified gaps in the coordination of prevention services on Guam, PEACE will strengthen and maintain ongoing communications in order to expand community partnerships in prevention and to ensure responsiveness and effectiveness with serving high need groups. Additional community partners who can successfully engage and connect with the military community and influence Chamorro and other Micronesian youth and young adults, and the LGBTQ community will be invited to join the PEACE Council and SEOW. Providing a voice to the specific needs of the entities they represent, their participation will strengthen the resource and funding coordination and allocation to assist with prevention capacity building within these high need groups.

Local prevention policies that define adherence to the Strategic Prevention Framework process at the state and community level (using the five-step process: Assessment, Capacity Building, Planning, Implementation and Evaluation) will result in the desired prevention outcomes for the people of Guam. The island's data-driven priorities and community needs will be clearly understood, services providers will be empowered with knowledge, skills and resources, and effective prevention and early intervention policies, programs, and practices will be implemented.

PEACE will initiate steps to work with community partners to improve services coordination.

Coordinated services will be enhanced through the leveraging of personnel services and expertise to address workforce development, infrastructure capacity building and development of local resources. Workplace policies and programs that are responsive to employees' identified needs with respect to mental health promotion and substance abuse prevention, early intervention and referrals for treatment will be developed. Training programs for certification of prevention specialists and employee assistance program managers in an identified evidence-based workplace program will be institutionalized.

Collaboration with local, regional, national and international organizations who share similar goals and objectives for healthier Pacific peoples and communities will continue (i.e. PEACE Council, Non-Communicable Disease Consortium, Pacific Behavioral Health Collaborating Council, Pacific Islands Health Offices Association, Pacific Islands Mental Health Network, Asian Pacific Partners for Empowerment, Advocacy and Leadership, National Asian Americans Against Substance Abuse, and the World Health Organization).

At the completion of the community stakeholders meetings and discussions held February 2012 thru September 2012, the following Goals, Objectives, Actions and Measurements have been initially identified for strengthening coordination of services among targeted priority populations and gaps in prevention topic areas:

Goal 1: **To improve access, availability and provision of coordinated comprehensive behavioral health programs and services among providers of mental health and substance abuse prevention and early intervention services on Guam targeting the (local) military residents and their families, youth and members of the LGBTQ community.**						
Objective 1.1: To conduct annual assessments of existing human services programs provided by the public, private and military sector, and identify gaps in services.						
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Action Step	**1.1:** Identify an assessment tool and use to obtain information from behavioral health, prevention and primary care program providers on available services and schedules.	X				
	1.2: Identify areas of duplication as well as gaps in programs and services; determine needed resources for the continued conduct of services in order of priority.	X				
	1.3: Establish agreements to strengthen collaborative partnerships and leverage resources needed to meet the prioritized behavioral health care needs of the targeted population/community.	X	X			
	1.4: Implement and evaluate programs and services in a coordinated fashion to ensure that resources and services are fully maximized and available to the intended audiences in a timely fashion.	X	X			
Goal 2: To expand and strengthen Guam's prevention and early intervention services network to include additional partners (locally, regionally, nationally and internationally) who have been identified as a resource for private school youth, the military population and other underserved community groups such as the people who identify as LGBTQ.						
Objective 2.1: To collaborate with local, national, regional and international organizations and agencies who are known advocates and who are connected directly with the targeted populations.						
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Action Step	**2.1:** Explore partnerships with agencies, organizations and networks that share PEACE mission and goals and are capable of engaging and influencing Chamorro and other Micronesian youth and young adults, LGBTQ and the military.	X				
	2.2: Establish written formal agreements or membership with identified agencies, organizations and networks.	X	X			
	2.3: Execute written agreements for joint projects and activities.		X	X	X	X
Goal 3: To jointly develop annual calendars (date, time, place and audience) of main events that reflect scheduled, unduplicated programs and services for targeted audiences.						
Objective 3.1: To identify a centralized scheduling center for coordinating prevention and early intervention behavioral health services to the community.						

		Year 1	Year 2	Year 3	Year 4	Year 5
Action Step	**3.1:** To develop and make public a master calendar of events which is monitored and updated quarterly.	X	X	X	X	X

Guam PEACE Enhancement
Technical Assistance and Training Action Plan

The purpose of Guam's PEACE Enhancement project is to strengthen Guam's prevention infrastructure and systems of care for individuals at risk of developing mental illness and engaging in substance abuse. Data gaps have been identified that will be addressed in order to strategically align PEACE enhancement planning, implementation and evaluation efforts successfully with current data, updated targeted priorities and relevant interventions.

On February 10, 2012, Guam's community and state-level stakeholders representative of Guam's PEACE Council and state prevention specialists convened to discuss Guam's funded proposal and intended outcomes for PEACE State Prevention Enhancement planning. Nine key stakeholders joined in a community participatory research process, whereby meeting participants engaged in a four-part planning process to assess existing resources, identify training and technical assistance gaps, determine targeted priorities and list strategic action steps relative to developing a Technical Assistance and Training Action Plan for Guam. Additionally, meetings were held with key partners such as members of the Non-Communicable Disease Consortium for which PEACE Council members also serve. Combined stakeholder input provided for this T/TA Plan would help to realize Guam's PEACE Enhancement goals, to:

1. Prevent or reduce consequences of underage drinking and adult problem drinking;
2. Prevent suicides and attempted suicides among populations at risk, including military families and LGBTQ youth;
3. Reduce prescription drug misuse and abuse;
4. Enhance state workforce development; and
5. Develop and enhance Government of Guam policy and funding to support needed services for mental health and substance abuse system improvements.

To bridge the prevention infrastructure with the mental health system of care, Guam's SPE planning for PEACE will be guided by the State Prevention Framework processes. PEACE will strengthen systematic linkages between Guam's substance abuse and mental health infrastructure and will establish a comprehensive training and technical assistance system that meets the needs of behavioral health, prevention and primary care services providers and the community. Stakeholders acknowledged Guam's PEACE priorities, reviewed available training and technical assistance services and resources, identified the following gaps and in the T/TA system and perceived barriers to coordinating, collaborating and leveraging needed prevention resources: *mental health promotion among the youth, LGBTQ and the military community.*

The input and recommendations provided during these meeting with stakeholders are reflected in this Action Plan. As noted in the Data Collection, Analysis and Reporting Action Plan, the infrastructure linkages between substance abuse and mental health are tenuous and are project/program-specific. The existing prevention infrastructure needs to be strategically reoriented to connect and align with the island's mental health and substance abuse treatment infrastructures. This will permit better T/TA coordination of mental health promotion, substance abuse prevention and early intervention services, as part of the entire spectrum of behavioral health care. With an eye toward accountability and

improvement, evaluation strategies will be developed, refined and put in place to more effectively encompass measurements of effectiveness in this broad-based, holistic perspective. When possible, the PEACE Council leverages funding and personnel support across its member organizations, highlights the potential use of tobacco tax revenues earmarked for Guam's Healthy Futures Fund and pursues grant opportunities to support PEACE efforts.

To address identified gaps in Guam's technical assistance and training system, PEACE will expand community partnerships in prevention to ensure responsiveness and effectiveness with serving high need groups. Additional community partners who can successfully engage and influence Chamorro and other Micronesian youth and young adults, LGBTQ and the military community need to be identified and invited to join the PEACE Council. Providing a voice to the specific needs of the entities they represent, their participation will strengthen the resource and funding coordination and allocation to assist with prevention capacity building within these high need groups.

Local prevention policies that define adherence to the Strategic Prevention Framework process at the state and community level (using the five-step process: Assessment, Capacity Building, Planning, Implementation and Evaluation) will result in the desired prevention outcomes for the people of Guam. The island's data-driven priorities and community needs will be clearly understood, services providers will be empowered with knowledge, skills and resources, and effective prevention and early intervention policies, programs, and practices will be implemented.

Given the limitation of funding and resources, duplication of efforts or working in silos will be minimized. T/TA services will be enhanced through the leveraging of personnel services, workforce development, infrastructure capacity building and development of local resources. Workplace policies and programs that are responsive to employees' identified needs with respect to mental health promotion and substance abuse prevention, early intervention and referrals for treatment will be developed. Training programs for certification of prevention specialists and employee assistance program managers in an identified evidence-based workplace program will be institutionalized.

Collaboration with local, regional, national and international organizations who share similar goals and objectives for healthier Pacific peoples and communities will continue (i.e. PEACE Council, Non-Communicable Disease Consortium, Pacific Behavioral Health Collaborating Council, Pacific Islands Health Offices Association, Pacific Islands Mental Health Network, Asian Pacific Partners for Empowerment, Advocacy and Leadership, National Asian Americans Against Substance Abuse, and the World Health Organization).

At the completion of the community stakeholders meeting and discussions held February 2012 thru October 2012, the following Goals, Objectives, Actions and Measurements have been initially identified for strengthening and restructuring existing technical assistance and training and addressing targeted priority populations and gaps in prevention topic areas:

Goal 1: **To update annually Guam's behavioral health and prevention and primary care workforce technical assistance and training needs to address mental health and substance abuse, including those serving private school youth, the military population and other underserved community groups such as the people who identify as LGBTQ.**						
Objective 1.1: To assess and prioritize current training and technical assistance needs among behavioral health, prevention and primary care professionals to address mental health and substance abuse.						
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Action Step	**1.1:** Assess local expertise in mental health and substance abuse among behavioral health, prevention and primary care professionals.	X				
	1.2: Identify, prioritize inter-disciplinary and multi-sectoral trainings and opportunities for peer mentoring.	X				
	1.3: Establish training programs for certification of prevention specialists and employee assistance program managers in an identified evidence-base workplace program to be institutionalized.	X	X			
	1.4: Establish written formal agreements between the Government of Guam and entities trained as trainers by the Government of Guam to conduct and provide T/TA.	X	X			
Goal 2: To expand and strengthen Guam's prevention network to include additional partners each at the local, national (US), regional and international levels, including those serving private school youth, the military population and other underserved community groups such as the people who identify as LGBTQ.						
Objective 2.1: To collaborate with local, national, regional and international organizations and agencies to ensure greater penetration into the targeted populations and strengthen the resource and funding coordination and allocation for capacity building.						
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Action Step	**2.1:** Explore partnerships with agencies, organizations and networks that share PEACE mission and goals and are capable of engaging and influencing Chamorro and other Micronesian youth and young adults, LGBTQ and the military.	X				
	2.2: Establish written formal agreements or membership with identified agencies, organizations and networks.	X	X			
	2.3: Execute written agreements for joint projects and activities.		X	X	X	X
Goal 3: To secure sustainable funding to maintain an updated comprehensive training and technical assistance plan that addresses the needs of behavioral health and prevention and primary care workforce and the community.						
Objective 3.1: To establish and strength Government of Guam policy that prioritizes and directs funding for needed mental health and substance abuse technical assistance and trainings that demonstrate data-driven evidence of effectiveness.						
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**

Action Step	**3.1:** Disseminate critical substance abuse and mental health data to key government and private sector leaders, to raise awareness about PEACE efforts and secure support for evidence-based policy development and resource allocation.	X	X	X	X	X

Guam PEACE Enhancement
Performance Evaluation Action Plan

The purpose of Guam's PEACE Enhancement project is to strengthen Guam's prevention infrastructure and systems of care for individuals identified to be at risk of developing mental illness and engaging in substance abuse. Data gaps have been identified that will be addressed in order to strategically move PEACE enhancement planning, implementation and evaluation efforts successfully with current data, updated targeted priorities and relevant interventions.

On May 16, 2012, Guam's community and state-level stakeholders representative of Guam's PEACE Council and state prevention specialists engaged in a structured discussion to review the intended outcomes of Guam's PEACE State Prevention Enhancement planning grant, with the end goal of contributing to the development of a performance/evaluation mini plan for Guam's Five-Year **C**omprehensive **S**tate **P**revention **P**lan for Mental Health Promotion and Substance Abuse Prevention (henceforth CSPP). Twenty one (21) key participants joined in this stakeholder input planning process, aiming to assess and leverage existing resources, recognize data gaps, identify targeted priorities and formulate strategic action steps towards fulfilling Guam's PEACE Enhancement goals, to:

7. Prevent or reduce consequences of underage drinking and adult problem drinking;
8. Prevent suicides and attempted suicides among populations at risk, including military families and LGBTQ youth;
9. Reduce prescription drug misuse and abuse;
10. Enhance state workforce development; and
11. Develop and enhance Government of Guam policy and funding to support needed services for mental health and substance abuse system improvements.

The session yielded a number of observations regarding the use of evaluation measures in the existing programs ~ both in the government and non-profit sectors~ that address tobacco use, alcohol abuse, mental illness and suicide risk. Because different entities and settings use a variety of evaluation instruments, participants reviewed current data collection systems and survey instruments used on Guam and data and targeted priorities as reported in Guam' s Subst ance Abuse Epide mi ol ogi cal Prof il e (September 2011) and A Profile of Suicide on Guam (August 2012). Among these instruments included both national (e.g., YRBS, BRFSS, ASQ-Se, DIAL 3, IFAM, PIR, CANS, CANS II, CAFAS, COXOCUS, ASAM, GAIN 1, GAIN Q, M90S, PSI, EIRF, TES, TUP-1, RNS, etc) and locally-
developed measures (e.g., DMHSA Training Exit Survey, DPHSS-GYTS Quit Line, etc.) that address targeted areas such as mental health promotion, suicide prevention, tobacco, alcohol, and other drug abuse priority areas. This exercise highlighted the seemingly disparate and fragmented system of program evaluation for prevention activities and services currently in place within the prevention infrastructure on island.

In an attempt to gauge the effectiveness of the PEACE input planning process, a survey was developed to generate perceptions and insights from stakeholders for a two-month period, from August to September 2012. Twenty-seven (27) stakeholders, including PEACE Council and SEOW members, completed the evaluation tool, a self-report survey. The study results indicated that PEACE stakeholders are committed constituents who have the island's best interest in their minds and hearts. A majority of these respondents

who took part in the PEACE sessions would volunteer to refine and strengthen the written action plans, if certain barriers (such as workload and time constraints) did not exist. Their primary goal is to see the development of a comprehensive state prevention plan that incorporates constituent and community input, and builds on evidence-based programs, practices, and policies that are already in place in the system of prevention on island. When the CSPP is finally written, they were certain that it will serve as a significant and critical guide for these constituents in their respective agencies as they serve Guam's youth, adults, and other special populations.

Through their survey participation, the stakeholders express their commitment to prevention work, which included discussion of the significance of evaluation to prevention planning in the May 16 session. It was therefore necessary for participants to review current data collection systems and survey instruments used by government entities and non-profit sectors on Guam. As shown in Attachment A, the specific areas identified where robust evaluation is taking place are among youth and adult programs, with notable gaps in special populations, like the military, LGBTQ, and service providers. A category of "Other" to encompass traumatized, homeless, PTSD, and "shadow people" was also discussed as part of the gap identification process vis-à-vis program evaluation. Consequently, a comprehensive evaluation process was considered in the aftermath of this discussion, with emphasis on these characteristics: systematic, integrated, and holistic. All the stakeholders were in agreement that the overall intent of evaluation is to determine program efficiency (i.e., process evaluation) and effectiveness (i.e., outcome/impact evaluation) of specific programs that address substance abuse and mental health promotion on island. As a result of the discussion, the sharing of best practices in evaluation was agreed upon as a critical movement away from silo-entrenched evaluation practices on the same priority areas engaged in by both government and non-profit sectors of the prevention care network on island. The group envisioned the development of a statewide data center that would serve as the repository of all evaluation activities that would move all stakeholders closer toward greater accountability and improvement of all prevention-related programs on Guam under their purview.

Out of this discussion, a comprehensive evaluation framework emerges as a critical need of the prevention care and services network on island. This mini plan describes this framework in order to provide a consistent, systematized, cyclical approach for planning and conducting evaluation processes in Guam's prevention system of care and services. This framework addresses the following evaluation components:

5. The methods used for conducting the evaluation;
6. The process for collecting, managing, and analyzing data that is reliable and trustworthy;
7. The process for interpreting data and disseminating information; and
8. The process of performance improvement as a result of evaluation findings.

Evaluation of all prevention-related programs encompassed by Guam's Five-Year **C**omprehensive **S**tate **P**revention **P**lan for Mental Health Promotion and Substance Abuse Prevention (CSPP) will use both *formative* and *summative* evaluation processes in order to determine the success in achieving the CSSP's stated goals and objectives. This process will include all the three (3) other mini plans included in the state prevention plan: Data Collection, Analysis, and Reporting Action Plan, Training & Technical Assistance Action Plan, and the Coordination of Services Plan. Components of both formative and

summative evaluation will be incorporated in data collection tools, within the purview of each of these plans, that will generate quantitative and qualitative data for analysis.

Significant groundwork has been accomplished to improve Guam's ability to gather and report on federally required performance measures. Much of the credit goes to Guam's current SEOW leadership, as it has developed and fostered relationships with various gatekeepers in order to facilitate data management procedures, to include data collection, analysis, reporting, and dissemination. For instance, DMHSA has technical agreements with the DYA and Sanctuary, Inc. that provide for the adoption of standardized questions from the YRBS into the screening battery in these organizations. As a prime example of data partnerships, this arrangement allows for meaningful comparisons in consumption and risk factor data between in-school and court-involved youth. To address identified data gaps, existing surveillance systems on Guam have been used to collect National Outcome Measures (NOMs) not previously collected. For example, a Memorandum of Understanding has been entered into by Guam's Department of Mental Health and Substance Abuse and the Department of Public Health and Social Services to utilize Guam's Behavioral Risk Factor Surveillance System (BRFSS) to collect adult required NOMs.

Indeed, efficient and meaningful prevention practice derives its strength from the use of credible data, and the State Epidemiological Outcomes Workgroup (SEOW), since 2007, has spearheaded the enhancement of Guam's data infrastructure through its institutionalization of a data-driven process that has streamlined the collection, analysis and sharing of critical data to key stakeholders. SEOW, as described in its Charter, aims to unify and integrate the data infrastructure systems on Guam, building on what currently exists, in order to:

1. Systematically collate and analyze relevant data (including but not limited to consumption and consequences of alcohol, tobacco, and other drug (ATOD) use, and risk and protective factors for mental health) to delineate and better understand the magnitude and nature of substance abuse prevention and behavioral health promotion;
2. Promote data-driven decision making across all stages of the Strategic Prevention Framework (i.e., Assessment, Capacity Building, Planning, Implementation and Evaluation) throughout the State substance use prevention and mental health system;
3. Strengthen and build capacity and data infrastructure for effective data utilization for substance abuse prevention and behavioral health promotion;
4. Facilitate interagency and community collaboration to optimize the exchange, access, and utilization of data across organizations and stakeholders working on substance abuse prevention, mental health promotion and other related fields;
5. Provide technical support to key health policy and program leaders, and community stakeholders to promote cross-systems planning, program integration, implementation and monitoring for substance abuse prevention and mental health promotion.

Toward this end, the updated data sets contained in the published versions of the Guam' s Substance Abuse Epidemiological Profile (September 2011) and A Profile of Suicide on Guam (August 2012) serve as the baseline data for all the priority areas identified in the PEACE Enhancement grant.

The formative or process evaluation component of the CSPP will measure program integrity or fidelity, adjust program practice, as deemed necessary, and evaluate the implementation plan. The plan also uses

process evaluation to assist in the interpretation of the outcome data by identifying the strengths and weaknesses of the program, providing information on intensity and dosage of services, identifying programmatic factors associated with program recipient outcomes, and identifying individual participant factors resulting in differential outcomes. Process evaluation for the implementation of this plan include the following descriptive elements:

5. Achievement of implementation goals and objectives;
6. Description of target population (demographics and other relevant characteristics);
7. Integrity, fidelity and adherence in the implementation and utilization of the selected evidence-based practices; and
8. Participant perceptions of overall program quality, program staff, and service delivery.

This evaluation framework systematizes data collection strategies and tools to gather relevant data that will ensure that evaluation processes will weave through all prevention activities, as outlined in the Data Collection, Analysis and Reporting Action Plan. The process evaluation component documents and monitors the prevention process by assessing the work of the Prevention and Training Staff, the Governor's PEACE Council and SEOW in achieving Guam's prevention goals and objectives. It also measures the extent to which the State Prevention Enhancement funding and related activities stimulate positive infrastructure and system changes and improve the effectiveness of prevention services delivery in the community.

To ensure that the CSPP is being implemented as planned, providing quality services, and attaining expected outcomes, performance improvement is a critical component of this evaluation plan. This entire plan in fact utilizes a structured strategy, which follows the **Plan-Do-Study-Act** or PDSA strategy (Deming, 1993). This strategy will utilize the following processes:

6. Identify and describe the deviation or unexpected outcome;
7. Generate a fishbone diagram to define all possible causes;
8. Collect data to correctly identify the cause related to the problem and pinpoint the area for intervention; and
9. Implement a corrective action to address the gap; and
10. Collect monitoring data to determine the effectiveness of the corrective action.

In addition, the process evaluation not only documents the procedures used to carry out the services, but also analyzes the degree to which the original design was followed and to document the problems encountered as well as the respective solutions. This consists of three (3) elements:

1. **Fidelity of Implementation** serves to track and evaluate the implementation and operation of specific programs under each of the plans (including this Evaluation Plan), determine adherence to specified timeframes, identify hindering factors to implementation, and describe any divergence from the implementation plan. As such, evaluation monitors the way each of the mini plans will be implemented to determine adherences and deviations and uses a performance improvement strategy to identify and define barriers, define strategies to reduce them, and collect and analyze data to determine effectiveness of barrier reduction. This type of evaluation provides regular feedback for improvement to service delivery programs under the umbrella of the CSPP.

2. **Monitoring of Fidelity** provides assurance that service delivery occurs as planned, and allows the early detection and correction of deviations. Fidelity monitoring will document the staff

members who provided what services, to which population staff delivered those services, in what context staff provided such services, as well as the dosage and frequency of services provided.

3. **Participants' Feedback** provides critical information in determining program effectiveness, as a rich supplement to other data gathered. Surveys of satisfaction will be administered to all program participants in order to capture information related to barriers in terms of access to services, access to staff when needed, and other issues related to both the quantity and quality of service delivery given to participants.

Measuring the impact of a program's effectiveness requires the analysis of quantitative or qualitative data, or a combination of both, where appropriate. Depending on the research design, a variety of methods and tools that may be used to assess outcome effectiveness include surveys, document review, pretest-posttest measures, key informant interviewing, focus group, among others. Through the use of appropriate instruments, and concomitant training necessary to utilize them, outcome-based evaluation under each of the mini plans addresses the success of the CSPP in attaining its desired outcomes.

The effectiveness of a coordinated system of prevention activities and services in increasing knowledge and awareness among youth and adults in the consequences of alcohol, suicide prevention, ATOD, workforce training, as well as the development of legislative policies affecting these issues and most importantly, the evidence, through quantitative and qualitative data indicators that support these improvements, remain to be the overarching goal of the CSPP.

Closely following each year of progress in the CSPP, yearly evaluation reports will be developed and disseminated to all State and community stakeholders. Furthermore, an annual PEACE Conference will be held in order to highlight and showcase significant progress made in terms of formative and summative evaluation of prevention-related programs island-wide. The analysis of measures and indicators described above will also be included in the annual Guam Substance Abuse Epidemiological Profile to make modifications, or support changes occurring in alcohol consumption and consequences, as well as the active promotion of mental health on Guam.

GUAM
SMVF STRATEGIC ACTION PLAN

VERSION 1.0

JUNE 14, 2013

VISION STATEMENT

Veterans, and their Families and all of Guam united, vested in creating a healthy, strong, and resilient island community that fosters harmony and respect.

INAFA MAOLEK YAN RESPETU!

MISSION STATEMENT

Our island cultures collaborate…to embrace…to educate…to prevent…to ask for help…to heal. We are an island community empowered towards healing, self-sufficiency. We devote our cultural strengths, resources to help our Service Members, Veterans, and their Families engage in the process of spiritual, physical, and emotional healing and wellness.

GOAL #1: POLICY CHANGE AND LEADERSHIP				
Strategies	**Actions**	**Responsible Entities**	**Measurement / Outcome**	**Timeline**
Develop Interagency Policy Council	Collaborate with leaders at all levels of government and across all sectors to support behavioral health needs of service members, veterans and their families. Identify additional core group members. Government: • Youth Affairs	GBHWC DOC DOL GNG GVAO	Finalize list of permanent standing interagency council of policy level decision makers Number and frequency of formal meetings	45 days Revisit membership every 6 months

	• Public Affairs • University of Guam • DPHSS – Medicaid • Dept. of Education • Guam Community College • Customs & Quarantine • Guam Memorial Hospital Authority • DPHSS – Bureau of Vital Statistics • Department of Revenue & Taxation (Drivers & Business License) • GPD/GFD/Local Law Enforcement and Security. Military: • Employer support for the National Guard & Reserve • Family Support Groups - 360 program • DOD / NRMC • DOD Law Enforcement & Security • US VA/VBA – Vet Center • U.S. Govt. Law Enforcement & Security. NGO: • USO • Salvation Army • Faith Based Organizations • Veteran's Organizations • Payuta (coalition of NGO's) • Guam Homeless Coalition/Continuum of Care • WestCare Pacific Islands • Catholic Social Services • PAYUTA			

	Private Component: • Business Community representatives: Chamber of Commerce • HMOs • Veteran family members			
Increase cross-agency collaboration and partnerships	• Create sub-committees to address strategic initiatives • Develop memorandums of understanding (re: data collection, disclosure of information, time on council)	GBHWC JOG GNG NGO	Designation of sub-committees and members Memorandums of understanding with various stakeholders	3 months
Formalize the SMVF Council under the auspices of the GBHWC	• Establish the council through statute • Governor to appoint council members • Insure veteran representation on the council • Legislature to confirm	32nd Guam Legislature	Legislation and formal appointments of council members/entities	3 months

GOAL #2: DATA COLLECTION, INTEGRATION AND OUTCOMES

Strategies	Actions	Responsible Entities	Measurement / Outcome	Timeline
Identify data needed and population to be served	• Create data subgroups and a data dictionary	GBHWC NGO GVAO DOC	Comprehensive list of the main data points necessary to inform the process	3 months
	• Create standard initial consent and initial intake forms	DOL JOG GHURA	Standardized data collection forms	6 months
	• Design uniform SMVF information and status validation process	DOD GNG	Uniform processes for information and status validation	6 months

	• Explore the establishment of a centralized database • Creation of a HIPAA/42 C.F.R. confidentiality agreements		Report on the feasibility of a centralized database and funding options Required compliance documents	12 months 3 months
Conduct Environmental Scan and Needs Assessments	• Create process to identify current service delivery systems for SMVF • Create island mapping with data on numbers, services and providers • Conduct a gaps analysis of services and access inefficiencies • Identify opportunities to improve utilization, integration and the coordination of services within the continuum of care	US VA GVAO MCOG UOG NGO	Comprehensive directory of services and service providers SMVF Maps Comprehensive report on the gaps in services and access inefficiencies with recommendations for improvement and coordination.	6 months 12 months 6 months 6 months
GOAL #3: DEVELOP A COMPREHENSIVE AND CONTINUOUS SYSTEM OF CARE (WRAP AROUND SERVICES)				
Strategies	**Actions**	**Responsible Entities**	**Measurement / Outcome**	**Timeline**
Increase access to a continuum of services through enhanced partnership and collaboration	Establish a community care initiative that addresses a comprehensive system of care for SMVF • Develop and maintain a provider network for behavioral and health services, financial and income assistance, housing, employment, peer mentoring and other support services for SMVF • Develop a cross agency matrix of resources and services that addresses	GBHWC US VA GVAO NGO	A comprehensive system of care that supports SMVF Policy level and service level groups all working together through development of MOU's and "No Wrong Door" policy	6 months 6 months

	eligibility based on military/veteran status		Matrix of services and eligibility	9 months
	• Develop a standardized intake and assessment process for SMVF's that addresses critical domains		Uniform intake and assessment process of critical domains for SMVF	6 months
	• Enhance the referral system for services and referral acknowledgements and feedback		Improved referral/acknowledgement system expanded for SMVF services	9 months
Integrate services for justice-involved service members and veterans	• Establish a specialized law enforcement response for service members and veterans at the point of crisis, arrest and detention	JOG US VA GPD DOC GVAO	Immediate identification of service members and veterans at intercept points	6 months
	• Explore the feasibility of a Veteran's Treatment Docket or a Veteran's Specialty Court in partnership with the Veteran's Administration and other government and private entities	GBHWC NGO	Court processes for handling eligible veteran's and service members	6 months
	• Identify and facilitate access to various treatment programs, medical care, housing, employment and foster interaction with other veterans (i.e. Veterans Mentoring Program)		Utilization of treatment and support services with mentoring	6 months
Improve access to stable, affordable housing and support services to SMVF's	• Increase awareness and access to homeless drop-in centers, transitional and emergency housing	GHURA CoC GHC GHURA	Numbers of SMV utilizing services	On going
	• Explore offering veteran's preference when applying for public or subsidized housing and housing vouchers	Interagency Council	Determination of veteran preference and numbers applied	6 months
	• Provide information on veteran home		Increase in VA loans and	6 months

	loans and housing assistance to SMVF who do not have the adequate resources to rent or purchase homes at fair market value • Improve access to supportive services for homeless and at risk SMVF to reduce financial vulnerability and facilitate independence		Shelter Plus Care or Supportive Housing Program vouchers/units utilized by SMVF Referrals to mainstream services	6 months
GOAL #4: WORKFORCE DEVELOPMENT				
Strategies	**Actions**	**Responsible Entities**	**Measurement / Outcome**	**Timeline**
Enhance workforce opportunities through portability for SMVF	• Create legislation for portability for licensing and credentialing for Service Members, Veterans and Spouses • Work with local boards to streamline the portability of licensing and credentialing processes for Service Members, Veterans and Spouses	32nd Guam Legislature GVAO DOL	Legislation for portability for licensing and credentialing Certification boards adopt new policies and procedures	6 months 9 months
Expand and improve access to higher education for SMVF	• Establish a program to get more SMVF enrolled in higher education/trades using the GI bill	GCC UOG	Outreach regarding educational benefits	9 months

	• Work with UOG and GCC to explore transferring military training and/or service into academic credit (American Council on Education A.C.E.)		Plan on academic credit for military training or services	On going
Establish training and workforce development programs and partnerships	• Identify transition work skills training programs to address the special needs of SMVF. • Expand training and hiring partnerships with the government and private sector • Leverage business sector employment opportunities by highlighting tax credit incentives • Improve access to work supports such as job coaching services	DOL ESGR US VA GVAO DOL AHRD Chamber of Commerce DISID DVR	Training programs and partnerships Priority placement for SMVF Jobs and trainings developed will include the special needs of service members and veterans Number of service members and veterans in employment utilizing job coaching services	9 months On going 6 months 9 months
GOAL #5: PUBLIC AWARENESS, OUTREACH AND ENGAGEMENT				
Strategies	**Actions**	**Responsible Entities**	**Measurement / Outcome**	**Timeline**
Increase public awareness of issues impacting SMVF	• Conduct military cultural competency and trauma informed care education and awareness campaigns • Publicize list and directory of services and internet based resources for providers, outreach groups and SMVF's • Develop a Guam SMVF website and portal • Develop a comprehensive information	GBHWC NGO DOC MCOG NGO GVAO	Number of education and awareness campaigns Directory of services Completed web portal	6 months 9 months 9 months

	sharing campaign (i.e. Pamphlets, websites, training, SMVF Month • Brochure is currently being prepared providing information about services provided which will be distributed to service providers	GBHWC NGO	Data Collection on numbers of website visits, pamphlets distributed and media/talk shows Provides SMVF information about service providers	Ongoing 2 months
Develop service engagement strategies for SMVF	• Promote targeted outreach activities to identify and link SMVF to programs and services • Identify a one-stop location for information • Explore 24/7 Hotline link to National Hotline and 211 system • Explore computer accessibility and resource programs at village level (Mayors' Offices and Libraries).	GBHWC NGO GVAO GNG	Increase awareness of resources for SMVF One Stop location for information and referral Guam link to national hotline and 211 system Plan for access at the village level	Ongoing 9 months 6 months 12 months

Legend:

- GBHWC Guam Behavioral Health and Wellness Center
- US VA U.S. Veteran's Affairs (Vet Center)
- GNG Guam National Guard
- JOG Judiciary of Guam
- GPD Guam Police Department
- DOL Department of Labor
- AHRD Agency for Human Resources Development
- DOC Department of Corrections
- CoC Continuum of Care
- GHC Guam Homeless Coalition
- DISID Department of Integrated Services for Individuals with Disabilities
- DVR Department of Vocational Rehabilitation
- UOG University of Guam
- GCC Guam Community College
- GVAO Guam Veteran Affairs Office
- MCOG Mayors Council of Guam
- GHURA Guam Housing & Urban Renewal Authority
- NGO Non-profit Group Organization

Review of Data Collection Systems and Use of Instruments
Performance/Evaluation Stakeholder Input Session
ATTACHMENT A

	Mental Health Promotion	Suicide Prevention	Tobacco	Alcohol	Other Drug Abuse
YOUTH - Ethnicity Specific - Gender Specific	-YFYLG-Exit Survey -Head Start-ASQ-SE, DIAL 3, Child Health Record Survey -IFAM- CANS, CAS II, CAFAS, COZOCUS, ASAM -Sanctuary - GAIN I, GAIN Q, M90S -DMHSA – YRBS -Surveys @ workshops	-DYA-ASIST & SafeTALK -DMHSA – Training Exit Surveys, YRBS -Surveys @ workshops -YFYLG – Exit Surveys -AOA - Youth Ministry workshop Eval Sheet, Education Curriculum Eval -GMH – Audit patient charts to determine if nursing staff thoroughly assessed suicide risk factors and proper linkage to DMHSA staff -Sanctuary - GAIN I, GAIN Q, M90S Inafa'Maolek-Pretest/Posttest, participant attendance and biodata, participant eval (students/teachers) -DOE – YRBS -CASD - CANS, CAS II, CAFAS	-DOE-YRBS -AOA-Youth Ministry workshop Eval Sheet, Education Curriculum Eval. -YFYLG-Exit Surveys -Sanctuary - ASAM, GAIN I, GAIN Q, M90S -DPHSS – GYTS Quit line matrix	-DMHSA-YRBS -YFYLG-Exit Survey -DOE-YRBS -Sanctuary-ASAM, GAIN I, GAIN Q, M90S -DYA – Enforcing Drinking Laws (EUDL), One Nation Cmpgn. -AOA – Youth Ministry workshop Eval Sheet, Education Curriculum Eval.	-YFYLG-Exit Survey -DOE-YRBS -DMHSA-YRBS -Sanctuary- ASAM, GAIN I, GAIN Q, M90S -GPD-Juvenile inv for drug offending work with DOJ, GREAT program, DARE

ADULT - Ethnicity Specific - Gender Specific	-Head Start – Parent Interest Survey, (PIR) Program Information Report	-DMHSA-Training Exit Survey -Head start-Parent interest survey, PIR Program Information report -DYA-ASIST, SafeTALK	-DPHSS-BRFSS Quit line matrix -Head Start- Parent interest survey, PIR Program Information report	-GPD-Highway patrol data collection crash reporting alcohol grant from DPW OHS -JOG-MAST Michigan Alcohol Screening Test -DPHSS – BRFSS -Head Start – Parent Interest Survey (PIS)	-JOG-(SASSI)Substance Abuse Subtle Screening Inventory for other drug use -Head Start – Parent Interest Form -DPHSS – BRFSS
MILITARY - Ethnicity Specific - Gender Specific		-DMHSA – Training Exit Survey			
LGBTQ - Ethnicity Specific - Gender Specific		-DMHSA – Training Exit Survey			
Other *People who have gone through trauma (homeless, PTSD, Shadow people, TBI)*					
Services Providers		-DMHSA – Training Exit Survey			

Community Stakeholders Meeting: Coordination of Services

	Mental Health Promotion	Suicide Prevention	Tobacco	Alcohol	Other Drug Abuse
YOUTH - Ethnicity Specific - Gender Specific	*Children's Mental Health month: May *Art Academy *Art of Healing *Children's Inpatient Unit/Ifamaguonta *Wrap around process *Transition to adulthood *Individual, Marriage and Family Therapy *Advocacy, support, training, resources, referral (GIFTS) * Referral (DOE) *ISA Psychological Center Counseling services (UOG students, staff, faculty) *Judiciary for adults/Juvenile -client services, individual marriage/family therapy, bio feedback, group counseling forensic/psychological evaluations *Rainbows for children *AOA Counseling in schools *Mental Health consultant proved observations/evaluations/consultation *Sanctuary- Anger management, IMFT, nonmedical CM, life skills *Judiciary-Play by the rules bullying prev. program. School resource off. *Pre-K curriculum for Mental Health promotion-second step *D&A *CIU *DISID-Divisions of vocational rehab & Support services – DOE: transition services to adulthood -- CSS: case management; comm. Habilitation program; respite care; DOE/SPED; GHURA (housing); Salvation Army (financial); MH: dual diagnosis	*D&A *CIU *CIU/PEACE *Training /referral *All staff are certified in Safe TALK/ASIST *AOA – workshops, training (ASIST), roundtable discussions youth ministry * Referral (DOE) *ISA Psychological Center	*D&A *CIU *CIU/PEACE *Parent training on tobacco cessation *Groups, outpatient/shelter *AOA – Schools classes for prevention (biology, human development) *youth ministry workshops *Chart (DOE) *ISA Psychological Center	*D&A *CIU *CIU/PEACE *AOA – Schools classes on prevention cause and effect *youth ministry (WYD) *conferences/workshops *IMFT – Education, outpatient, intensive outpatient, residential, AIC *Boy scouts of America *Teach young children dangers of violence and drugs *Chart (DOE) *Group and individual treatment *Juvenile drug court *Alcohol education program * ISA Psychological Center	*D&A *CIU *CIU/PEACE *AOA-school projects *A-CRA, ACC *YORP-youth offender re-entry program *Referral/Chart (DOE) * ISA Psychological Center

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Community Stakeholders Meeting: Coordination of Services

ADULT - Ethnicity Specific - Gender Specific	*counseling services for adults in community ex: relationship/drugs/abuse *coordinate w/DMHSA for consumers who are dual diagnosis *make involvement, fatherhood initiative, activities/focus *Judiciary-sex offenders treatment, individual & group treatment *AIU *AOA-Parish individual counseling *Advocacy, support, training, resources, referral (GIFTS) *FU Men's group, women's group, Chuukese men group, Bio feedback, individual marriage and family therapy *mental health court *supervision/monitoring *case management *anger management, parent skills/support, IMFT, non-medical CM *Transitional services with DOE (Sped) to adult services *Incredible years preventing program *GMH's HR dept. initiates purchase orders for employees needing psychiatric or mental health counseling services *CSEFL parent training promoting social emotional development of children *DISID-Divisions of vocational rehab: employment for individuals w/disabilities 18+ *ISA Psychological Center	*D&A *PEACE *AOA-workshop, training (ASIST), counseling, ethnic group dealing, alcohol related suicide groups *GMH patient safety program includes risk assessments for patients w/suicide tendencies history as such, nursing staff and patient doctor initiate measures for patients safety *ISA Psychological Center	*D&A *PEACE *GMH nursing staff reviews tobacco cessation handouts w/individual patients. If in depth education/training is needed our patient educator goes to meet w/the patient *ISA Psychological Center	*D&A *PEACE *GMH trains nursing staff on alcohol abuse handouts so that the nurses can discuss w/individual patients. If more info needed, GMH's patient educator meets w/patient *AOA- workshop/meeting esp. islanders affected by suicide /alcoholism *Group and individual counseling *Adult drug court *DWI court *ISA Psychological Center	*Judiciary-Juvenile drug court/adult drug court, group/individual treatment, supervision/monitoring, drug testing (intensive & non intensive tracks) *more promotion - nothing to be ashamed of *GMH several times a year conducts random drug screening tests on hospital staff. *ISA Psychological Center
MILITARY - Ethnicity Specific - Gender Specific	*Counseling services for military *Director of Psychological Health (Assessment and Referral) *MFLC Marriage Family Life Consultant *Department of Veterans Affairs (PTSD)	*State Suicide Prevention Program Manager *ASIST Trained Service Members *Resiliency Trained Service Members	*Prevention Treatment and Outreach Program *Prevention Coordinator	*Prevention Treatment and Outreach Program *Prevention Coordinator	*Joint Substance Abuse Program (Drug Testing) *Prevention Treatment and Outreach Program *Prevention Coordinator

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Community Stakeholders Meeting: Coordination of Services

		*Suicide Prevention Hotline 24h			
LGBTQ - Ethnicity Specific - Gender Specific					
Other	*Homeless outreach (adults, youth) *Outreach case management *Serenity home (TCH, ROH) *Coordinate w/service providers i.e. GHURA-mainstream program *AOA-CSS *Provide vocational counselors for individuals w/disabilities seeking employment			*Compact impact 1986 money grants US Gov.	*Boy Scouts of America *Council members *Merit Badge counselors *Start new troops *Girl Scouts of America work w/churches
Services Providers	*Provide care management services for individual w/disabilities *AOA-training of ministries & teachers *ISA psychological services center (UOG) *ISA Psychological Center	*AOA-workshop/trainings ASIST		*Redo Dededo Drug Free Organization	

- AIU: Adult Inpatient Unit, Department of Mental Health and Substance Abuse
- AOA: Archdiocese of Agana
- ASIST: Applied Suicide Intervention Skills Training
- CIU: Children Inpatient Unit, Department of Mental Health and Substance Abuse
- D&A: Drug and Alcohol Branch, Department of Mental Health and Substance Abuse
- DISID: Department of Integrated Services for Individuals with Disabilities
- DOE: Department of Education
- DOE/SPED: Department of Education, Special Education
- DWI: Driving While Intoxicated
- GHURA: Guahan Housing and Urban Renewal Authority
- GIFTS: Guam Identifies Families with Terrific Strengths
- GMH: Guam Memorial Hospital
- MH: Mental Health
- UOG: University of Guam
- PEACE: Prevention Education And Advisory Community Empowerment

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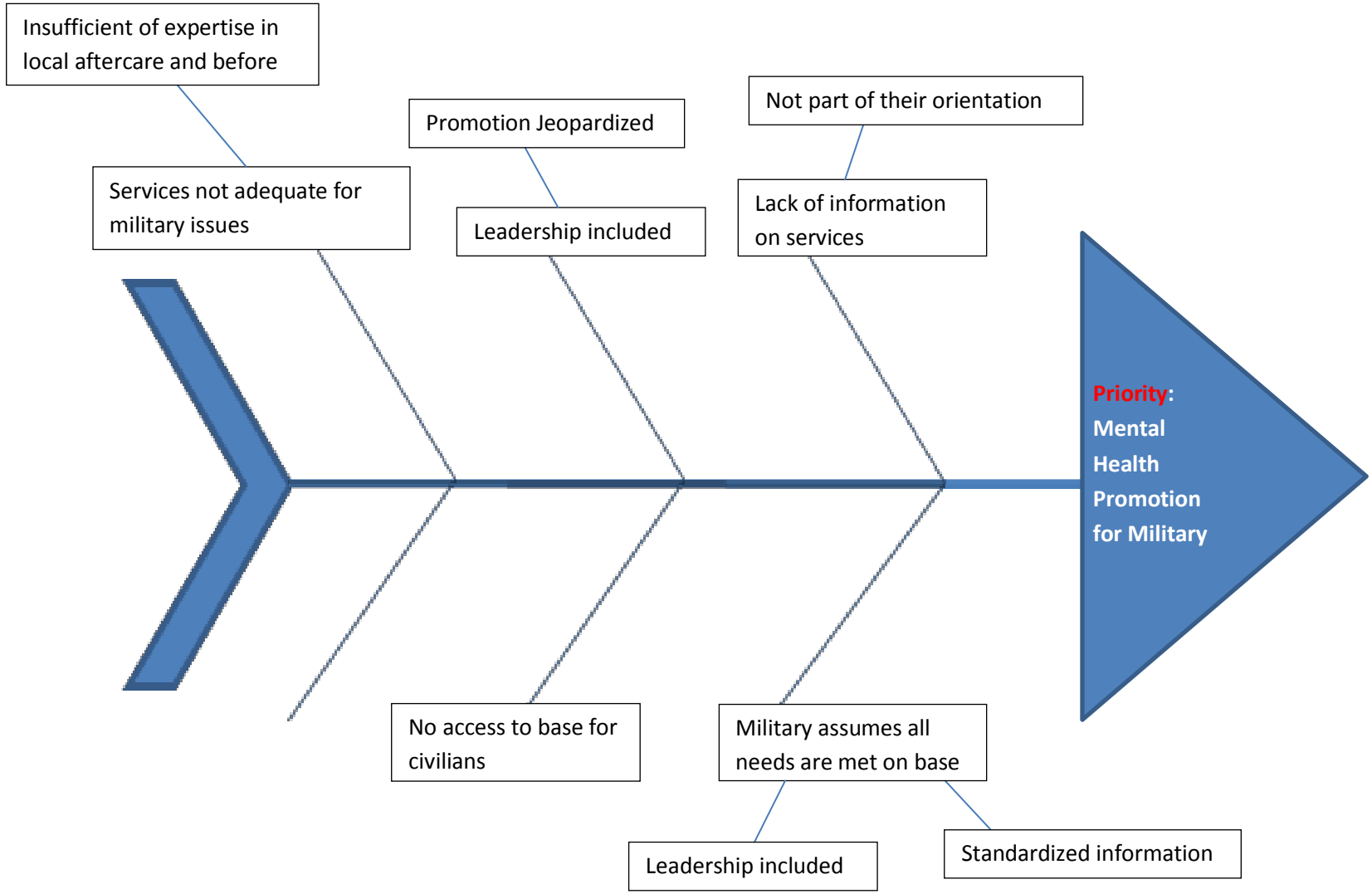
Community Stakeholders Meeting: Coordination of Services

SELECTED PRIORITY: Mental Health Promotion for Military

FISHBONE ANALYSIS:



Community Stakeholders Meeting: Coordination of Services

ACTION STEPS:

Action Steps	Training/Technical Assistance	Evaluation Indicators
1. Assumption that military provides all needed services a) Data from military affairs (VA) on magnitude of the utilization of community services (not covered by military services) b) Collaboration w/faith based groups and Collaboration w/orientation group c) Outreaches d) Facilitate relationship between military and community	- Building relationship - Orientation to military life and issues	a) Utilization of services pre & post-data reported to PEACE Council b) Invitation to orientation in community services including orientation packet c) Percentage of military participants
2. Insufficient local expertise in mental health services for military issues a) assessment of available expertise b) VA resources, delineate referral infrastructure, VA system c) assessment of the demand for needed services	-Military psychologist/psychiatrist training -VA on board with council -Military psychologist/psychiatrist give in-services with local providers	a) How many services available including those not being serviced by military and civilian services b) How many cross training occurred and who accessed it c) Number of community providers who attended orientation
3. Engage military in PEACE Council		Increase in membership, attendance and representation from different military corps.

Community Stakeholders Meeting: Technical Assistance and Training

	Mental Health Promotion	Suicide Prevention	Tobacco	Alcohol	Other Drug Abuse
YOUTH - Ethnicity Specific - Gender Specific	*Consumer Talk on experiences w/ mental illness, Substance Abuse services. *Behavioral emotional & mental health, ADD, Behavioral challenges & emotion, Mental Health challenges, Mediation. *Suicide: 2 major causes: unresolved conflicts & w/ significant other-need for conflict resolution/training.	*Student Training. *Support Groups. *Teachers Workshop.	*Tobacco prevention & control programs, Brief Tobacco Intervention for youth/adult, Youth For Youth Live / Agencies/Public.	*Town Hall Meetings. *GPD enforcement of Laws, community volunteer program, CAPE, CSTR/SME, Prevention through DPS, alcohol enforcements.	*Treatment for Adolescents, ? matrix, documentation, clinical supervision.
ADULT - Ethnicity Specific - Gender Specific	*Consumers can provide talk on experiences w/MI & services. *Needs Assessment, focus group. *Parent Education, Emotional & MH concerns, Leadership Skills, Consumer Education.		*Department of Public Health and Social Services/ Brief Tobacco Intervention (BTI).	*GPD enforcement of Laws, community volunteer program: CAPE, CSTR/SME, Prevention through DPS, alcohol enforcements.	
MILITARY - Ethnicity Specific - Gender Specific					
LGBTQ - Ethnicity Specific - Gender Specific	*Talk on experiences w/mental illness & substances abuse services			*D&A Branch, coordination for Training of Trainers, For treatment providers.	
Other	*Strategic planning.		*BRFSS/Data Collection.	*D&A-credential for Alcohol Dependence Counselor/Prevention Specialist, Professionals, Co-occurring disorders, credentials	*GPD enforcement of laws, training other local law enforcement agencies coordination, drug recognition for law enforcement or other organizations.
Services Providers	*Asset Mapping. *Survey's/Data collections. *Education to Parents about behaviors, Emotional & MH concerns, Develop/provide Leadership skills & Consumer Education.		*Guam Comprehensive Cancer Control/Diabetes prevention & control-focus groups/coalitions outreach.		

- BTI: Brief Tobacco Intervention

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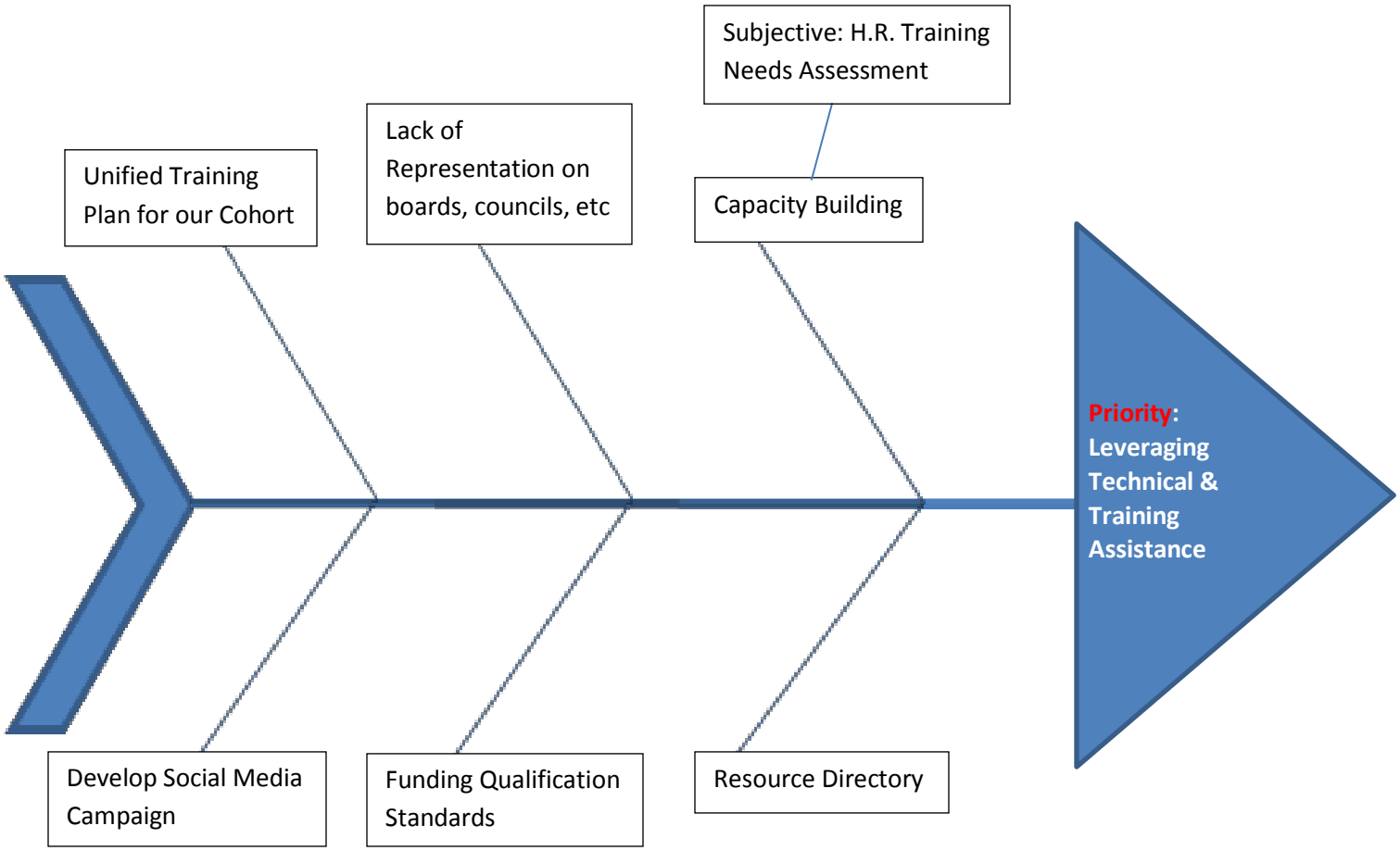
Community Stakeholders Meeting: Technical Assistance and Training

SELECTED PRIORITY:

FISHBONE ANALYSIS:



Community Stakeholders Meeting: Technical Assistance and Training

ACTION STEPS:

Action Steps	Training/Technical Assistance	Evaluation Indicators
1. Develop social media campaign	Increase access to training	
2. Develop strategy for unified training	Prioritize training, identify needs (youth)	
3. Establish cohorts training reference	Identify available trainers in the community	
4. Peer mentoring training strategy	Increase transitional TA (mentoring programs for sustainability)	

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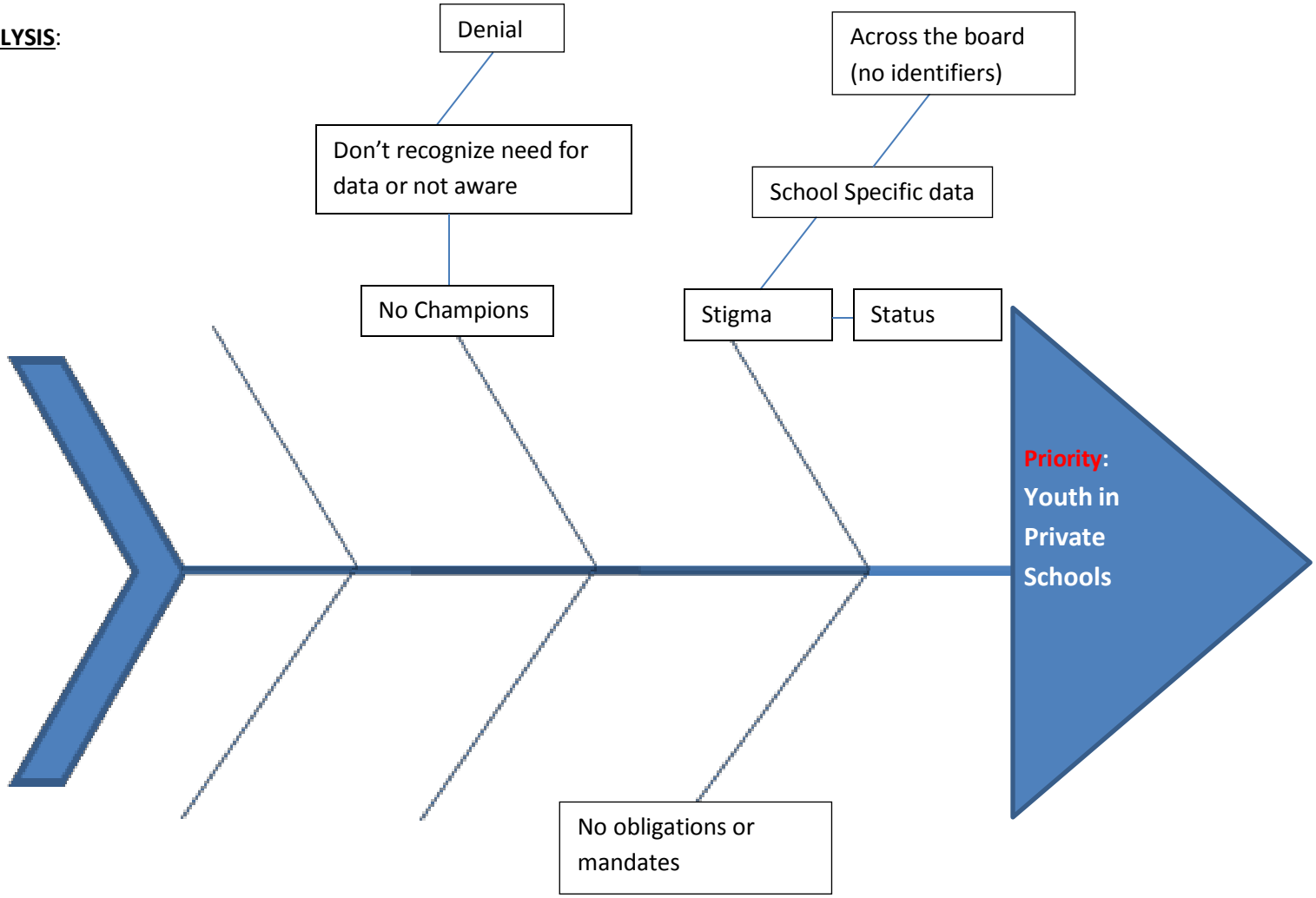
Community Stakeholders Meeting: Technical Assistance and Training

	Mental Health Promotion	Suicide Prevention	Tobacco	Alcohol	Other Drug Abuse
YOUTH - Ethnicity Specific - Gender Specific **BSP 2010 Guam Statistical Yearbook 2010 Guam Census	UOG Mental Health Promotion Month	Training Exit Survey Knowledge & Awareness Survey YRBS – DOE Suicide Deaths Early Identification and Referral From (EIRF) UOG Suicide Behavior	DOE – YRBS Tobacco – UOG	DOE – YRBS UOG- Alcohol Screening Q-Mark-One Nation Pre-Campaign Focus Group	DOE - YRBS
ADULT - Ethnicity Specific - Gender Specific **BSP 2010 Guam Statistical Yearbook 2010 Guam Census	UOG Depression Screening	Training Exit Survey Early Identification and Referral From (EIRF) Knowledge & Awareness Suicide Deaths	BRFSS	One Nation Social Marketing Campaign BRFSS Q-Mark One Nation Pre-Campaign	BRFSS
MILITARY - Ethnicity Specific - Gender Specific **BSP 2010 Guam Statistical Yearbook 2010 Guam Census		Knowledge & Awareness Training Exit Survey			
LGBTQ - Ethnicity Specific - Gender Specific		Knowledge & Awareness Training Exit Survey			
Other			Synar		
Services Providers					

Community Stakeholders Meeting: Technical Assistance and Training

SELECTED PRIORITY:

FISHBONE ANALYSIS:



Community Stakeholders Meeting: Technical Assistance and Training

ACTION STEPS:

Action Steps	Training/Technical Assistance	Evaluation Indicators
1. Recognition of data needs knowledge and acceptance a. Advocate to private school stakeholders on why we need data and benefits b. Showing how data can link to services		Number of Private schools participating in YRBS and number of LOA/MOU's
2. Establish confidentiality rules a. Reassure on aggregate data b. Clarify process w/CDC for data submission	DOE mentoring on administrating data survey/protocol	
3. Identify representation on Council		

Performance Evaluation

Action Steps	Training/Technical Assistance	Evaluation Indicators
-Include LGBTQ (GALA) representation • Military Sectors • People with trauma	-Bias desensitization training -Media	
-Preliminary assessment of LGBTQ and military using services and people with trauma	*Gender Training for professionals *Cultural competence training *CLAS **NOTE: identified T/TA apply to all delineated action steps.**	
-Increase awareness through media and community mobilization -Review of existing data sources for at risk population		
-Qualitative research into families dynamics as it relates to suicide		

Performance Evaluation

	Mental Health Promotion	Suicide Prevention	Tobacco	Alcohol	Other Drug Abuse
YOUTH - Ethnicity Specific - Gender Specific	-YFYLG-Exit Survey -Head Start-ASQ-SE, DIAL 3, Child Health Record Survey -IFAM- CANS, CAS II, CAFAS, COZOCUS, ASAM -Sanctuary - GAIN I, GAIN Q, M90S -DMHSA – YRBS -Surveys @ workshops	-DYA-ASIST & safeTALK -DMHSA – Training Exit Surveys, YRBS -Surveys @ workshops -YFYLG – Exit Surveys -AOA - Youth Ministry workshop Eval Sheet, Education Curriculum Eval -GMH – Audit patient charts to determine if nursing staff thoroughly assessed suicide risk factors and proper linkage to DMHSA staff -Sanctuary - GAIN I, GAIN Q, M90S Inafa' Maolek-Pretest/Posttest, participant attendance and biodata, participant eval (students/teachers) -DOE – YRBS -CASD - CANS, CAS II, CAFAS	-DOE-YRBS -AOA-Youth Ministry workshop Eval Sheet, Education Curriculum Eval. -YFYLG-Exit Surveys -Sanctuary - ASAM, GAIN I, GAIN Q, M90S -DPHSS – GYTS Quit line matrix	-DMHSA-YRBS -YFYLG-Exit Survey -DOE-YRBS -Sanctuary-ASAM, GAIN I, GAIN Q, M90S -DYA – Enforcing Drinking Laws (EUDL), One Nation Cmpgn. -AOA – Youth Ministry workshop Eval Sheet, Education Curriculum Eval.	-YFYLG-Exit Survey -DOE-YRBS -DMHSA-YRBS -Sanctuary- ASAM, GAIN I, GAIN Q, M90S -GPD-Juvenile inv for drug offending work with DOJ, GREAT program, DARE
ADULT - Ethnicity Specific - Gender Specific	-Head Start – Parent Interest Survey, (PIR) Program Information Report	-DMHSA-Training Exit Survey -Head start-Parent interest survey, PIR Program Information report	-DPHSS-BRFSS Quit line matrix -Head Start- Parent interest survey, PIR Program Information report	-GPD-Highway patrol data collection crash reporting alcohol grant from DPW OHS -JOG-MAST Michigan Alcohol Screening	-JOG-(SASSI)Substance Abuse Subtle Screening Inventory for other drug use

		-DYA-ASIST, safeTALK		Test -DPHSS – BRFSS -Head Start – Parent Interest Survey (PIS)	-Head Start – Parent Interest Form -DPHSS – BRFSS
MILITARY - Ethnicity Specific - Gender Specific		-DMHSA – Training Exit Survey			
LGBTQ - Ethnicity Specific - Gender Specific		-DMHSA – Training Exit Survey			
Other *People who have gone through trauma (homeless, PTSD, Shadow people, TBI)*					
Services Providers		-DMHSA – Training Exit Survey			

The 6 A's in Prevention (Performance Evaluation) **CURRENT**

	Mental Health Promotion	Suicide Prevention	Tobacco	Alcohol	Other Drug Abuse
ACCESS	-Head start Program		-Dept. of Public Health & Social Services -Dept. of Youth Affairs -Dept. of Mental Health & Substance Abuse – Prevention	-Dept. of Youth Affairs	-Youth for Youth Live Guam
AFFORDABILITY			-Dept. of Public Health and Social Services -Guam Comprehensive Cancer Control Coalition		
ATTRACTIVENESS			-Dept. of Public Health & Social Services -Guam Comprehensive Cancer Control Coalition -Counterdrug Program	-Guam Police Dept. -Guam Comprehensive Cancer Control Coalition -Inafa'Maolek -Counterdrug Program	-Guam Police Dept. -Inafa'Maolek -Counterdrug Program
ACCEPTABILITY	-Judiciary of Guam		-Dept. of Public Health & Social Services -Dept. of Education - Archdiocese of Agana -Private Schools -Counterdrug Program	-Private Schools - Archdiocese of Agana -Dept. of Education -Judiciary of Guam -Counterdrug Program	-Guam Police Dept. -Dept. of Education -Judiciary of Guam -Counterdrug Program
ASSIST those who want help	-Children Adolescent Service Division -Head start -Youth for Youth Live Guam	-Guam Police Department - Archdiocese of Agana -Dept. of Education -Private School	-Guam Memorial Hospital -Dept. of Mental Health & Substance Abuse-Prevention -Youth for Youth Live Guam -Head start -Dept. of Public Health & Social Services -Health Partners	-Head start -Youth for Youth Live Guam - Children Adolescent Service Division	- Children Adolescent Service Division
ACCOUNT for		- State Epidemiological Outcomes Workgroup	-Dept. of Public Health & Social Services	- State Epidemiological Outcomes Workgroup	-University of Guam

Change		-Dept. of Mental Health & Substance Abuse -Bureau of Statistics & Plans -Children Adolescent Service Division -Dept. of Youth Affairs	-State Epidemiological Outcomes Workgroup -University of Guam - Dept. of Youth Affairs -Bureau of Statistics & Plans	- Bureau of Statistics & Plans	-State Epidemiological Outcomes Workgroup -Bureau of Statistics & Plans

The 5 A's in Prevention (Performance/Evaluation) **FUTURE**

	Mental Health Promotion	Suicide Prevention	Tobacco	Alcohol	Other Drug Abuse
ACCESS	-Youth for Youth Live Guam -Head start Program	-Youth for Youth Live Guam	-Dept. of Public Health & Social Services -Youth for Youth Live Guam	-Youth for Youth Live Guam -DMHSA-Prev. & Trng.	
AFFORDABILITY			-Dept. of Public Health and Social Services	-Guam Community College	
ATTRACTIVENESS	-Archdiocese of Agana	-Inafa'Maolek -Private Schools	-Dept. of Public Health & Social Services -Guam Comprehensive Cancer Control Coalition	-Guam Police Dept. --Guam Comprehensive Cancer Control Coalition	-Guam Police Dept.
ACCEPTABILITY	-Private Schools	-Private Schools	-Dept. of Public Health & Social Services		
ASSIST those who want help	-Children Adolescent Service Division -Head start	-Children Adolescent Service Division -Head start -Dept. of Mental Health & Substance Abuse	-Guam Memorial Hospital - Archdiocese of Agana -Head start -Dept. of Public Health & Social Services -Children Adolescent Service Division -Health Partners	-Head start -University of Guam - Children Adolescent Service Division	- Children Adolescent Service Division
ACCOUNT for Change	-State Epidemiological Outcomes Workgroup -Bureau of Statistics & Plans -Dept. of Youth Affairs -Judiciary of Guam	- State Epidemiological Outcomes Workgroup -Dept. of Mental Health & Substance Abuse -Dept. of Education -Bureau of Statistics & Plans -Archdiocese of Agana	- Archdiocese of Agana -Judiciary of Guam -Dept. of Education -Dept. of Public Health & Social Services -State Epidemiological Outcomes Workgroup -University of Guam - Dept. of Mental Health & Substance Abuse -Bureau of Statistics & Plans	-Dept. of Education - State Epidemiological Outcomes Workgroup -Dept. of Mental Health & Substance Abuse - Bureau of Statistics & Plans -Judiciary of Guam	-Dept. of Education -Judiciary of Guam -University of Guam -State Epidemiological Outcomes Workgroup -Bureau of Statistics & Plans

SPE Stakeholders' Meeting
January 31, 2013
Marriott Resort, Guam

DATA:

What more do you want to know?

- Data on FSM community, faith-based community, LGBTQ, Youths, children of incarcerated parents.
- Tobacco import data
- Prescription drug use (where/how getting them) (youth usage)
- Suicide completions/attempts not reported
- Mental health issues in homeless/substandard living
- Validity of surveys (need variety of collection – focus groups)
- Depression screening – is it offered community wide?
- How is it collected?
- How is it analyzed?
- Is it consistent?
- Distribution of information and awareness

What services do you need?

- Language specific education
- Chief Medical Examiner
- Through partnerships, community-based organizations (FSM Church Leaders, GALA)
- Training (overall)
- Software type used
- Experts
- Collaboration

What training or technical assistance do you need?

- Training on evaluation tools
- Training on languages
- Interpreters and translators
- Training of trainers
- Connection of suicide to drug/alcohol use
- Gain trust to ask personal questions (use churches/pastors)
- Training on utilizing software
- Training in useful resources and technology including tools/instruments being used
- Settings and target groups

COORDINATION OF SERVICES:

What more do we want to know?

- Availability of languages specific education
- Treatment services serving LGBTQ population
- Cross-cultural education
- What services are available?
- How to better publicize? Increase awareness?
- What do you have to pay for vs. free? Costs for services
- How much time do I need to invest?
- Time of response from providers
- Are more confidential methods available?
- How do we reduce stigma on these services?
- What services are provided at the school level?

What services do we need?

- Training of interpreters and translators
- Better enforcement (stores, ID checks)
- Education!
- Raise minimum purchase age for tobacco =21
- Get pastors/churches involved
- Get law enforcement active (increase busts/presence)
- Increase neighborhood ownership (crime watch program)
- Increase signage/eye-catching/emphasize fine
- Translation into major languages
- Emphasize prevention & respect!
- Workshops
- Cultural language services/training – OMH
- Resource information center/directory

What technical assistance do we need?

- Children of incarcerated parents
- Drugs and alcohol awareness and prevention (life skills)
- Awareness among foster parents
- Resource training
- Wellness trainings within organizations/agencies

TRAINING AND TECHNICAL ASSISTANCE:

What more do we want to know?
What services do we need?
What technical assistance do we need?

- Training members of targeted groups in all areas of prevention
- Training of trainers: ASIST, tobacco cessation
- Services providers identify who the target groups are and who mentors in each group
- Connect with the FSM CLAG (Church Leaders Association Guam)
- Translations of all prevention tools and materials
- Solicit compact-impact funding for prevention
- Language barriers
- Bring TA/T to participant rather than participant to training
- Mental health training for service providers
- Collaboration/networking
- GONA/holistic approaches
- Training for top levels in addition to bottom
- Grant writing
- Work skill/work ethics
- Get into homes (benefits/incentives)
- What's being offered?
- Who are the experts/trained individuals
- Funding/grant opportunities
- Calendar of events
- Grant writing skills
- Directory of stakeholders
- Collaboration with organizations (NGOs, military, faith-based, government, private corp.)
- Policy mandates
- Grant writing
- More training of trainers
- Update policy/procedures of consistency
- Sustainability

NEXT STEPS:

- Answer questions (e.g. data)
- Invite more youths
- Discuss surveys
- Invite others (mayors)

SPE Stakeholders' Meeting
February 26, 2013
Marriott Resort, Guam

DATA:

What more do you want to know?

- Prevention strategies (i.e. awareness, campaigns)
- Import/Export of products (tobacco, alcohol) and appropriation of sin tax (going to prevention/treatment?)
- Military base data
- Breakdown of data by islands
- Data on different subcultures (ie. Recovery group, sports groups)
- Capture data on underlying factors not just symptoms (drug use and suicide attempts are just symptoms of something deeper)
- Co-occurring factors (ie. those in sex and beauty industry exhibit risky behaviors)

What services do you need?

- Culturally competent strategies
- Language interpreters/media information
- Cultural values (understanding and gaining knowledge of the population's values)
- Pre-doctrination/education (education before arriving into the island; collaboration with airlines in passing out documents/informational booklets the way they pass out customs forms)
- Translation of data (into other languages; for ordinary people to understand)

What training or technical assistance do you need?

- Train members from respective cultures/communities
- Involvement of various community in activities (ie. Anti-bullying in schools; workshop events; researching culture; hands on experience)
- Qualitative data (testimonials/personal experiences)
- Accessibility of training (transportation issues; getting the right attendees)

COORDINATION OF SERVICES:

What more do we want to know?

- How do we access our resources?
- How do we link our clients to available resources?
- What resources are available?
- How do we collaborate with other agencies?
- How do we assess the individual levels of need?

- How do we assess the program needs?
- How do we evaluate the services available?
- What services are free? And, what qualifies you to receive these services?
- What transportation services are there? (coordination of outreach programs so that multiple services are available at one location at one time)
- How do we culturally adapt our services?

What services do we need?

- Proper training for qualified personnel (qualified personnel per need)
- We need TOT to be cost effective
- Local adaptation of training
- Additional services for those with disabilities that battle addiction
- More services for youth (focus on prevention)
- More services for our elderly
- More support groups

What technical assistance do we need?

- Current 24 hour hotlines – does the public know?
- Training on devices used for data gathering
- Access to communication tools to adapt to other cultures (translators)
- More outreach programs that are culturally diverse (workshops/townhall meetings) to include media
- What the budget (sources of funding)?
- More, more, more love

TRAINING AND TECHNICAL ASSISTANCE:

Issues that need to be addressed:

- Underage Drinking (penalties)
  - Community service (more eye opening experiences like “scared straight”)
  - Harsher penalties (lawmakers, research from other states, advocacy from the community)
  - Stronger enforcement (private sector, language specific)

- Suicide
  - Being able to provide the service (professionals, service providers)
  - Be more proactive than reactive
  - Be aware of policies
  - Make it a part of professional curriculum/certification

- Youth Prevention Activities
  - Inclusive of different cultures
  - More encouraged in the schools

    - Buy in from the community
    - Perception of substances (raise awareness of effects; some youth say “I’m not smoking marijuana or ice” when referring to consuming alcohol)

- More services available (more accessible venues; more incentives)

- Coping skills
    - Youth and adults
    - Encourage community groups and clubs to initiate drug prevention and suicide prevention
    - Groups to be the support system

- Not enough professionals

- To partner culture specific organizations for community education
    - Sensitivity training

DAY 1 July 30, 2013

7:30a.m. – 8:30a.m. Preparing for the Journe

- Registration
- Participant check-in
- Photo release forms
- Affirmation activity

8:30a.m. -10:00 a.m. BELONGING

Purpose : To experience actions, words and rituals, which make each person fully appreciate that we "belong" in this Gathering of Pacific Islanders (GOPI). To acknowledge and support the protective factors associated with belonging. To create an open, safe, and trusting environment so participants can begin the work of joining together as a community to develop Guam's 5-year comprehensive PEACE Plan. To provide an opportunity for individual community members to have their contributions heard, valued, and respected and establish a foundation for the duration of the GOPI and beyond. For participants to join together and help establish the direction of the community's plan to stop suicide and prevent substance abuse on our island.

- Welcoming: Bendishion (Pa'a Taotao Tano)
- "Vision for PEACE"
- Gathering of Pacific Islanders overview
- Logistics overview
  - Healing room – I Pulan Room
- Overview of GOPI themes: Dr. Iris PrettyPaint, "A Review of the theoretical foundations of cultural resilience, support, and empowerment"
- Storytelling (Jerry Crawford)
- Group structured activity

10:00 a.m. -12:00 p.m. MASTERY

Purpose: To understand how the losses and grief that stem from historical trauma undermine our well-ness today; to let go and release the effects of historical trauma and embrace well ness as a community; to understand that it can be stressful and unhealthy to carry this loss and trauma around; and to recognize the importance of traditional cultural practices in the healing. Mastery is the next important developmental step in an individual's and a community's journey toward the wholeness and balance necessary to address important issues. This day will include a "letting go" and renewal activity. This day is also intended to develop the common community vision and direction necessary to shape the plan around existing resources and stakeholders.

- Introduction to theme
- Storytelling (Toni Ramirez)
- Environmental scan
- Introduction to historical trauma/crisis theory

12:00 p.m. -1:30 p.m. lunch Tiul Dancers

1:30 p.m. – 3:30 p.m. MASTERY continued

- What broke apart our world? What holds our world together?
- Group Breakout Session

3:30 p.m.- 3:45 p.m Break

3:45 p.m. – 5:00 p.m. MASTERY continued

- "Letting Go" candle ceremony
- Music by Santa Teresita Parish Youth Choir: "Go Light Your World."

Be Part of the Change!

DAY 2 July 31, 2013

7:30a.m.- 8:30a.m. **Preparing for the Journey**

- Registration
- Participant check-in
- Photo release forms
- Affirmation activity
- Logistics Overview

8:30a.m. -10:00 a.m. **INTERDEPENDENCE**

Purpose: To experience through activities and stories, the interdependent roles and responsibilities that will help heal and provide positive standards for the future. To help reestablish and maintain the balance necessary to solve common problems, celebrate common achievements, and continue to survive and thrive as a people. This day will conclude with an identification of the major strategic directions for moving forward, forming the framework of the prevention plan.

- Opening Ceremony (Onania Snively}
- Review of day 1/Overview of day 2
- Framework for Planning: JoAnn Kauffman, "Overview of Indigenous Planning and Self-Determination Models"
- Storytelling (Michelle Sasamoto)

10:00 a.m. -12:00 p.m. **Group Breakout Session**

12:00 .m. -1:30 p.m. **Lunch Primitiva Muna**

1:30 .m.- 2:30 m. **GENEROSITY**

Purpose: To recognize as one of the highest values of our Pacific Island cultures is the importance of giving back to others and to the community. To honor the important role of participants who share knowledge to our future generations, and finally, to recognize the many resources residing with in our Pacific Islands that contribute to the overall wellness of the community. Building upon the work conducted on the first day, participants will address the strategic planning for each of the major goals identified.

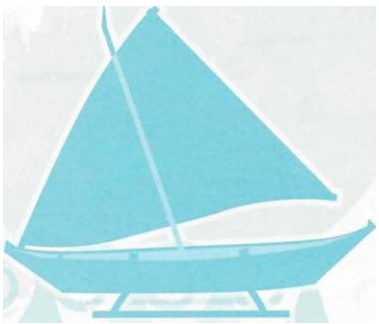
- Participatory Exercise
- Transition to community planning: Words from the community

2:30 .m.- 4:00p.m. **Group Breakout Session**

4:00 .m.- 4:15 .m. **Break**

4:15 .m.- 5:00 .m. **Closing Ceremon beachside**

- Benediction: Pastor Steven McManus and Christian Life Center



GOPEACE Shared Vision for Guam in 2018					
Culture Sensitivity Awareness Values Acceptance Spirituality	**Safety** Personal Public Involvement	**Health** Accessibility Primary Behavioral Choices Affordable	**Infrastructure** Leadership Policies Laws Partnerships Economy Prosperous	**Education** Empowerment Funding Healthy Lifestyle Healthy Relationships	**Environment** Stewardship Sustainability Clean Awareness
Youth Team	**Green Team**	**Blue Team**	**Yellow Team**	**Purple Team**	
Person-to-person safety	Community education and training	Peace begins with me	Kina 'Ole: Culture of unification, culturally healthy community	A safer Guam	
Sustaining our ecosystem	Environmental Stewardship	Safe and clean environment	Environmental awareness and practice	Better and healthier choices	
Improving infrastructure	Safer community	Healthy sustainable future	Community accessibility	Community empowerment	
Improving our economy	Proactive leaders, policies and programs	Healthy relationships and society	Inafa Maolek: To make life better	Effective partnerships	
More public safety	Cultural awareness and acceptance	Community involvement	Safety	Culturally sensitive	
Altering Visa laws		Culture and family values	Affordable and accessible primary and behavioral healthcare	Spiritually connected	
Reviving Guam's culture			Healthy lifestyles		
More funding for school systems			Positive action: **prosperity** for individual, family and community		
Less focus on **technology** and more on real world					

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GOPEACE				
Shared Strategies and Actions for Guam in 2018				
Youth Team	**Green Team**	**Blue Team**	**Yellow Team**	**Purple Team**
Excelling in education	Create and develop a culturally responsive social media plan	Empowering communities to action	Educate and train	Promoting awareness through multi-media
Increasing public transportations availability	Develop an action plan with key stakeholders	Research traditional, best practices	Mobilize "roll out" community and self	Foster and define common identity
Encouraging R^3	Foster community involvement	Seek and secure funding opportunities	Manage resources	Promoting proactive approaches to policy development
Uniting our community	Secure and commit policy leaders	To evaluate and change public policies		Formulating partnerships through networking
Jumping into reality	Enforcement environment campaign	Getting the commitment of leaders and stakeholders		
Creating opportunities	Engage and empower youth	To educate community and ourselves		
Budgeting wisely				
Educating our community				
Reviving cultures				
Taking steps to success				

Youth Team

- **Excelling in education**
  - Better educational system
  - More education
  - Schools
  - Sports
- **Increasing public transportations availability**
  - Make all public transportation reliable
  - Lack of public transportation: funding for more buses and cars!
- **Encouraging R^3**
  - More coastal clean-ups
  - Lack of money: recycle can in schools & box tops – Improve on Sat 10
  - Promote recycling at big events and popular places
  - Trash – by going green, stop littering
  - Sustaining our ecosystem
- **Uniting our community**
  - Uniting the community
  - Finding common grounds
- **Jumping into reality**
  - Decreasing technical distractions
  - Focus on reality
- **Creating opportunities**
  - Establish more businesses
  - More airlines/tourism
  - More job opportunities
- **Budgeting wisely**
  - Adjusting the budget
  - Smarter budgeting
  - Lack of resources: [unreadable] programs
  - Savings accounts
  - Fundraising
  - Positive advertising
  - Give donations
- **Educating our community**
  - Conferences
  - Prevention against negative influences by reaching out to the community
  - Starting an organization that's against negative influences
  - More youth participation
- **Reviving cultures**
  - Accepting other cultures, religions, and beliefs
  - Restoring our culture
  - Revitalizing the culture
  - Promote our culture
- **Taking steps to success**
  - Helping others
  - Lack of initiatives: change of philosophy - by taking initiative – by setting
  - Motivation

Green Team

- **Create and develop a culturally responsive social media plan**
  - Awareness and advertisement; we need to make it know/to share that vision to make people aware of it
  - Multi-language informational brochures

- Execute and implement: advertisement, ed. outreach, sustainability, programs and policies that will be implemented and sustain
- Collaborate with partners to identify culturally relevant education topics and training needs (mass calendar)
- Learn about other cultures
- All cultural awareness and celebrations

- **Develop an action plan with key stakeholders**
  - MOU between healthcare providers
  - To create clear timelines to insure commitment to the work plan
  - Seek funding – seek available funds
  - Commitment to the task – goals – complete
  - Identify target group
  - Have accurate inventory (inventory of resources)
- **Foster community involvement**
  - Village community meetings
  - Townhall (village) meetings – voices are heard by going to the and facilitating conversation – it buys representation
  - Working together with community leaders: mayors, educators, faith-base
  - Conduct outreach
  - Outreach begins w/ me: family, friends, neighbors
- **Secure and commit policy leaders**
  - Leaders attending GOPI
  - Address the policy makers; provide our vision to secure the funding for the resources
  - Enforcement of policies
  - Identify and define legislation, policy changes/improvement needed
  - Positive involvement by island and community leaders
  - Identify the champions community and govt leaders who will comprise a working group to meet monthly to accomplish the work plan
  - Policy makers
- **Enforcement environment campaign**
  - Enforcement of laws – environmental issues…
  - Report illegal activities. Don't be afraid.
  - Be more involved in recycling
- **Engage and empower youth**
  - Youth program partnerships – ex: electric light festival
  - Learn and implement best practices to engage the youth

Blue Team

- **Empowering communities to action**
  - Integrate elements and vision in the organizations in which we work/minister
  - Start/implement more communities outreach programs within the villages
  - Including individuals note: referred to people seeking/receiving services
  - Step one: go back to family, friends, co-workers and share about GOPEACE/vision/experience
  - Step two: Ask them if what they think or if they have any ideas about making Guam a better place
  - Step three: Collaborate – energy, talent, resources to help make the Vision come alive
- **Research traditional, best practices**
  - Research/improve accuracy of data collection and documentation
  - Asking our elders
  - Healing approaches
  - More research on problems: scientist as environment development
  - Construct agencies in the community
  - Students in economics as a division of Peace Corp
  - Historians of wars, as a consultant of Peace
- **Seek and secure funding opportunities**

- Identify and sustain funding sources
- Seek and secure funding sources
- Provide better public transportation
- Funding: identify funds
- Identify cost $
- Financial budget
- Grant writers

- **To evaluate and change public policies**
  - Increase availability of recreational programs to youth
  - Less talk: instead of talking actually do it
  - Policy evaluation
  - Devise a systematic plan (written)
  - Support: getting our island leaders involved
  - 1) a clear and written vision statement
  - 2) bring the vision statement to the people, having them endorse the statement. A petition
  - 3) put the vision statement on a voting ballot for the people to further endorse
  - 4) if ballot is a go, keep our leaders accountable
- **Getting the commitment of leaders and stakeholders**
  - Getting our senators/legislature to commit
  - Form partnerships
  - Community involvement
  - Involve community leaders (public and private)
  - Engaging the community
  - Promote diversity through more island/cultural fairs
  - Community friend: get to know your community
  - Community commitment
- **To educate community and ourselves**
  - Create film production showcasing diverse cultures
  - Youth: connect to young people
  - To have a positive mindset
  - Families: ask for guide, communicate
  - Believe in yourself, you can do it
  - Commitment: better ourselves
  - Be proactive rather than reactive
  - Open a One Stop Center to link people to resources on island
  - You: be aware
  - Provide more outreach in community – ex. Vaccines, health check-ups
  - Renewed, regained
  - Promote public awareness
  - Educational approaches/ outreach
  - Educate our youth – implement curriculum

Yellow Team

- **Educate and train**
  - Read the bible
  - Activities: conference and training
  - Finding other ways of communication
  - Training/guidance
  - Translation; reaching and understanding
  - Translators/interpreters: form an organization; train them professionally; pay them adequatly
  - Linguistically appropriate promotions
  - Advice from man'amko (elderly)
  - Increase awareness
  - Influence

- Provide education/awareness of the vision
- Career-education: bring job fairs to the various (villages, schools, public centers); inform students about their options
- Safety and emergency training

➢ **Mobilize "roll out" community and self**
- Cooperate and collaborate
- Youth groups to be involved in the community
- Allow for more public input
- Getting the team together and all meeting together on date and time set every time
- Outreach to educate and promote awareness
- Community initiations
- Community base (working together to make a difference)
- Coming to the level of the community
- Community involvement
- Volunteers
- Enlist
- Outreach
- Start at home
- Network collaboration (feds/govt)
- Outreach
- Motivate
- Engage
- Initiate – penetrate: address each individual community; get them educated – communicate – educate – motivate
- Ignite
- Lead and follow
- Open minded
- Taking initiative

➢ **Manage resources**
- Strategies: Planning group of different agencies and cultural/ethnic groups; commitment; communication
- Better and healthier choices
- Conserve before GPA serves your power bill
- Local farmers market
- Proper planning with gov. agencies
- Initiates: legislative involvement; legislature implementation of laws addressing obstacles; implement activities that promote awareness
- Govt leaders buy-in
- Accountability
- Define!!
- Accountability
- Money management "less anger management"
- Free health care
- Provide funding/resources
- Financial needs are the major obstacle in pursuing the goal. Money
- Being smarter and more efficient with money (accountability)
- Funding resources
- Money, finance

Purple Team

➢ **Promoting awareness through multi-media**
- Develop public information to reach all ages and segments of the community to promote collaboration
- Create a multi component media campaign
- Using social media to promote initiatives – "like", share, twitter, etc.
- Offer public awareness and education/finance

- Delegating responsible leader (role model) to oversee

- **Foster and define common identity**
  - Promote a stronger sense of island/community identity
  - Self-reflect. What do you believe?
  - Respect and embrace cultural diversity
- **Promoting proactive approaches to policy development**
  - Persuade legislature to create healthy policies
  - Creating a community "watch group" to monitor good governance!
  - Form neighborhood watches
  - System to monitor student progress and teacher effectiveness
  - Promote recycling w/ incentives that we can put in place
  - Leadership interested in generations economic growth for all citizens not special interest
  - Implement mental health and high risk activity screeners in schools, clinics, DPH, etc.
  - Develop natural resources – fishing, farming, etc.
  - Educate those from outer islands about Guam laws
  - Advocating: policy makers for effective partnerships
- **Formulating partnerships through networking**
  - Design a program where all ages and generations will exchange information about their different and shared values
  - Facilitate small groups (listen + educate)
  - Make outreaches to reach out to the community and educate them on healthy choices
  - Collaboration across the community
  - Strengthening and healing of families(basic unit of a community)
  - Conduct village outreach/townhall meetings to educate stakeholders
  - Strengthening communities through education
  - Partner with church groups and a faith-based organization
  - Organize faith-based committee
  - Townhall meetings, assemble
  - Collaborate w/ community partners to create culturally sensitive media and promotions
  - Building initiatives: schools, churches, families
  - More collaboration within the community
  - Start community gardens
  - Outreach (schools, malls)
  - Reach families members (through family functions)
  - Cross-cultural education
  - Partners with schools and promote making the right choices
  - Educational funding targeted to direct activities in the school classroom
  - Arrange a mentoring program between younger and older persons and between islands
  - Avoid stereotyping and improve communication/cooperation
  - Encourage the development of youth policing
  - Increase youth involvement
  - Empower youth to become more engage in positive community activities
  - Empower youth
  - Promote activities where everyone collaborates for the common good/benefit, i.e. Inafa' Maolek
  - Form a community of human services providers
  - Increase workforce development/training opportunities and encourage education
  - Partner with the NCD consortium (Aug 9, 2013: Nikko Hotel)

Gathering Of Pacific Islanders for PEACE
GOPEACE
JULY 30 – 31, 2013

July 30 – Day One

BELONGING (Plenary Session)

Activity #1
A group structured activity was held at 10:00am. Each table had a large piece of paper, marked "Shared Values". Each table was asked to talk among themselves as follows:

- Introduce each other
- Discussed the values that you all shared when it comes to planning for the prevention of suicide, youth violence, substance abuse and improved mental health. What are your values?
- Make a list of the shared values that bring to the PEACE collaborative process
    - ***Activity Results***

1. Identity
2. Culture
3. Life
4. Respect
5. Prayer for elders and others
6. Hard work
7. Motivation
8. Problem solving
9. Bonding with relationship
10. Peace of mind
11. Family
12. Children
13. Independence
14. Compassion
15. Empathy
16. Support
17. Accountability
18. Heritage
19. Meditation
20. Education
21. Love
22. Faith
23. Hope
24. Community
25. Sobriety
26. Spiritual beliefs
27. Self-respect
28. Honor
29. Courage
30. Freedom of self-rights
31. Thankfulness
32. Culture identity
106. Understanding
107. Family cultural
108. Careers
109. Knowledge
110. Innocence
111. Freedom
112. Generosity
113. Opportunities
114. Hospitality
115. Peace
116. Human race
117. Leaders
118. Laws and morals
119. Determined
120. Young
121. Smart
122. Funny
123. Weird
124. Creative
125. Spontaneous
126. Dancers
127. Understandable
128. Responsible
129. Mature
130. Artistic
131. Authentic
132. Peaceful
133. Loving
134. Caring
135. Sweet & sour
136. Community helpers
137. Social

33. Trust / communication all = success
34. Financial responsibility
35. Healthcare for self & family/sustenance
36. Patience
37. Bonding
38. Persistence in doing good
39. Suicide – free /alcohol free or free of addiction
40. Acceptance
41. Understanding
42. Communication
43. Commitment
44. Advocacy
45. Encouragement
46. Forgiveness
47. unconditional support
48. Self-care
49. Self-dignity
50. Self-worth & enrichment
51. Self-understanding
52. Love for self
53. Laughter
54. Joy
55. Interaction
56. Service & volunteerism outreach
57. Discipline / respect for nature, environment
58. Prevention of avoidable crisis disasters
59. resilience
60. others
61. time
62. honesty
63. loyalty
64. Jobs, vision
65. Resiliency
66. Mutual Understanding
67. Empathy religion / spirituality
68. diversity
69. self- compassion
70. Genuineness / prayer
71. Sharing
72. Believe in God
73. Health
74. Dream
138. Singers
139. Hard workers
140. Diverse
141. Individuality
142. Freedom
143. Senses
144. Surroundings
145. Being an advocate
146. Leadership
147. Ourselves
148. Civil rights
149. Cultural sensitivity
150. Family values
151. Mutual respect among communities
152. Understanding & empathy for those who are suffering
153. Happiness
154. Sharing
155. Courage to take a stand
156. Transportation
157. Chances
158. Ability
159. Endurance to keep going
160. Shared Commitment
161. Language
162. Our land/ sea
163. Religion / believe in God
164. Our knowledge
165. Our history
166. Money
167. Grief / happiness
168. Positive energy
169. Open mindedness
170. empathy
171. Integrity
172. Courage
173. Sense of spirituality
174. perseverance
175. Responsibility
176. Humility
177. Perseverance
178. Endurance
179. Understanding
180. coping
181. humility
182. consideration
183. generosity

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75. Earth trust
76. Team-work
77. Homes
78. Equality
79. Food
80. God
81. Helpful
82. Kindness
83. Non-judgmental
84. Positivity
85. Knowledge
86. Forgiving
87. Individual
88. ethnicity
89. Religion
90. Choices: healthy, freedom, partners, who to love, friendship, etc.
91. Prevention
92. Collaboration / partnerships
93. peace
94. We believe in GOPI
95. Unity
96. Recovery
97. Support
98. Thoughtful
99. helpful
100. Friendship
101. Mind over matter (overcome)
102. Mind open
103. Harmony
104. Cooperation
105. Coherence
184. spirituality
185. follow through
186. showing up (integrity)
187. belonging (humanistic)
188. substance
189. wisdom
190. Families
191. Empowered
192. Generosity
193. Peace
194. Endurance
195. Growth
196. Collaboration
197. Sharing
198. Listening
199. Belonging
200. Put it in action
201. Church
202. Willingness to change
203. Responsibility
204. Business
205. Communities
206. Neighbor
207. Talent
208. Service
209. Abilities
210. Integrity
211. Gratefulness
212. Language
213. Courage
214. Generosity
215. Our island
216. Creativity
217. Ideas
218. Our stories
219. Value of each one of us
220. Racial
221. Appreciation (life, beauty, uniqueness, talents, weakness)

MASTERY (Plenary Session)

Activity #2
A group structured activity was held at 11:00am that asked participants at their tables to speak with each other to identify 3 main topics. Two large pieces of paper was placed each table. On one was split

in half and on each half was titled “What broke apart our world?” and “What holds our world together?” and the last paper was titled “Current trends (External and Internal)”. Each table will be asked to talk among themselves as follows:

- Historical Trauma and Other risks: What broke apart our world? Protective Factors and Resilience: What keeps our world strong and together?
    - ***Activity Results:***

What broke apart our world?	**What holds our world together?**
• Violence • Racism • Ignorance • Lack of respect • Drugs/alcohol • Pride • Disconnected with God • Poverty • Low self-esteem • Illness • Legal Issues • Domestic violence • Drugs/alcohol • Death • Discrimination • Heart breaks • Cyberbullying • Gossip • Selfishness • Wars Violence • Conflict • Senior-citizen abuse • Family abuse • Death, sickness, suicide, tragedy • Addictions (drugs, alcohol, etc.) • Hatred (racism, sexism, profiling, labeling) • Prejudice • Religion • Drugs/alcohol • Suicide/murder • History • Covenants • Cultural changes • Domineering/bullying • Hate • Rape/molestation • Misunderstanding	• Family • Faith • Friends • Hope • Values/beliefs • Peace • Love • Respect • Charities • Our children • Culture • Experiences • Supporters • Group Organizations • Love • Hope • Faith • “I’m gonna make a change, gonna make a difference” • Respecting others • Trust • Share/help one other • Patience • Culture • Being spiritual/religious • Resilience (courage) • Acceptance of each other, of our problems • Faith • Love • Hope • Talking openly about your brokenness (transparency) • Compassion • Meditation • A sense of community, belonging • Expression • Being focused

• Selfishness • Disobedience • Failures • Poverty • Absence of shared values • Colonization • Fragmentation of family, community • Absence of faith • Denial of mental illness, self-worth, historical family dysfunction • Loss of personal power • Intolerance • Anger • Non-communication • Jealousy • Greed • Lies/deceit • Ignorance • Stealing • Technology • Media • Lack of communication • Lack of faith • Government • Breaking down in family system • War • Conflict • Envy • Discrimination • Religion • Greed • Miscommunication • Misunderstanding • Status • Hatred • Power • Racism • Law • Revenge • Culture • Gender • Colonialism • Language • Crisis • Drugs/alcohol • Peer pressure	• Music • Healthy pride/self-image • Restoring identity • Perseverance • Sustaining shared values • Faith • Hope and love • Respect • Trials and tribulations • Peace • Love • Happiness • Faithfulness • Honesty • Getting Along • Communication • Gentleness • Technology • Communication • Onania's laugh • Have faith • GOPEACE conference • Connected to a group • Love • Respect • Peace • Trust • Culture (embrace!) • Belief • Family/friends • Understanding • Communication • Forgiveness • Acceptance • Cooperation • Honesty • Life, living, loving • Holidays • Celebrations • Fiestas • Parties • Weddings • Crisis • Funeral • Education • Community activities

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• Ignorance • Lack of information • Greed • Pride • Cultural loss • Racism • Lust • Anger • Jealousy • Power/control • Poverty • Substance abuse • Morals/values • Communication • Knowledge • Money • Fear of the unknown • War • Greed • Miscommunication • Changing in society • Reaction • Peer pressure • Outside cultures' influences • No consideration of circumstances • Selfishness • Hate • Hate • War • Ownership • Racism • Isolation • Abuse • Violence • Lack of communication • Judgments • Power • Money/greed • Racism • Segregation • Hatred • Attitude • Pride • Jealousy/deceit • Economy/cost of living • Bitterness	• Relationships • Love • Forgiveness • Acceptance • Compassion • Sharing • Thoughtfulness • Morals/values • Unity • Education • Faith • Communication • Sport/advocacy • Knowledge • Money • Willingness • Hope • Education • Learning to forgive • Sharing, helping others • Understanding differences • Learning to adapt • Learn to be proactive • Making right choices • Appreciation of our own culture and learning about other cultures • Think and be open-minded • Respecting others • Love • Love • Compassion • PEACE • Empathy • Humanity • Justice • Harmony • Unity • Faith • Peace • Love • Happiness • Obedience • Communication • Responsibilities • Respect • Strength

• Evils • Substance abuse • Loss of religion • Lack of communication • Disrespect • Rebellion • Gossip • Family orientation • A hope for a better future • Hope for our children's future • Equality between one another • The pursuit of happiness • Good influence • Good communication • Understanding each other • Cultural understanding • Respecting each other's feelings • Unity • Avoiding violence • Successful goons • Bravery • Sexual abuse • Substance abuse • Rejection • Disrespect • Violence • Prejudice/discrimination • Ignorance • Instability • Power/greed • Loss of love/vision • Broken families/homes • Discrimination • Abandonment/neglect • Abuse • Drugs/alcohol/tobacco • Infidelity • Crime/jailtime • Financial challenges • Poverty • Stigma of mental illness • Lack of healthcare services • Illness/disease • Never acknowledged • Too much pride • Emotional distress	• Courage • Shame/learn and respect cultures • Listening • Trust • Faith/beliefs • Loyalty • Positive organization skills/practices • War • Racism • Pollution • Inequality • Greed • Crime • Alcohol abuse • Suicide • No communication • Distrust • Cultural understanding • Segregation • Drug abuse • Vision • Hope • Recovery • Prayer/faith • Restoration • Resilience • Rehabilitation • Family/friends • Knowledge/education • Peace • Support system • Willing to accept differences • Forgiveness/love • Customs • Traditions • Cultural beliefs • Hope • Faith • Love Trust • Familia • Support • Acceptance • Respect • Pride • Honor • Selflessness

• Rigidity • Joblessness • Isolation • Complacency • Change • War • Hatred • Indifference • Lack of forgiveness • Pride • Superiority • Grudge • Lack of trust • Suspicion • Prejudice • Misunderstanding of religious beliefs; celebrating faith • Greed • Selfishness • Miscommunication • Closed mindedness • Apathy • Dictatorship • Colonization • Greed • Money • Power • Political System • Temptation • Pride • Ethnic diversity • Disease • Racism • Prejudice • Substance Abuse • Drugs/alcohol • Devil/demon • Different religion • Poverty • Divorce • Loss of a loved one • Drugs/alcohol • Hatred • Racism • Disrespect • Confusion	• Generosity • Church • Food/clothing/shelter • Volunteer • Charity • Government/laws • Compassion • Actions • Forgiveness • Education • Contentment • Growth • Family • Love • Understanding • Acceptance • Empathy • Trust • Forgiveness • Humility • Equality • Generosity • Communication • Openness to healing • Respect • Morals/values • Selfishness • Strong; collaborative leadership • Engagement (honest) • God/Love • Respect • Family/friends • Collaboration/unity • Selflessness • Acceptance • Tolerance • Forgiveness • Obedience • Communication • Laughter • Resilience • Compassion • Good health • Jesus • Hope • Faith

• Violence • Selfishness	• Purpose • Acceptance • Peace • Love • Experience • Positivity • Faith • Family • Friends • Communication • Sobriety • Forgiveness • Love • Respect • Food • Activities • Acceptance

- Current Trends: List current trends or factors impacting our community from within (Internal) and from outside (External)
    - ***Activity Results:***

INTERNAL	EXTERNAL
▪ Loss (family, friends) ▪ Confused (drama) ▪ Stress (work, school, family) ▪ Drugs (coping) ▪ Relationship (cheating) ▪ High blood pressure ▪ Anger management ▪ Argument ▪ Suicide ▪ Hormones ▪ Diseases ▪ Hungry ▪ Military ▪ Traditional trend ▪ Chamorro language in school ▪ Community famer ▪ Texting universal ▪ Domestic violence ▪ This GOPEACE movement ▪ Cultural/social revival ▪ Sustained traditions (*fiestas, funeral/* ▪ *rosaries, the community based* ▪ *identity*) ▪ Re-evaluating our views toward all members of the community (*pacific*	▪ Domestic violence ▪ Pollution of land ▪ National violence ▪ Pollution of air ▪ Community disagreements (riots) ▪ Pollution of water ▪ Government issues ▪ Domestic issues (bills, taxes, etc) ▪ Technology ▪ Military ▪ Modernization ▪ Monopoly ▪ Social Media (facebook) ▪ Impact of video games ▪ Magazine ▪ Close caption in movie ▪ Globalization / western culture (*fashion* ▪ *identity, music, social influence a* ▪ *stylized way of life*) Being “colonized” (*a sense of* ▪ *voicelessness, an uncontrolled* ▪ *destiny*) Tourism (*are we more than just one* ▪ *massive beach resort/ shopping* ▪ *center*)

▪ *islanders, state siders, military, immigrants, etc.*) ▪ Rallying together to peacefully discuss differences ▪ Mental disorders ▪ Substance abuse ▪ Peer pressure ▪ Stress ▪ Depression ▪ Hatred ▪ Rejection ▪ Prejudice / racism ▪ Social networking ▪ Gangs ▪ Violence / war ▪ Culture ▪ Addictions (alcohol, drugs, gambling) ▪ Religious beliefs ▪ Prevention ▪ Post-vention ▪ Intervention ▪ Collaborating by networking with all service/ providers ▪ DO SOMETHING ▪ Make a difference ▪ Hotline crisis ▪ Recovery ▪ Disability ▪ Therapy (individual) ▪ Psycho-education ▪ Culture adaptation (acceptance, tolerance) ▪ Growing economy ▪ Higher cost of living ▪ Increased diversity ▪ Religious structure (struggle) ▪ Parenting ▪ Family structure ▪ New laws for Guam ▪ Suicide ▪ Family loss ▪ Neighborhood watch ▪ Accidents ▪ Substance abuse ▪ Curfew ▪ Legislation ▪ Disrespect of others ▪ Personal cultural ▪ Indifferences with generation	▪ Alcoholism ▪ Domestic violence ▪ Bullying ▪ Child abuse / neglect ▪ C.S.C ▪ Social networking ▪ Violence / war ▪ Religious beliefs ▪ International laws ▪ Hurt people hurt people ▪ Trauma- global (*we all experience in* ▪ *some ways no matter what our cultures* ▪ *are)* ▪ abortion ▪ identity ▪ abuse (substance & alcohol) ▪ crime ▪ transition ▪ Technology ▪ Transportation ▪ Public laws (local, federal) ▪ Military buildup ▪ Other cultures ▪ Increased awareness of social “taboo” issues ▪ Migration ▪ Perceptions ▪ Change ▪ wars ▪ famine ▪ economy ▪ gas prices/ cost of living ▪ social media (facebook, instagram, twitter, path, youtube) ▪ crime rates ▪ natural disasters ▪ War ▪ Crime ▪ Cultural indifferences ▪ Government ▪ Technology ▪ Social demands ▪ Drugs and alcohol ▪ Personal interaction ▪ Internet ▪ Peers ▪ Economy ▪ Migration (adjusting, assimilating)

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▪ Family values ▪ Faith & beliefs ▪ Internet ▪ Siblings ▪ Family income ▪ Chamorro values of respect for elders decreasing ▪ Financial ▪ Lack of access to health care ▪ Labeling based on economic status ▪ Graffiti ▪ Robbery ▪ Drugs/ alcohol ▪ No respect ▪ Too many wild (boonie) dogs loose ▪ Too many road ragers ▪ No community involvement ▪ No spirituality ▪ No neighbor interaction ▪ More community get togethers (major getting involved) ▪ Regular or quarterly meeting with Governor ▪ Deterioration of family values ▪ Traditions loss of a sense of community ▪ Fences / doors ▪ Gangs ▪ Communication ▪ Gambling ▪ Vandalism moderation ▪ Loss of culture ▪ Loss of time and quality time ▪ Commitment ▪ Loss of faith/ identity ▪ Conveniences ▪ Reduce, reuse, recycle ▪ Patience (instant gratification) ▪ Family violence ▪ Pride ▪ Status ▪ Government corruptions (misuse of funds, technical malversation of funds) ▪ Abuse of power ▪ Politics (its whom you know not what you know) ▪ Labeling /judgmental ▪ Negativeness (divorce, suicide, addiction, etc)	▪ Global war ▪ Job loss ▪ Judgmental ▪ Robbery ▪ Fiestas ▪ Drugs/alcohol ▪ No respect ▪ Too many road ragers ▪ No community involvement ▪ No spirituality ▪ No neighbor interaction ▪ More community get togethers (majors getting involved) ▪ Cost of living ▪ Sequestration ▪ Fashion ▪ Racial differences ▪ Economic status ▪ Disrespect of Environment (Rhino Beetle) ▪ Technology ▪ War ▪ Drugs/alcohol/guns ▪ Oil/gas ▪ Music/media/pop culture ▪ Respect ▪ Identity loss ▪ Conflicts in other countries war, terrorism, shootings ▪ Military deployments ▪ “snowden” scandal ▪ Economic global/ financial issues ▪ Same sex marriage ▪ Health system reform ▪ Illegal immigrants ▪ Migration ▪ Promiscuity ▪ Drug dealing ▪ Society is changing ▪ Technology ▪ Kids being disrespectful ▪ Bullying (cyber) ▪ Young kid become parents more and more ▪ Military influence (land & economically) ▪ Drug abuse ▪ Internet (facebook, tumbler, instagram, kik, myspace) ▪ Gangs ▪ TV

▪ Positiveness (peace coalition, church involvement, people willing to change) ▪ Mistreatment of others ▪ Judgment ▪ Misunderstanding ▪ Family breaking down ▪ Western influence (kids following, their favorite movie stars, what they watch on TV.) ▪ Crimes (CSC) ▪ Church ▪ Schools ▪ Family ▪ Friends ▪ Mentors ▪ Our entire environment ▪ Depression ▪ Peers ▪ Culture ▪ Fiesta ▪ Disobedience ▪ Obedience ▪ Poor modeling ▪ Judgmental ▪ Go green ▪ Technology/ social networks ▪ Drugs ▪ Behavior ▪ Sexuality ▪ Cultural empowerment ▪ Women empowerment ▪ Loss of control ▪ Loss of community ▪ Loss of traditions (sense of) ▪ Loss of identity ▪ Pressure in family system ▪ Economic union (family) ▪ Loss of personal sense of safety ▪ Increase in utility bills ▪ Increased cost of living ▪ Self over community ▪ Violence ▪ Recreation ▪ Parties ▪ Politics ▪ Media ▪ Peers ▪ Isolation	▪ Music ▪ Cyberbully (general) ▪ Domestic violence ▪ Divorce ▪ Selfishness ▪ Corruption ▪ Greed ▪ Bad websites ▪ Alcohol ▪ Commercialism ▪ Drop outs ▪ Technology / social networks (youtube) ▪ Outreach programs ▪ Executive laws & policy ▪ Media ▪ International conflict ▪ Drugs ▪ Sexuality ▪ Research ▪ Women empowerment ▪ Military buildup ▪ Open system/open door policy ▪ Media & technology ▪ Migration ▪ Sense of journey/ nomadic ▪ Crime (worldwide) ▪ Climate change ▪ Competitive rivalry ▪ Objectification of humanity ▪ Procreation ▪ media (music & movies) ▪ technology (games such as angry birds & internet) ▪ Technology ▪ 'western' ideals / influence ▪ Consumerism ▪ Tourism ▪ Entertainment ▪ Convenience ▪ Poverty/ decrease economy ▪ Drugs ▪ Social networking ▪ Cultural diversity ▪ Lack of funding ▪ Terrorism ▪ Global economy decreasing ▪ Fed money cut backs ▪ Marriage equality

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▪ Teen pregnancy ▪ Lack of education ▪ Gambling ▪ Government assistance / dependency ▪ Loss of cultural identity ▪ Fast food ▪ Crime increase ▪ Drug use (marijuana, ice) ▪ Increase incarceration ▪ Joblessness ▪ Bullying ▪ High school drop outs ▪ Drunk driving ▪ Social acceptance ▪ Tolerance ▪ Sports/ hobbies ▪ Outreach ▪ Teen pregnancy ▪ Substance abuse ▪ Economy ▪ Pollution ▪ Cultural (language, values, respect, marriage) ▪ Effects of war ▪ Increase in community ▪ Awareness of social problems ▪ Break down of extended family support ▪ Changing in social community movies	▪ Teen pregnancy ▪ Substance abuse ▪ Economy ▪ Pollution ▪ Cultural (outside influence) ▪ Effects of war ▪ Military buildup ▪ Diversity ▪ Internet ▪ Inculturization ▪ Human trafficking ▪ Globalization ▪ Dependence on technology ▪ Colonization ▪ Immigration ▪ Global economics

July 31 – Day Two

INTERDEPENDENCE (Plenary Session)

Activity #3

1. What are the challenges, obstacles or contradictions that stand between us and our vision?
2. What must we overcome or address in order to move closer to our vision?

Obstacles	Overcome
• Drug addictions/alcohol • Money • Education/training • Acceptance to change • Lack of support • Lack of desire/commitment • Lifestyle/social challenges	• Racism • Pride • Stigma • Fear • Closer family support • Selfishness • Effort/determination

• Time management • Corruption within the community (everyone working towards our goal) • Policy makers – to reinforce and maximize efforts/vision • Budget/funding • Collaboration between state and federal (sharing is caring) • Self initiative/commitment • Preserving/,maintain our natural environment • Language barrier – communication • Cultural differences • Laws (amendments) • Funding • More motivation/commitment • Community partnership • Lack of free health/wellness facilities • Education of cultures (all) • Funding • Management of resources • Technical malservation of funds • No accountability • Repeating/following “trends” • “I don’t care” attitude • Behavior patterns • Unity in mind/perspectives • Cultural diversity • Funding • Economic sustainability • Good/reliable leadership • Differences in faith • ASL in the education system • Employment philosophy/special education • Financial/funding • More skilled sign language interpreters (ex: 3 interpreters to 6 for ASL/Deaf/HH students) • Deaf sports • People being true to their words/commitment • Fixed mindset • Complacency • Lack of awareness (resources) financial/human	• Intuitive • Root cause = lack of respect • Good and better financial planning • Hones and good policy makers • Think “out of the box” and re-assess what we really need • Activities/deaf socials • Funding/fundraising • Check out facilities that are ADA approved for the deaf • GCC classes to support more elementary schools/DHH • Education/empowering Buy in of ownership Personal conversion • Community invitation/engagement • Networking Establishing relationships Social marketing (culturally appropriate and competent) • Diverse outreach program • Be really dedicated and show real motivation to achieve that vision, goal and objective • Be a real pioneer to your own community for our next generation of youth to follow and to continue the good examples in order to maintain the expected vision for the year 2018 • Reflect and always focus on the spirituality that will make our conscience more aware of ourselves in order to achieve that vision • Follow the set timeframe and deadline to act on the plan without any delay •

• Racism/discrimination (local turf rights) • Perception of scarcity insecurities->hoarding • Access to quality healthcare • Prejudice • Religious belief • Disagreement with our world leaders • Great depression • Broken peace treaty with other nations • Stereotyping • Funding problems • Money/financials • Age • Education (lack of) • Family beliefs • Community support • Communication barrier • Governmental block • The roots beyond our vision • Finances/E • Language barrier • Politics • Capitalism • Cultural differences • Need more stakeholders input • Lack of commitment • Lack capacity • Lack of awareness • Buy-in (lack, weak) • Lack of community involvement • Ethnic perceptions (ie: values, traditions) • Religious beliefs • War • Racism • Political ideologies • Pride • Close-mindedness • Apathy • People (women) are overwhelmed (gender roles) • Colonial mentality (ex. Stateside mentality) • Dependence on U.S. military	

• Our history • Modernization/pop culture • Government policies (leadership) • Selfishness • Greed • Laziness/couch potato • Close-mindedness • Low socio-economic • Procrastination • Insecure • Lack of planning • Bullying • Low-self esteem • Negative energy • Lack of communication • Indifference • Arrogance • Conflicting interest • No pride • Division • No community recourses • No vision • No money • Politics • Lack of training • Funding, poor planning for a prosperous and effective infrastructure • Overdevelopment • Funding for quality education • Ignorance • Funding for health and wellness • Lack of time • Difficulty retaining • Lack of resources • High cost food/healthcare • Ignorance of other cultures • Intolerance • Pride • Language barriers • Segregation • Stereotypes • Financial status • Passing the buck • Complacent • Inaction	

• Lack of community involvement • Fear of unknown/success • Sequestration/budget cuts • Lack of new leadership • Acknowledging the problem • Procrastination • Apathy • Transportation • Affordable childcare • Communication barriers • Competing agendas/priorities • Jealousy/selfishness • Coming to terms with everyone's perspective • FOU complacency with how things are done • Lack of belief in self-determination • Teaching people to help themselves	

GENEROSITY (Breakout Session)

Activity #4

In this session the facilitators asked the following questions. Responses were recorded as follows:

- **Who needs to be involved in the PEACE planning process?**
  - Adults/Parents
  - Youth/Young Adults
  - People who have gone through troubles
  - Manamko
  - Children
  - Those incarcerated (youth and adults)
  - Victims of crime
  - Other organization
  - Grass roots
  - Church
  - Migrants
  - Policy Makers
  - Experts/researchers/consultants
  - Businesses
  - Educators
  - Mayors
  - Teachers
  - Private
  - Non-profit
  - Statisticians
  - People with disabilities
  - Performers/entertainers
  - Judicial Branch

- Environmentalists/EPA
- Cultural groups
- Military
- Sport steams
- RAWR
- Farmers/fishermen
- Home makers
- Doctors/nurses
- Insurance Companies
- Foreign aid/investors
- Sainas (Elders/Community Leaders)
- Mayors' Council
- Youth (DYA)
- Governor
- Other Faith Based Organizations
- Survivors of Suicide (Immediate and extended secondary)
- Business Community
- Rotary/chamber/HRA
- Legislators
- Leaders of other islands consulates
- Financial Institutions
- Professional associations
- People receiving services
- Youth
- Parents
- Cops/law enforcement
- Sponsorship
- Counselors
- Uneducated people
- Different organizations
- Government officials/governor (hopefully Obama)
- Teachers
- Priests/pastors/bishops
- Media
- Military officials
- Employers
- G.V.B.
- Senior citizens
- Health processionals
- Guam Medical Society
- Parent groups
- Soroptimist
- Rotary clubs
- GBHWC
- Human service providers
- Low cost housing association
- Fisherman's co-op
- I-recycle

- GAIN
- Rev and Tax
- All schools
- Asians and pacific groups
- Mayors council
- Non-governmental organizations (NGOs)
- NCD
- Consulate offices
- Stakeholders
- Faith based groups
- Policy makers
- Center for Micronesian empowerment
- Law enforcement
- 3 branches of government
- FSM community care
- Businesses/chamber of commerce
- Military
- Youth
- Local and federal
- Policy makers, elected leaders, community leaders
- Youth
- Families
- NPOs
- Support Groups
- Advocates
- Military
- GHURA
- Schools
- Health Care Providers
- Faith-based Organizations
- Insurance companies
- Mayors Council
- PEACE
- Parents
- Teachers
- Counselors
- Senior Citizen Community
- Business Owners
- Government Agencies and Heads
- Tourism – GHRA, GVB
- DOE
- Private Schools
- DODEA
- DPW
- Guam Mass Transit
- UOG and GCC students
- GMH
- Judiciary

- **How will we know if we are succeeding? How can we tell?**
  - Statistics (pre and post surveys)
  - Home, clothes
  - Basic necessities
  - 10 people in prison/no prisons
  - When people take action on their own and share it
  - Crises almost never happen and handle it
  - High school graduations increase
  - Medical services are FREE
  - More celebrations!
  - Everyone respects each other
  - More exercising
  - Number of clients goes down
  - People are seeking/receiving more services
  - Less discrimination (see/hear about it less often and be able to address it)
  - Less pollution
  - Evaluations (evaluate and report back to community)
  - Celebration
  - Visual symbol of where we came from and where we're at
  - Numbers
  - Loop information back to participants
  - Monitoring and evaluation
  - Determine outcomes
  - Crime rate
  - Feedback from community
  - Feels like Christmas
  - Newsletter/GOPI FB
  - Make the news (not be the news)
  - Use technology for communication and sharing
  - Organizational chart (circles)
  - Streamlining coalitions/board
  - Get info/feedback back to community
  - Future scheduled meetings
  - Consistent participation
  - Follow up meeting with GOPI participants
  - Referrals/recruitment of participants
  - Community involvement and volunteer
  - Create an endowment
  - Cleaner Island
  - Decrease in homelessness
  - Improved and reliable public transportation
  - Attitude/Lifestyle changes
  - No more 6 o'clock bad news
  - Increased availability of resources
  - Economic improvement
  - Increased graduation rate
  - Changes in policy and budget allotment
  - Improved infrastructure

- Ask target audience
- Data
- Surveys (Pre and Post)
- Focus Groups
- Reduction of Crime
- Decrease in deaths
- Improved student performance
- Service utilization data
- Less fighting amongst ethnic groups
- Island outlook improvement
- Campaign Implementation

- **What can I do as an individual to put this in place?**
  - Get family involved
  - Volunteer time, talent, treasure
  - Educate self and others
  - Empower everyone towards involvement
  - Social media to spread awareness
  - Recruit people to be involved
  - Dissemination of celebration
  - Positive reinforcement
  - Community advocates
  - Organizations provide incentives
  - Trainings/conferences
  - Update contact info
  - Surveys
  - Facebook
  - Monthly Community Organization Gathering
  - Talk and spread word
  - Take initiative
  - Participant list sharing
  - Commit to stay connected
  - Keep each other accountable
  - Be a good neighbor
  - Social networking
  - "I am part of the change"
  - Take Responsibility
  - Listen
  - Survey
  - Community needs assessment
  - Focus groups
  - Outreach
  - S.W.A.T.
  - Creation of an action plan
  - S.E.O.W.
  - Data Driven
  - Progressive results

- Volunteering/participating in activities
- Attending more workshops
- Letters to people in power/petitioning
- Just say no (to drugs and alcohol)
- Being a positive role model
- Donating/participate in fundraising/comfort others
- Practice effective communication
- Cooperate with others
- Practice the P's
- Plant and garden more
- Be key training
- Take part in sports/school activities
- Start school fundraising/respect school property
- Start a youth club
- Take initiative instead of waiting around
- Participate, get involved
- Stay committed
- Spread the word
- Grade-level/school presentations
- Advertisement
- Sponsorship
- Campaigns
- Share resources
- Motivate and encourage others
- Open-mindedness
- Acknowledgment
- Be responsible
- Set examples
- Workforce training and In-services
- Revisiting Processes/Programs
- Get personal (sharing your experience)

GUAM State Epidemiological Outcomes Workgroup Charter
(Guam SEOW)

Article I: Name

Section 1. This entity shall be known as the "Guam State Epidemiological Outcomes Workgroup" or "Guam SEOW."

Article II: Mission Statement, Principles and Purposes/Functions

Section 1. Mission Statement

The Mission of the GUAM SEOW is to promote the strategic use and dissemination of data for informing and guiding Guam's substance abuse prevention and behavioral health promotion policy and program development, decision-making, resource allocation and capacity building.

Section 2. Guiding Principles

The Guam SEOW operates around 5 guiding principles:

A. Using evidence for action – The Guam SEOW intends to use epidemiological and other data as the foundation for outcomes-based prevention, linking evidence to policy and program action to prevent and reduce substance abuse and promote mental health.
B. Promoting a people and community-centered approach to prevention – We support a public health approach to substance abuse prevention and mental health promotion, which prioritizes the needs of our community and people.
C. Ensuring cultural competence – Our work will be conducted in a manner that is consistently respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of our multicultural island community and in compliance with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.
D. Focused on reducing inequities – We acknowledge that social determinants such as race, ethnicity, gender and economic status can influence differential health outcomes relative to substance abuse and mental illness. When conducting our work, we will consider social determinants of health in our data collection and analysis to better understand their impact on substance abuse and behavioral health and to guide program planning and decision making so that interventions address both the health issues and the underlying social inequities.
E. Fostering intersectoral collaboration and partnerships – We will continue to work across sectors and in partnership with the diverse prevention stakeholders and the general community, valuing community participation in the SEOW process and supporting the community to attain better health.

Section 3. The purposes/functions of the Guam SEOW are as follows:

A. Systematically collate and analyze relevant data (including but not limited to consumption and consequences of alcohol, tobacco, and other drug (ATOD) use, and risk and protective factors for mental health) to delineate and better understand the magnitude and nature of substance abuse and mental illness on Guam and to effectively and efficiently utilize resources for substance abuse prevention and behavioral health promotion
B. Promote data-driven decision making across all stages of the Strategic Prevention Framework throughout the State substance use prevention and mental health system
C. Strengthen and build capacity and data infrastructure for effective data utilization for substance abuse prevention and behavioral health promotion
D. Facilitate interagency and community collaboration to optimize the exchange, access, and utilization of data across organizations and stakeholders working on substance abuse prevention, mental health promotion and other related fields
E. Provide technical support to key health policy and program leaders, and community stakeholders to promote cross-systems planning, program integration, implementation and monitoring for substance abuse prevention and mental health promotion.

Article III: Creation, Duration, and Expiration

Section 1. The Guam SEOW was officially created with the endorsement of this Charter on March 30, 2011 by properly authorized entities. This Charter was updated on January 25, 2012. The Guam SEOW will build upon the previous Guam State Epidemiological Workgroup (SEW) under the Strategic Prevention Framework State Incentive Grant 2004-2010, which was created by Executive Order 2005-08, signed on March 23, 2005, by then Guam Governor Felix Camacho.

Section 2. The duration of the Guam SEOW shall be indefinite unless sooner dissolved by agreement of the Department of Mental Health and Substance Abuse (DMHSA), the Prevention Education And Community Empowerment (PEACE) Council, and the SEOW members, in accordance with the law.

Article IV: Principal Office, Main Point of Contact and Key Positions and Members

Section 1. The Principal Office of the GUAM SEOW shall be located at the designated office of the Prevention and Training Branch, Department of Mental Health and Substance Abuse.

Section 2. The main Point of Contact (POC) for the Guam SEOW will be the DMHSA Prevention and Training Branch Supervisor or a duly designated representative. The address and contact information of the POC is:

Barbara S.N. Benavente, MPA
Supervisor, Prevention & Training Branch
Department of Mental Health and Substance Abuse
790 Governor Carlos G. Camacho Road
Tamuning, Guam 96913
671-477-9079 thru 9083 (phone)
671-477-9076 (Fax)
Barbara.benavente@mail.dmhsa.guam.gov
Bbena@guamcell.net

Section 3. Other key positions in the Guam SEOW include

A. Chair/Epidemiologist: Dr. Annette M. David
B. Project Director: Ms. Barbara S.N. Benavente (see contact details above)
C. Current Members: A list of current SEOW members is included as Annex A.

Article V: Work Plan: Activities and Expected Outcomes of the Guam SEOW

Section 1. The activities and expected outcomes of the Guam SEOW will include, but will not necessarily be limited to the following work plan:

Stages	Action Steps	Outcomes
Re-set the SEOW Stage	1. Assess what additional behavioral indicators are desired. 2. Identify existing data sources and data gatekeepers for these additional indicators. 3. Identify and invite these data gatekeepers and additional technical data experts as new SEOW members. 4. Revise and update, as needed, the SEOW charter. 5. Establish and expand coordinating mechanism for SEOW.	1. Expanded list of SEOW indicators 2. Expanded list of data sources 3. Increased membership of SEOW 4. Revised SEOW charter 5. Effective coordinating mechanism established
Data Collection	1. Collate data on expanded list of indicators. 2. Create central repository for expanded inventory of data sources.	1. Central data repository from diverse data sources
Data Analysis	1. Promote peer review process for data analysis and review. 2. Based on data analysis, delineate behavioral health priority areas for action and identify data gaps.	1. Data products with descriptions of baseline, trends, patterns in data 2. Identified priority areas for action

		3. Identified data gaps
Integration and Communication	1. Assess data to elucidate recommended actions to improve substance abuse prevention and behavioral health policies, strategic planning and practice. 2. Create community-friendly, practical data products to support capacity building in prevention and mental health promotion. 3. Inform stakeholders on the use of behavioral health data for data driven prevention planning. 4. Widely disseminate and share data findings and recommendations. 5. Gradually create a sustainable data system for monitoring trends over time.	1. Recommendations for program development, service delivery and resource allocation 2. Data products that integrate SEOW findings and present a cohesive picture 3. Training toolkit for use with state and community-level stakeholders 4. Dissemination mechanisms identified 5. Monitoring/surveillance system established

Article VI: Organization: Management and Operating Structure

Section 1. The Guam SEOW management/administrative personnel and staff shall include the following:

A. DMHSA Prevention & Training Branch will lead in the management of the SEOW project and leverage needed resources to achieve its goals and objectives to include the use of its present facilities. DMHSA commits the following Prevention and Training Branch staff to provide management and administrative support to Guam's SEOW efforts: 2 senior Program Coordinators, 1 Special Projects Coordinator, 1 Research and Statistical Analyst II, 1 Data Entry Clerk II, 1 Public Information Officer, 1 Administrative Officer, and 1 Word Processing Secretary II. Each staff member will devote no less than 10% of his or her time to Guam SEOW activities.

B. As the single state authority on Guam for mental health and substance abuse prevention and treatment services, DMHSA issued an RFP for the recruitment and retention of the SEOW lead, in compliance with Government of Guam procurement regulations.

Section 2. The Guam SEOW management/administrative staff will perform the following duties:

A. The P&T Branch Supervisor, **Barbara S.N. Benavente, MPA**, will oversee the administration and implementation of the SEOW project.

B. **Remedios Malig**, Program Coordinator III, Certified Prevention Specialist, will provide support on the integration of behavioral health indicators and common risk and protective factors as they relate to substance abuse.
C. **Helene Paulino**, Special Projects Coordinator, Certified Prevention Specialist, will serve as liaison with community coalitions and prevention stakeholders, prepare project reports, and perform other responsibilities that will ensure successful achievement of project goals and objectives
D. **Mary Grace Rosadino**, Research and Statistics Analyst II, will assist in the development and administration of National Outcome Measures work for substance abuse and mental health prevention and treatment. She will work closely with the SEOW Program Administrator, SEOW Lead and Members, and support staff to ensure the integration of behavioral health indicators and common substance abuse intervening variables and to assist in the needs assessment, data gathering and data management to ensure that project goals and objectives are achieved. Ms. Rosadino will be directly responsible for managing the central data repository of the SEOW.
E. **April Aguon**, Data Entry Clerk II, will assist with technical and data management support for all data collection activities.
F. **Sara Dimla**, Public Information Officer, will be responsible for developing social/media marketing campaigns with prevention stakeholders including the media and will direct the overall production of informational and educational materials. She will work closely with the SEOW to ensure that laymen's versions of data reports, fact sheets and other materials are produced
G. **Maria Teresa Lozada**, Administrative Officer will oversee the finances of the SEOW project and will ensure that all financial rules and regulations governing the distribution of funds are adhered to.
H. **Deborah Duenas**, Word Processing Secretary II will provide technical and administrative support for all activities related to the project and will work closely will all project staff and report directly to the SEOW Program Administrator.

Section 3. The Guam SEOW technical working group shall include the following:

D. The Guam SEOW Lead, Dr. Annette M. David, selected through the DMHSA RFP process, will serve as the chief technical assistance resource for the Guam SEOW. This individual will directly oversee and provide epidemiological expertise on the data collection and analysis, and will be the primary technical writer/author for the creation of data products. The SEOW Lead will also represent the Guam SEOW at relevant meetings, conferences, stakeholder/town hall sessions, public hearings, etc.
E. At a minimum, the SEOW Working Group will include representatives from key agencies currently engaged in data collection and analysis. These agencies include, but are not limited to, the Departments of Mental Health and

Substance Abuse, Public Health and Social Services, Education, and Youth Affairs, Bureau of Planning and Statistics, Guam Memorial Hospital, the University of Guam, Guam Community College, Guam National Guard, Guam Police Department, Drug Enforcement Agency, the adult and juvenile drug courts, Sanctuary, Inc. and the Guam Alternative Lifestyle Association (GALA). Selection of members to this group will be based on knowledge and experience in data collection/analysis/management, ability to translate data into useable recommendations to drive policy and decision-making, familiarity with Guam's socio-political and cultural context, involvement in and access to critical State data on substance-related problems and prevention strategies, and possession of additional skills such as GIS mapping, professional credibility and integrity. These members will be selected primarily based on their roles as data gatekeepers within their respective agencies and institutions and their expertise in data collection and analysis. They will be directly responsible for ensuring access to the various data sources for substance abuse and mental health information in Guam. Together, they will also serve as a technical working group for examining and analyzing the data and developing data products. Criteria for selection into the Guam SEOW include:

i. Access to critical State data on alcohol, tobacco, and illicit drug related consequences and related use patterns, such as health data (i.e., morbidity and mortality), law enforcement (i.e., crime statistics), and school data (i.e., student self-reports of substance use).
ii. Capability to analyze and interpret data to gain an understanding of the relative seriousness of various substance use problems likely to be present in any particular State.
iii. The ability to apply the outcomes of data analyses to decisions regarding prevention planning, funding, and strategy selection.
iv. Extensive knowledge of State context (i.e., socio-political, economic, cultural). Such information is crucial to understand problems and make prevention recommendations.
v. Access to State decision makers and good knowledge transfer skills to communicate and move the findings of the SEOW beyond the workgroup.

F. Members of the Guam SEOW will include representatives from the various mental health and prevention stakeholders within the Guam community. Current members will be retained, and additional members, particularly within the mental health field, will be recruited, as needed.

Section 4. Advisory Council

A. The Governor's PEACE Council will continue to guide the work of the Guam SEOW throughout the planning and implementation phases. This Council is comprised of key government entities within the three branches of government and community-based organizations that have collectively endorsed sustaining the Guam SEOW and the integration of SAMHSA's

Strategic Prevention Framework (SPF) Process in Guam's prevention infrastructure.

Article VII: Deliverables

Section 1. The Guam SEOW "deliverables" are the various documents and reports that will be created and submitted as part of the SEOW's responsibilities. The content and deadlines for each deliverable is stipulated in the SEOW subcontract document. The deliverables include:

A. Progress Reports – due February 15, 2013 and May 15, 2013
B. SEOW Charter –2nd update due December 3, 2012
C. State and Community Instrument – 2nd update due February 8, 2013
D. State and Community Epidemiological Profiles – State profile due April 12, 2013; Community profile due June 14, 2013
E. Data and References used in the Epidemiological Profiles – due with the Profiles
F. Epidemiological Training Tool – Due date to be determined
G. State/Community Monitoring System – due July 19, 2013
H. SEOW Product – Plan due January 25, 2013, product due August 1, 2013

Article VIII: Monitoring Methods

Section 1. The monitoring methods to be employed by the GUAM SEOW shall include the following:

A. Administrative monitoring of progress using process indicators will be conducted on a monthly basis by the Guam SEOW management/administrative staff in collaboration with the SEOW Lead.
B. Technical monitoring of progress will be addressed at the quarterly meetings of the Guam SEOW Working Group.
C. A report of progress of the SEOW will be delivered to the Governor's PEACE Advisory Council at each of its meetings.

Article IX: Schedules and Procedures of GUAM SEOW Meetings

Section 1. Electronic/Conference Call Meetings – Members of the Guam SEOW and support staff will belong to an email group, to permit informal and speedy e-mail communication. Electronic meetings will be conducted as needed to facilitate data collection and administrative and technical decision-making.

Section 2. Face-to-Face Meetings - Regular meetings will be held quarterly at a site and date to be specified by the SEOW management/administrative staff and SEW Lead.
A. These quarterly meetings will be used to:

i. Conduct the initial SEOW orientation and relevant training and technical assistance workshops;
ii. Collectively perform needs assessment, identify indicators and data sources and select priority indicators for data collection;
iii. Examine and analyze collected data and draft program and policy recommendations based on the evidence generated;
iv. Review and critically assess draft data products prior to their formalization and public release; and,
v. Deliberate and decide upon on critical issues as needed.

B. Should the need arise, additional face-to-face meetings may be convened by the SEOW Lead and management/administrative staff.

C. The Guam SEOW Lead, or, if the Lead is not available, his or her duly designated representative, will facilitate/chair the face-to-face meetings.

D. For issues requiring a vote, a simple majority of members present will suffice.

Article X: Linkages

Section 1. The Guam SEOW Linkages with substance abuse prevention system will be further developed as follows:

A. Currently, Guam's SEOW is considered the definitive authority on substance abuse epidemiology on the island. Its data products are readily acknowledged as comprehensive community resources, and its work has consistently influenced substance abuse policy and program development, prevention resource allocation and service delivery decision-making at the State government level as well as within individual agencies, institutions, and community organizations. The SEOW is highly valued as a technical resource for substance abuse prevention data. Over the past 6 years of the SPF State Incentive Grant, the SEOW's work has been cited and utilized by the Office of the Governor and Lt. Governor, the Guam Legislature, the University of Guam and Guam Community College, the Departments of Public Health and Social Services and Mental Health and Substance Abuse and various other policy leaders and program managers on Guam. The SEOW has contributed significantly to various policies directly related to substance abuse prevention, including Public Law 28-80 (Guam's smoke-free law, 2005), Public Law 30-80 (raising tobacco taxes and earmarking tobacco tax revenues for cancer prevention and health promotion, 2010) and Public Law 30-156 (raising the minimum legal drinking age from 18 to 21 years, 2010). It has also guided substance abuse prevention program planning and resource allocation, as well as related health programs. For instance, the SEOW's Epidemiological Profile is widely quoted in the Guam Comprehensive Cancer Control Plan and is a major reference for the Guam Non-communicable Disease Control and Prevention strategic plan and the Guam Focus on Life suicide prevention program.

B. The utility of the Guam SEOW will be further enhanced by:
   i. Expanding its membership base to include mental health stakeholders;
   ii. Promoting its data products to prevention and mental health partners for use in their grant applications, program development, resource allocation and program assessment; and
   iii. DMHSA will rely on the Guam SEOW for its policy and program decision-making, and will incorporate the data products of the Guam SEOW into its annual reporting, NOMs reporting and new grant applications.

ANNEX A: Current composition and membership of Guam SEOW

Organization	Individual Representative(s)	Designation
Bureau of Statistics and Plans	Calvin Saruwatari	**SEOW Member**
Guam Police Department (GPD)	To be designated	**SEOW Member**
Juvenile Drug Court, Superior Court of Guam	Jeannette Quintanilla	**SEOW Member**
Guam Department of Education (GDOE)	Paul Nededog Eloise Sanchez	**SEOW Member** **SEOW Alternate**
Health Partners, LLC	Dr. Annette M. David Roxanne Mad	**SEOW Epidemiologist** **Research Assistant**
Department of Public Health and Social Services (DPHSS)	Roselie Zabala Alyssa Uncangco	**SEOW Member** **SEOW Alternate**
Department of Youth Affairs (DYA)	To be designated	**SEOW Member**
Guam Behavioral Health and Wellness Center (GBHWC)	Remy Malig Helene Paulino M. Grace Rosadino Sara Dimla Don Sabang	**Program Coordinator III** **Special Projects Coordinator** **Research and Statistics Analyst II** **Special Projects Coordinator/Public Information Officer** **Supervisor, Drug and Alcohol Branch**
Guam Community College	Dr. Ray Somera	**SEOW Member**
University of Guam Cooperative Extension Services (UOG-CES)	Peter Barcinas	**SEOW Member**
University of Guam, Psychology Program	Dr. Michael B. Ehlert	**SEOW Member**
University of Guam, Division of Social Work	To be designated	**SEOW Member**
University of Guam Cancer Research Center	Dr. Yvette Paulino	**SEOW Member**
Sanctuary, Incorporated	To be designated	**SEOW Member**
US Probation Office	To be designated	**SEOW Member**
Guam Memorial Hospital	To be designated	**SEOW Member**
Guam National Guard	Joshua Tyquiengco	**SEOW Member**
Guam's Alternative Lifestyle Association (GALA)	Evan James San Nicolas	**SEOW Member**

Additional members to be identified.

ANNEX B: List of Data Sources

Surveillance Data:

Behavioral Risk Factor Survey
Youth Risk Behavior Survey
Guam Global Youth Tobacco Survey
GBHWC Adult and Youth Substance Abuse Surveys

Registry and Program Data:

Guam Cancer Registry
Office of the Chief Medical Examiner Suicide Fatality Data
GBHWC Drug and Alcohol program data
Department of Youth Affairs screening data
Sanctuary, Inc. program data
Juvenile Drug Court program data
US Probation Office program data

Guam Laws & Policies
Deterring Minors from Alcohol Consumption

Law/Policy and Source	Description
Responsible Alcohol Sales and Service Act **Public Law 32-051**	Requires standardized server/seller classroom training, for employees who serve or sell alcoholic beverages, or who supervisors others who sell or serve alcoholic beverages, to be a requirement for obtaining an ABC Alcohol Employee License. Requires employees employed by any on-sale and off-sale licensee who sells or serves alcoholic beverages, or who supervisors others who sell or serve alcoholic beverages to obtain an ABC Alcohol Employee License.
Guam Social Host Act **Public Law 32-001**	**§70.53. Intoxication of Persons Under the Age of Twenty- One** (a) No person twenty-one (21) years or older shall knowingly give or otherwise make available any alcoholic beverage to a person under the age of twenty-one (21) years. A person violates this Section who gives or otherwise makes available an alcoholic beverage to a person under the age of twenty-one (21) with the knowledge that the person to whom the alcoholic beverage is made available will be in violation; (b) A person violates this Section who owns, occupies, or controls premises on which alcoholic beverages are consumed by any person under twenty-one (21) years of age, and who knows of alcohol consumption by persons under twenty-one (21) years of age on such premises, and who reasonably could have prohibited or prevented such alcohol consumption; c) The prohibitions of this Section apply only to a person who is present and in control of the location at the time the consumption occurs. The prohibitions of this Section do not apply to the owner of rental property, or the agent of an owner of rental property, unless the consumption occurs in the individual unit in which the owner or agent resides. (d) his Section shall not apply to any religious practice, observance, or ceremony. (e) The violations of this Section and the resulting penalties prescribed herein, supra, are in addition to other violations of public law related to alcoholic beverages."
P**rohibits sale of alcohol to any person under the age of twenty-one (21) years.**	**§3419. Same: To Minor**. A licensee, his agent or employee shall not sell, give nor permit to be sold, given or served any alcoholic beverages to ***any person under twenty-one (21) years of age***. For the purpose of preventing any violation of this section, any licensee or his agent or employee may refuse to sell or serve alcoholic beverages to any person who is unable to produce adequate written evidence that he or she is over the age of ***twenty-one (21) years***. In any criminal prosecution or proceeding for the suspension or revocation of any license and based upon a

Source: **Public Law 30-156**	violation of this section, proof that the defendant licensee or his agent or employee demanded and was shown, before furnishing any alcoholic beverage to a minor, an identification card or other bona fired documentary evidence of majority of such person shall be a defense to such prosecution or proceeding for the suspension or revocation of any license. Every person who violates this section shall be guilty of a petty misdemeanor.
Prohibits persons under twenty-one (21) of age from purchasing or publicly possessing alcoholic beverages. Source: **Public Law 30-156**	**§3619. Same: Minors**. Any person under the age of ***twenty-one (21) years of age*** purchasing or consuming alcohol beverages or in possession thereof shall be guilty of a petty misdemeanor. This provision, with regards to possession of alcoholic beverages, does not apply to persons eighteen (18) to twenty (20) years of age who are performing paid work for and on behalf of a licensed establishment that provides alcohol. For purposes of this Section, 'provide' means various methods of distribution or retrieval, including, but not limited to, selling, serving, or transporting alcoholic beverages.
Prohibits minors using false identification for obtaining alcohol Source: **Public Law 30-156**	**§3420. Same: To Minor**. Any person ***under twenty-one (21) years of age***, who exhibits a false identification card or false document for the purpose of purchasing or obtaining alcoholic beverages, shall be guilty of a petty demeanor.
Designates areas within Guam Territorial Park System as "Alcohol Free Zones" Source: **Public Law 30-65**	**§77101.1 Establishment of an Alcohol Free Zone.** Any person who possesses or consumes alcohol in an "Alcohol Free Zone" shall be in violation of this provision and shall be issued a citation and punished. All Territorial Park Patrol and Guam Police Officers shall have jurisdiction to enforce this provision of law.
Drug Free School Zones Sources: Guam Code Annotated Title 17. Education	Drug Free School Zones is any area within one thousand (1,000) feet of a public or private elementary, secondary or post secondary educational institution or its accompanying grounds; within the vehicle of any school bus which transports students while in motion; or within two hundred fifty feet (250') of any school bus not in motion or a designated school bus stop or shelter, including any school bus transfer station. Drug Free School Zones shall not include private real property which is not a school or the accompanying grounds of a school.

Division 5. Miscellaneous Training & Education Chapter 48. Drug Free School Zones **Public Laws 23-87 and 26-125** Offenses and Penalties **Public Law 24-149** **Note: There are no provisions indicating alcohol as a drug for the Drug Free School Zone Act.**	It is the responsibility of the schools, both private and public, to coordinate the establishment and designation of the drug free school zones, and shall place and maintain permanently affixed and plainly visible signs at the main entrances of each school which identify the school and its accompanying grounds as a drug free school zone and which outline the penalties associated with Drug Free School Zones Act; and must prepare a drug free school zone map for their respective jurisdiction and shall submit copies of the original maps to the Office of the Attorney General as well as to the Department of Land Management for purposes of record-keeping.
Graduated Driver's Licenses for New Drivers Guam Code Annotated Title 16. Vehicles Chapter 3. Graduated Drivers Licenses **Public Law 25-96** **Note: Federal Local indicates the Blood Content Alcohol for person under the age eighteen (18) year = 0.02%**	The Graduated Licensing requirements consist of three (3) distinct stages: **Learner's permit –** the minimum age for a learner's permit is fifteen and one-half (15½) years, and required to pass vision and written knowledge test, completed 50 hours of supervised driving and 10 hours of night driving. **Intermediate (provisional) license** – minimum age 16 years, required passing a behind-the-wheel, on-road test, completed driver's education approved by the Department of Revenue & Taxation, and must be accompanied by a parent or adult guardian who is a fully licensed driver at all times while driving between the hours of 10:00pm and 6:00am on weeknights and 12:00am and 6:00am on weekend nights, except while driving to and from work; and **Full license**- must be at least 17 years of age, must have completed the intermediate licensing stage. **All drivers under the age of 18 years must follow rules of the road and traffic signs and signals, must *not* have a blood alcohol content (BAC) that exceeds 0.02 (*Zero Tolerance for Alcohol*) at any time while driving, not be at fault in any collision and remain conviction free of all traffic and motor vehicle code violations**. Young drivers are required to demonstrate responsible driving behavior in each stage of licensing before advancing to the next stage.

Safe Streets Act Guam Code Annotated Title 16. Vehicles Chapter 18. Safe Streets Act **Public Law 22-20** **Note: Guam's Local indicates the Blood Content Alcohol for person under the age twenty one (21) year = 0.04%**	**§18102. Influence of Alcohol and Controlled Substances; Causing Bodily Injury to Person Other Than Driver; Alcoholic Content in Blood; Proof**. (g)(11) A person under the age of twenty one (21) shall be guilty of a violation if such person shall be found within three (3) hours of his or her arrest for a violation of this section to have **four one-hundredths of one percent (0.04%)** or more, by weight, of alcohol in his or her blood. **§18119. Drinking While Driving a Motor Vehicle Upon Any Highway**. No person shall drink any alcoholic beverage or consume a controlled substance while driving a motor vehicle upon any highway. **§18120. Drinking in Motor Vehicle Upon Highway**. Any person who drinks any alcoholic beverage or consumes a controlled substance while in a motor vehicle upon a highway shall be guilty of a misdemeanor. **§18121. Possession of Opened Container in a Motor Vehicle**. Any person who has in his or her possession on his or her person, while in a motor vehicle upon a highway, any bottle, can, or other receptacle, containing any alcoholic beverage which has been opened, or a seal broken, or the contents of which have been partially removed shall be guilty of a misdemeanor. **§18122. Storage of Opened Container.** A person shall be guilty of a misdemeanor if he or she is the registered owner of any motor vehicle, or the driver if the registered owner is not then present in the vehicle, keeps in a motor vehicle, when the vehicle is upon any highway, any bottle, can, or other receptacle containing any alcoholic beverage which has been opened, or seal broken, or the contents of which have been partially removed, unless the container is kept in the trunk of the vehicle, or kept in some other area of the vehicle not normally occupied by the driver or passengers, if the vehicle is not equipped with a trunk. A utility compartment or glove compartment shall be deemed to be within the area occupied by the driver and passengers.
Business Establishments that Sell Alcoholic Beverages to Host Social Events for Persons under Eighteen Years of Age. Guam Code Annotated Title 11: Chapter 3. Entry Forbidden	No person under eighteen (18) years of age shall enter an establishment where alcoholic beverages are consumed, *unless* such establishment is a public eating place. Establishments may open their doors and allow for teen events; provided: no beverages with any amount of alcoholic content are sold during the events; all teens entering the premises shall be checked to ensure that no alcoholic beverages are brought into the premises; the management of the establishment shall ensure that no alcoholic beverage is being consumed outside the premises which is under the direct control of ownership of the establishment; all lewd, pornographic pictures, objects and other paraphernalia *not* suitable for teens *prior* to opening its doors for teen events; must comply with *all* other statutes governing conduct of minors, who are defined as anyone under the age of eighteen (18) years old; identification marking (stamp) the individual is

Public Law 26-133	participating in teen events; provide adequate adult supervision and surveillance of such events; must acquire a business permit for conducting such teen events from the Department of Revenue & Taxation and remove or cover all pictures, objects and other related items *exclusively* for advertising alcohol or tobacco products.
Hours of Sale **Source:** **Public Law 30-154**	Hours of Sale. On-Sale Premises. An on-sale licensee shall not sell or serve any person alcoholic beverages between the hours of 2:00am and 8:00am, provided, however, that all alcoholic beverages must be consumed within fifteen (15) minutes of the time permitted for the sale thereof the premises(s) shall be closed no later than 3:00am thereafter. A licensee may begin selling or serving alcoholic beverages at 8:00am, Monday through Sunday, inclusive.
Penalties for Licensees. **Source:** **Public Law 30-155**	**§3613. Same: Hearing, Penalties for Licensees.** (a) The Board, upon receipt of the report required in §3612, shall, as soon as practicable, hold a hearing on such report. (b) The Board shall impose a penalty on a licensee found guilty of violating any of the provisions of this Chapter amounting to One Thousand Five Hundred Dollars ($1,500.00) for the first offense; Two Thousand Five Hundred Dollars ($2,500.00) for the second offense; and Three Thousand Five Hundred Dollars ($3,500.00) for the third offense. For the fourth offense, the Board may impose a penalty of up to Ten Thousand Dollars ($10,000.00), but not less than Five Thousand Dollars ($5,000.00), and a forty-eight (48) hour suspension for every subsequent offense. Contingent on the severity of any violation, the Board may use its discretion and suspend or revoke the license of any licensee found guilty of violating any of the provisions of this Chapter. (c) In addition to the aforementioned fines in Subsection (b), the Board shall suspend, for a period of not less than thirty (30) days and no more than ninety (90) days, the license of any licensee found guilty of violating §3413 of this Chapter as a second offense. The Board shall revoke the license of any licensee found guilty of violating §34l3 of this Chapter as a third offense.

Guam Code Annotated
Title 11. Finance & Taxation
Division 2. Taxes
Chapter 26. Business Privilege Tax Law
Article 3. Alcoholic Beverage Tax

Public Law 27-104 (2004)

§26302. Excise Tax on Alcoholic Beverages.

An excise tax is imposed upon all alcoholic beverages (except alcoholic beverages manufactured in Guam) sold in Guam by manufacturer, manufacturer's agents, rectifiers or wholesalers or sellers of alcoholic beverages selling alcoholic beverages with respect to which not tax has been paid within areas of which the Federal government exercises jurisdiction at the following rates:

Beverage Type	**Tax Amount**
Malted Fermented Beverage	Seven Cents (0.07) per each twelve (12) fluid ounces or fraction thereof on all malted fermented beverages to be applied to the measure of the container in which it is offered for sale.
Distilled Beverage	Eighteen Dollars ($18.00) per gallon on all distilled beverages to be applied to the measure of the container in which it is offered for sale; provided further that any fraction of One Cent ($0.01) shall be taken as a whole cent.
Vinous Beverages	Four Dollars and Ninety-Five Cents ($4.95) per wine gallon on all vinous beverages to be applied to the measure of the container in which it is offered for sale; provided, however, that the tax levied by this Section shall be prorated in units of measure less than one (1) gallon; and provided, further, that any fraction of One Cent ($0.01) shall be taken as a whole cent.

Creation of Safe Homes, Safe Streets Fund. There is hereby created in the Department of Administration a fund, separate and apart from other funds of the government of Guam, known as the "Safe Homes, Safe Streets Fund." This Fund shall not be commingled with the General Fund and shall be kept in a separate bank account. The Safe Homes, Safe Streets Fund shall be expended on public safety and social programs that enforce alcohol regulations, reduce underage drinking, support traffic safety, reduce drug-related violence and abuse, an/or support community-based drug and substance abuse prevention programs at the Guam Police Department, the Guam Public School System, the Department of Public Health and Social Services, the Department of Youth Affairs, the Department of Mental Health & Substance Abuse and other agencies deemed appropriate by I Liheslaturan Guahan. All expenditures of the Safe Homes, Safe Streets Fund shall be by appropriation by I Liheslaturan Guahan. The Department of Administration shall report on a quarterly basis to the Speaker of I Liheslaturan Guahan the revenues collected and expended from this Fund.

Distribution of Excise Tax on Alcohol Beverages. Fifty percent (50%) of all proceeds from taxes collected under this Section shall be deposited in the Safe Homes, Safe Streets Fund. All remaining proceeds from taxes collected under this Section will be deposited in the Healthy Futures Fund.

Guam Laws & Policies
Tobacco Control

Law/Policy and Source	Description
Public Law 31-102	Prohibits smoking in a motor vehicle when a child is present.
Public Law 30-163	Prohibits the importation and sale of ingestible tobacco film strips, ingestible tobacco sticks, tobacco hard candies, nicotine lollipops, nicotine lip balm and nicotine water.
Public Law 30-80	Increases tobacco taxes, the Healthy Futures Fund and creating a Guam Cancer Trust Fund.
Public Law 30-63	Prohibits smoking within 20 feet of an entrance or exit of a public place where smoking is prohibited.
Public Law 28-170	An act to repeal and re-enact Chapter 6 of Title 11 Guam Code Annotated, Relative To The Licensing Requirements for the Retail and Wholesale of Tobacco Products; To add a new Article 6 to Chapter 6 of Title 11 Guam Code Annotated, To Restrict Importation of Tobacco Products to Manufacturer's Representatives; and to Amend §26601(C) of Chapter 26 of Title 11, Guam Code Annotated, Relative to the Tobacco Tax.
Public Law 28-80	An act to amend §90100, §90103, §90105 and §90107 of Chapter 90, Division 4 of Title 10, Guam Code Annotated, Relative to the Regulation of Smoking Activities, to be known as the "Natasha Protection Act of 2005."
Public Law 27-69	Appropriates money from the Youth Tobacco Education and Prevention Fund to DMHSA for youth compliance monitoring and tobacco and drug prevention and education programs.
Public Law 27-05	Amends and increases tobacco tax rates effective May 1, 2003.
Public Law 26-166	Authorizes tax credits against excise taxes, including tobacco and alcohol taxes, to individuals and businesses that contribute to the upgrading, repair and maintenance of the Paseo Stadium and ancillary facilities.
Public Law 26-68	An act to appropriate funds from the Series 2001A subaccount of the Youth Tobacco Educational Fund to the Department of Mental Health and Substance Abuse for the purpose of Youth Compliance Monitoring and Tobacco and Drug Prevention and Education Programs pursuant to P.L. 25-187
Public Law 26-07	Adopts a model statute under the Master Settlement Agreement.

Public Law 26-04	An act to add Chapter 80 to Title 12 of the Guam Code Annotated, relative to authorizing GEDA to issue Tobacco Settlement Revenue Bonds, to sell and assign to GEDA the Government's settlement payments of the purpose of securing and paying such bonds, and to approve the issuance of said bonds.
Public Law 26-03	Repeals and amends existing laws relative to adopting a model statute under the master settlement agreement.
Public Law 25-187	Established the Healthcare Security Fund.
Public Law 25-150	Rehabilitates the Guam memorial Hospital and creates a reserve fund to receive the tobacco settlement monies.
Public Law 25-104	Equalizes the tobacco tax on cigars to a level comparable to other forms of tobacco.
Public Law 24-278	Requires sellers of tobacco products to obtain a tobacco license and enforces the prohibition of sales of tobacco products to minors.
Public Law 24-174	Establishes the Health and Human Services Fund and sets guidelines for deposit of settlement money.
Public Law 22-90	Prohibits smoking on airline flights.
Public Law 21-139	Regulates smoking within public places and places of employment.
Public Law 21-25	Prohibits the sale of tobacco to minors.
University of Guam Tobacco Free Policy	Total ban on sales, smoking and the distribution and use of tobacco and tobacco-based products on the campus.
Government of Guam's Executive Order 2007-18	Establishes a Tobacco Free Workplace environment department policy for the Executive Branch of the Government of Guam.

EDDIE BAZA CALVO
Governor

RAY TENORIO
Lieutenant Governor

Office of the Governor of Guam

Memorandum September 30, 2015

To: Rey Vega, Director
Guam Behavioral Health and Wellness Center

From: Governor Eddie Baza Calvo

Subject: Endorsement of Guam's Focus on Life – Territorial Plan For Suicide Prevention, Early Intervention, and Postvention (FY 2016 – FY 2020)

As stated in Executive Order No. 2011-03 issued by the Office of the Governor, the Governor's PEACE Council and Guam's State Epidemiological Outcomes Workgroup (SEOW) will be retained with the appointment of key organizational members. The members will serve to guide and advise the Office of the Governor and the Office of the Lt. Governor in strategic prevention framework processes that involve assessment, capacity building, planning implementation, and evaluation steps to ensure that substance abuse prevention, mental health promotion and suicide prevention work is data-driven, culturally relevant, effective and sustainable.

The ***Focus on Life*** Suicide Prevention and Early Intervention Plan, as submitted by Guam Behavioral Health and Wellness Center (GBHWC) (formerly known as the Department of Mental Health & Substance Abuse), addresses the strategic prevention framework processes. This five-year plan is comprehensive, strategic, and clearly describes the necessary steps that we, the leaders of this territory, the youth services organizations in the public and private sector, and the island's residents must be actively involved in to stop suicide on Guam.

The Office of the Governor has reviewed and officially endorses the Focus on Life Suicide Prevention and Early Intervention Plan (2016-2020) for the Territory of Guam.

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OFFICE OF THE GOVERNOR
HAGÅTÑA, GUAM 96910
U. S. A.

EXECUTIVE ORDER NO. 2011-03

RELATIVE TO AMENDING EXECUTIVE ORDER NO. 2003-29 WHICH CREATED THE GOVERNOR'S PEACE (PREVENTION AND EARLY INTERVENTION ADVISORY COMMUNITY EMPOWERMENT) COUNCIL

WHEREAS, the Governor's PEACE Council was created in 2003 and whose appointed members represent the executive, legislative and judicial branches of government, the private sector and community-based prevention advocates charged with the development of policies, programs and practices to address Guam's substance abuse and suicide problems, and to include planning, implementing and evaluating comprehensive evidence-based prevention strategies that result in positive environmental changes; and

WHEREAS, Guam's State Epidemiological Workgroup (SEW), is represented on the Governor's PEACE Council and leads in the collection, analysis, reporting and strategic use of Guam's data to inform and guide decision-making processes for the allocation of funding and resources to promote positive mental health and prevent substance abuse and suicide among targeted priorities; and

WHEREAS, this SEW body of key data gatekeepers will be now known as Guam's State Epidemiological Outcomes Workgroup (SEOW) whose areas of responsibilities are to manage Guam's mental health and substance abuse related data collectively and collaboratively and to facilitate annual Profile updates and data sharing with program and policy leaders and managers in government and the private sector; and

WHEREAS, the PEACE Council endorsed the publications of the Guam Substance Abuse Epidemiological Profile and the Profile of Suicide on Guam (and subsequent updates) which serve as a tool for strategic and comprehensive planning among state and community level mental health and substance abuse prevention and treatment partners; and

WHEREAS, the Governor's PEACE Council and the Guam's State Epidemiological Outcomes Workgroup (SEOW) will be retained with the appointment of key organizational members who will serve to guide and advise the Offices of the Governor and Lt. Governor in strategic prevention framework processes that involve assessment, capacity building, planning, implementation and evaluation steps to ensure that substance abuse prevention, mental health promotion and suicide prevention work is data-driven, culturally relevant, effective and sustainable; and

WHEREAS, our island community recognizes the need to improve the quality of life for the people of Guam, as reflected in a vision of good physical and mental health, long life, and the assurance that basic needs for primary health care and behavioral health services for Guam's residents are met; and

WHEREAS, the Governor's PEACE Council will work collaboratively with the Department of Mental Health and Substance Abuse (DMHSA) and the Department of Public Health and Social Services (DPHSS) to jointly and strategically develop and/or strengthen, comprehensive state plans for mental health promotion and the prevention of substance abuse, suicide, ill health and deaths resulting from non-communicable diseases, via behavioral health and primary health care service systems and within community-based settings on Guam; and

WHEREAS, the Governor's PEACE Council will help to guide and advise DMHSA staff as they facilitate opportunities to strengthen Guam's capacity to create a healthier island community following a strategic prevention framework (SPF) process for planning, implementing and evaluating culturally relevant, evidence-based programs, practices and policies that build upon the strengths and resources of the people of Guam.

NOW, THEREFORE, I, EDWARD J.B. CALVO, *I Maga'Låhen Guåhan*, Governor of Guam, by virtue of the authority vested in me by the Organic Act of Guam, as amended, do hereby order that:

1. PEACE now stands for Prevention Education And Community Empowerment and that the PEACE Council shall consist of state and community-level members (not to exceed 25) representing the following:

    a) Youths between the ages of 15 and 21 (Representing established youth organizations)
    b) Parents (Representing established parent organizations)
    c) Healthcare Providers
    d) Private Businesses (Not Involved in the Alcohol or Tobacco Industry)
    e) Media Company (Involved in Promoting Good Health)
    f) Faith-Based Organization
    g) Civic or Volunteer Organizations
    h) Military Sector
    i) State Epidemiological Outcomes Workgroup (SEOW)
    j) Guam Department of Education
    k) Department of Youth Affairs
    l) Emergency First Responders (e.g., Guam Police Dept. and/or Guam Fire Dept.)
    m) Department of Mental Health & Substance Abuse
    n) Department of Public Health & Social Services
    o) Guam Memorial Hospital
    p) Mayors' Council of Guam
    q) Superior Court of Guam
    r) U.S. District Court of Guam – U.S. Probation Office
    s) *I Liheslaturan Guåhan*, Committee on Health and Human Services

2. Each PEACE Council member shall be appointed by the Governor of Guam and shall serve for a period of up to four years, unless removed sooner by the Governor of Guam, and until the Governor of Guam either formally renews his or her term or replaces him or her with a new, qualified member; and

3. The PEACE Council shall elect a Chairperson and Co-Chairperson from among its members and shall meet bi-monthly to review and revise its By-laws as necessary and to support the State Epidemiological Outcomes Workgroup in meeting its stated goals and objectives; and

4. The Department of Mental Health and Substance Abuse shall remain the lead Government of Guam entity for substance abuse and suicide prevention with the administration of SAMHSA grants and to include the Garrett Lee Smith Memorial Act - Youth Suicide Prevention Grant and the State Epidemiological Outcomes Workgroup Sub-grants and their implementation.

SIGNED AND PROMULGATED at Hagåtña, Guam this 31 day of **January, 2011**.

EDWARD J. B. CALVO
I Maga'låhen Guahan
Governor of Guam

COUNTERSIGNED:

RAYMOND S. TENORIO
I Segundu na Maga'låhen Guahan
Lieutenant Governor of Guam

Suicide Prevention, Early Intervention, Postvention and Referrals Plan for Guam
FY 2016 thru FY 2020

The Guam Behavioral Health and Wellness Center (GBHWC), formerly known as the Department of Mental Health and Substance Abuse was created by Public Law 17-2 1 and serves as the island's single state agency mandated to provide essential mental health and substances abuse prevention and treatment services to Guam's people relative to carrying out its stated vision and mission:

Vision: *A healthy island community.*

Mission: *Our mission is to provide culturally respectful behavioral health services that support and strengthen the wellbeing of persons served, their families, and the community.*

Problem Statement:

Guam continues to endure a disturbingly high rate of suicide among its youth and adult population. In 2012, suicide was the seventh leading cause of death on Guam with approximately one suicide death every two weeks. Youth and young adults are at a particularly high risk of dying from suicide. On average, from 2000 to 2014, there were 26 suicide deaths per year. Age adjustment to the standard U.S. 2000 population results in a significant increase in the suicide death rate. The latest age-adjusted suicide death rate for the U.S. is derived from 2013 mortality statistics, and is 13.0 per 100,000 people. The 2013 age-adjusted Guam death rate from suicide is 19.3 per 100,000, which is almost 50% higher than the national rate.

The total numbers of suicide deaths and suicide rates per year from 2008 to 2014, disaggregated by sex, show that suicide deaths on Guam occur predominantly among males, who outnumber suicide deaths among females with a ratio of 6:1. That is, 85% of deaths by suicide on Guam happen among males.

Deaths by suicide on Guam occur predominantly among young people. Cumulatively from 2000 to 2012, 20% of suicide deaths occurred in those aged 10-19, and 37% of deaths happened among those aged 20-29 years. Altogether, close to 60% of all suicide deaths in Guam from 2000-2012 occurred in those younger than 30 years. Suicide deaths are highest for Chamorros, followed by Chuukese.

Nearly one in five (19%) of those who died of suicide from 2008-2012 left direct evidence (suicide note) of intention to commit suicide; about one in eight (11%) left indirect evidence of intent.

In 2014, Alcohol is implicated in 27% of all suicide-related incidents. Other drugs of abuse are involved in 3% of suicides. A history of mental illness is implicated in 17% of suicide-related incidents, and about 7% of suicide-related incidents are repeat attempts. These serve as red flags that indicate a heightened risk for suicide.

These data indicate that there exist windows of opportunity to successfully intervene to prevent suicide among Guam's young people. For example, the information on intention to commit suicide demonstrates that if community members were better trained

to pick up on intention to commit suicide, it may be possible to intervene before a suicide death occurs. Other population-based suicide prevention strategies that would likely result in positive outcomes in Guam; include preventing alcohol and drug abuse and early detection and treatment of severe emotional distress and mental illness.

State and Community-Level Prevention:

The Governor's PEACE Council and the Guam's State Epidemiological Outcomes Workgroup (SEOW) has been retained to guide and advise the Office of the Governor and the Office of the Lt. Governor in strategic prevention framework processes that involve assessment, capacity building, planning, implementation and evaluation steps to ensure that substance abuse prevention, mental health promotion and suicide prevention work is data-driven, culturally relevant, effective and sustainable. Executive Order No. 2011-03 was signed January 31, 2011 by Governor Edward J.B. Calvo and Lt. Governor Raymond S. Tenorio. This Council will help to guide and advise GBHWC staff and PEACE partners, as they facilitate opportunities to strengthen Guam's capacity to create a healthier island community following a strategic prevention framework (SPF) process for establishing evidence-based programs, practices and policies that build upon the strengths and resources of the people of Guam.

The Guam Behavioral Health and Wellness Center shall remain the lead Government of Guam entity for substance abuse and suicide prevention with the administration of Substance Abuse and Mental Health Services Administration (SAMHSA) grants and as other resources are attained.

Current Services:

The Prevention and Training (P&T) Branch within GBHWC's Division of Clinical Services continues to set suicide prevention and intervention as a priority area for which services throughout Guam's community is provided. Over the past 21 years, and more recently with GBHWC's receipt of Garrett Lee Smith Memorial Grant funds awarded by SAMHSA, educational and training programs have been implemented with youth serving agencies in the public and private sector, as well as with community-based organizations, parent and youth groups. Accomplishments to date include:

1. Establishment of a supportive network among survivors of suicide;
2. Establishment of the Governor's PEACE Council and a State Epidemiological Outcomes Workgroup (SEOW) for Guam's Strategic Prevention Framework/State Incentive Grant (SPF/SIG) and Partnerships for Success (PFS) efforts;
3. Development of the Guam's Substance Abuse Epidemiological Profile (2007 and updates), Profile on Suicide on Guam (2009 and updates) and merging into one Guam Epi Profile (2011 and updates);
4. Establishment of prevention coalitions as part of Guam's Strategic Prevention Framework processes to build community-based prevention and early intervention capacity;
5. Development of Guam's pool of certified trainers in ASIST (Applied Suicide Intervention Skills Training), SafeTALK (**S**uicide **A**lertness **f**or **E**veryone-**T**ell, **A**sk, **L**isten and **K**eepsafe), Connect Suicide Post-Vention, Suicide Prevention Tool Kit for Primary Health Care Providers, LifeLines Trilogy for Suicide Prevention, Intervention and Postvention, Team Awareness and SAPST (Substance Abuse Prevention Skills Training);
6. Establishment of a GBHWC's 24/7 Crisis Hotline (647-8833);

7. Increased awareness and utilization of the National Suicide Prevention Lifeline 1-800 273-TALK;
8. Development of suicide prevention electronic and print resources for use in training trainers and educating the community-at-large on recognizing signs and symptoms, conducting effective intervention and making appropriate referrals for treatment;
9. Development and implementation of mass media campaign strategies and maintenance www.peaceguam.org
10. Established network with Asia and Pacific Islander members affiliated with the World Health Organization (WHO);
11. Establishment of a partnership with the University of Guam's Isa Psychological Services Center and I Pinangon - Campus Suicide Prevention Program, Guam Memorial Hospital Authority and the Department of Education for the conduct of ASIST, SafeTALK, CONNECT Suicide Postvention and Lifelines Trilogy, Screenings and Referral for Alcohol and Depression, and/or counseling services; and
12. Provide training services in ASIST, Connect, SafeTALK, Suicide prevention and early intervention awareness to military personnel including the Guam Army National Guard, Navy and Air Force.

GBHWC's Prevention and Training Branch Supervisor serves as Principal Investigator for Guam's Partnerships for Success Grant (FY 2014 – FY 2018); members of the P&T Branch have taken the lead for the initial development of Guam's Suicide Prevention and Early Intervention Plan (FY '07 thru FY '11). As a collaborating partner with the World Health Organization - Western Pacific Regional Office (WHO-WPRO), GBHWC Prevention and Training Branch contribute to the Suicide Trends in At-Risk Territories (**START**) Study and collect relevant data from Guam's data gatekeepers to include the Guam Medical Examiner's Office. Wherever feasible and dependent upon the readiness of the existing personnel resources and infrastructure all aspects of START's four main program components will be considered and implemented:

1. **Monitoring of Suicide Deaths and Attempts** (including deliberate self-harm) – Data based on fatal and non-fatal suicidal behavior will be gathered, as well as standardized monitoring forms will be developed and implemented.
2. **Randomized-Controlled Trial with Suicide Attempters** (the brief intervention project) – Persons who have attempted suicide will be monitored as well as information gathered on circumstances surrounding and preceding death of suicidal persons.
3. **Psychological Autopsy Cross-Cultural Study;** and
4. **Follow-up of Medically Serious Suicide Attempters**

The implementation of START on Guam aids in the increase in suicide awareness and the need for a more comprehensive development of suicide prevention, early intervention and postvention policies, programs and practices. Accurate and standardized monitoring procedures will enhance Guam's knowledge of risk and protective factors in suicidal behaviors.

Suicide Prevention and Early Intervention Framework:

For the period of October 2015 through September 2020 Guam's Plan for Suicide Prevention and Early Intervention will be led by the Prevention and Training Branch of the Guam Behavioral Health and Wellness Center. It is anticipated that a Focus on Life (FOL) Taskforce will be created as a sub-committee under the auspices of the Governor's PEACE Council to oversee the pursuit of the following goals, and will promote the strategic use and dissemination of data for informing and guiding Guam's substance abuse prevention and behavioral health promotion policy and program development, decision-making, resource allocation and capacity building:

Goal 1 – Strengthening Guam's **data collection, analysis and surveillance system** for monitoring and reporting the rates of suicide attempts and suicide, as well as preventable injuries and risk-taking behaviors on Guam.

Goal 2– Strengthening Guam's **workforce, recruitment and capacity building process** within the public, private and community-based entities for responding effectively to the community's identified needs for suicide prevention, early intervention and referral, treatment and follow-up services, inclusive of the development and implementation of Guam's Crisis Response Team.

Goal 3– A sustainable **Comprehensive Strategic Youth Suicide Prevention and Early Intervention Plan** endorsed by Guam's Executive, Legislative and Judicial Branches of Government, established state and community level Councils, community-based youth service organizations and survivors of suicide. This plan shall establish, update, and strengthen agreements, policies, and procedures for suicide prevention, intervention, postvention, and referrals among government agencies and community organizations.

Goal 4 – Successful collaboration and **implementation of culturally and linguistically appropriate evidence-based prevention policies, programs and practices among** Guam's key stakeholders and advocates for suicide prevention.

Goal 5 – Process and Outcome Evaluation measurements that demonstrate effectiveness in the reduction of preventable injuries and suicide attempts on Guam.

The following notional chart depicts the anticipated timeline for meeting the identified Goals for Guam's ***Focus on Life*** - Youth Suicide Prevention and Early Intervention on Guam:

	FY 2016 (10/1/15 – 9/30/20)				
***Focus on Life* Schedule (Notional) Project Steps:**	**Year One**	**Year Two**	**Year Three**	**Year Four**	**Year Five**
Goal 1 – Assessment					
Establish the Focus on Life Taskforce under the PEACE Council and initiate quarterly meetings.	X	X	X	X	X
Retain Evaluation Lead Consultant	X	X	X	X	X
Convene Quarterly Meetings of State Epidemiological Outcomes Workgroup (SEOW)	X	X	X	X	X
Strengthen Suicide Surveillance and Monitoring System for Assessing Current Data Collected, Identifying Gaps in Systems	X	X	X	X	X

Strengthen standardized data collection instrument and reporting system for Guam.	X	X	X		
Maintain official partnerships with WHO-WPRO Collaborating Centre for Research and Training in Suicide Prevention	X	X	X	X	X
Strengthen formal partnerships with PIMHnet (Pacific Islands Mental Health Network)	X	X	X	X	X
Conduct ongoing research on current suicide prevention legislation established on Guam and in other areas that may be appropriate for Guam.	X	X	X	X	X
Continue Implementation of START – **Component 1– Retention** of a Mortality Data Base and Register for Attempters		X			
Update annually and disseminate Guam's Substance Abuse Epidemiological Profile and Profile on Suicide on Guam	X	X	X	X	X
Evaluate and Report on Project Process and Outcomes of Goal 1	X	X	X	X	X
Goal 2– Capacity Building					
Continue to Assess and Respond to current workforce knowledge and capacity building needs within the public/private sector as well as among Guam's community of survivors.	X		X		X
Conduct monthly suicide prevention, intervention and postvention trainings.	X	X	X	X	X
Identify and respond to critical training needed among health and mental health services providers in the areas of assessment, screening, case management and counseling and facilitate the provision of such.	X	X	X	X	X
Update current Manual for training educators in Guam's public and private school systems, as well as in youth-serving agencies in both government and community-based organizations.		X	X	X	X
Initiate the planning process for the implementation of START – **Component 2.**		X			
Update and schedule the conduct of needed T/TA with the assistance of key International, National, Regional and Local Experts (i.e. SPAN USA, WHO-WPRO, SPRC, SAMHSA, and PIMHnet)	X	X	X	X	X
Support community of survivors; empower individuals and families in prevention, early intervention and postvention strategies and accessing treatment services.	X	X	X	X	X
Provide needed training and technical assistance services among gatekeepers for the continued collection, analysis and reporting of suicide –related data.	X	X	X	X	X
Evaluate and Report on Project Process and Outcomes of Goal 2	X	X	X	X	X
Goal 3 - Planning					
Strengthen Focus On Life's Evaluation Component highlighting what will be measured and evaluated as a result of all stakeholders' planning and implementation processes and anticipated outcomes.	X	X	X	X	X
Assess project status, levels of accomplishment, and resources developed and sustained.	X	X	X	X	X
Modify Project Plan as necessary to reflect current resources and needs of suicide prevention, early intervention, treatment and follow-up services among providers, survivors of suicide, and other advocates.	X	X	X	X	X

Conduct ongoing assessment of current workforce knowledge, skills and capacity within the public/private sector as well as among Guam's community of survivors.	X		X		X
Continue to respond to critical training and resources needed in order to effectively build knowledge, skills and capacity for all aspects of suicide prevention, early intervention and postvention planning, implementation, monitoring and evaluation.		X	X	X	X
Continue to conduct relevant technical assistance/training of identified community key leaders and other key stakeholders, to include Crisis Hotline/Youth Helpline volunteers.	X	X	X	X	X
Develop and/or strengthen legislation, program Policies & Procedures that support the planning and implementation of suicide prevention resources (i.e. research, workforce development, prevention and treatment services).	X		X		X
Initiate the planning process for the implementation of START – **Components 3 & 4.**			X	X	X
Update and schedule the conduct of needed T/TA with the assistance of current International, National, Regional and Local Experts and partners, as well as new partnerships. (i.e. SPAN USA, WHO-WPRO, SPRC, NIMH, SAMHSA).			X	X	X
Re-establish and maintain a Survivors of Suicide Support Group that is empowered to advocate for themselves, for the development and implementation of policies, programs and practices that are culturally and linguistically appropriate and effective in prevention, early intervention and postvention strategies, and for accessing treatment services.	X	X	X	X	X
Include in Prevention & Training Branch's Media Campaign strategies that are effective in eliminating the stigma surrounding mental illness and suicide and one that promotes understanding that suicide prevention is a data-driven priority and is a preventable public health problem.		X	X	X	X
Continue collection, analysis and reporting of suicide and deliberate self-harm data and the strengthening of Guam's surveillance and monitoring systems and capacity building.	X	X	X	X	X
Evaluate and Report on Project Process and Outcomes of Goal 3	X	X	X	X	X
Goal 4–Implementation					
Conduct critical suicide prevention, early intervention and postvention training and education, as well as develop necessary resources to strengthen the current knowledge, skills and capacity among community key leaders, prevention and treatment service providers, survivors, and other key stakeholders.	X	X	X	X	X
Advocate for establishing legislation that supports strategic data-driven priority planning, implementation and sustaining of suicide prevention resources (i.e. research, workforce development, prevention and treatment services).	X	X	X	X	X
Continue implementation of START – **Components 4;** Implement START – **Component 5.**				X	X
Provide comprehensive and strategic training and technical assistance throughout the Guam community, to include service to survivors and all electronic and print media partners.			X	X	X
Maintain supportive network with and for Survivors of Suicide Support Group and other prevention advocates	X	X	X	X	X

Strengthen and maintain utilization of Guam's Crisis Hotline	X	X	X	X	X
Develop and Implement Guam's Crisis Response Team in relation to suicide behaviors	X	X	X	X	X
Maintain Media Campaign strategies and www.peaceguam.org website and in collaboration with other health initiatives and campaigns that promote positive mental health, illness management and recovery.	X	X	X	X	X
Continue collection, analysis and reporting of suicide and deliberate self-harm data and the strengthening of Guam's surveillance, monitoring systems and capacity building.	X	X	X	X	X
Evaluate and Report on Project Process and Outcomes of Goal 4	X	X	X	X	X
Goal 5- Evaluation					
Improve evaluation tools and processes for use by program administrators, staff and community partners to measure process and outcome activities in the implementation of all identified goals and objectives.	X	X	X	X	X
Develop a feedback mechanism and tools that are "user friendly" for service providers, community stakeholders and survivors.	X	X	X	X	X
Conduct Evaluation-focused training for all project stakeholders.	X	X	X	X	X
Consolidate all Evaluation Reports for each year's end of project activities.	X	X	X	X	X
Highlight Guam's project accomplishments, lessons learned and determine the way forward for sustaining ***Focus on Life*** efforts.	X	X	X	X	X

Sustained funding for comprehensive suicide research, strategic plan development and implementation is critically lacking on Guam. Opportunities for continued funding and leveraging of suicide prevention and mental health promotion resources will continue to be pursued to support full development and implementation of Guam's ***Focus On Life*** Plan.

Focus on Life
1st Stakeholder's Meeting

Thursday, March 26, 2015
Pacific Star Hotel

Notes below feature participant feedback from discussions and activities.

Meeting Notes:

1. **Focus on Life Background**
    a. Data Highlights
        i. Need: Screening in primary care; focus prevention strategies at family level
    b. FOL Goals and Objectives (Feedback from Stakeholders)
        - To educate
        - To understand
        - To build support systems
        - Figure out what works and what doesn't work
        - To bring suicide to 0
        - To change life—help the young people
        - Increase resources
    c. Stakeholders not present: Invite youth from youth clubs, Guam Coalition for Violence Prevention
2. **"S" Word Activity - Reasons we don't talk about suicide:**
    a. Opens up other problems, people (person at risk) think they are a burden, perceptions, unexpected, language, fear, cultures, stereotyping, labels, judgment, family secrets, religion, trainings to help, difficulty expressing pain, hope, taboo, hard to confront issues, open conversations, shame, awkward/uncomfortable, guilt, glamorizing, don't know of help/services, liability, self-worth, pride (person at risk and family/caregivers), not understanding, social status, superstition, scary, silence "we don't talk about it," employment/job status, gossip, bullying (cyber/social media), "what do we bring to the table?"
3. **Group Discussion – Resource Mapping Activity** (see Resource Mapping)
    a. Resources from the group were categorized into themes within each area of focus
4. **Group Discussion – Gaps & Needs Activity** (see Gaps & Needs identified by stakeholders within disciplines)
5. **Flower Garden**
    a. YRBS Respondents:
        i. High School = 1431 (78% response rate)
        ii. Middle School = 1504 (77% response rate)
    b. Stakeholders to invite: Youth from youth clubs, Guam Coalition for Violence Prevention, Guam Coalition Against Sexual Assault and Family Violence (Phone: 479-2277), GPD's Victim Assistance Unit (Phone: 475-8620), Immaculate Heart

of Mary Church (Phone: 477-9118), parents invite PTO – Parents Empowering Parents representative, Mayor's Council of Guam, Catholic Schools' representative (Cynthia Agbulos), Archdiocese – Family and Youth Ministry, Capuchin representative (Fr. Eric Forbes), Parish DRE's (Director of Religious Education), Alcohol industry, Insurance company representatives, other survivors of suicide, DOA Health Insurance Negotiators

c. Additional microphone
d. Data includes - MVA, MVP, Other "accident" per Medical Examiner office or other authority
e. Develop app for youth
f. GFD EMTs – want training for warning signs and/or refresher course
g. Screening tools for GMH, primary care

PREVENTION:

Theme:	Resources:
Formal Supports (organizations /services)	Education: DOE counseling services to students, workplace programs (needs to increase), community-based events and projects, positive behavior intervention supports (PBIS) – framework for dealing with school climate, teaching positive character building, service learning Law Enforcement: Guam Police Department, Social Services: GBHWC, I'Famagu'on-ta, DISID disability groups, support services coping with your disability, support groups for individuals with disabilities and family members (parents-siblings), Needs Assessment report – PFS-FSM community, Oasis substance abuse treatment, Parents Empowering Parents, parenting workshops, Sanctuary, Harvest, Erica's House, catholic schools, Oneop, private practice providers, I'Pinangon Suicide Prevention UOG campus, work place programs, Lighthouse Recovery Center, Island Girl Power youth/adult programs, support group (PEACE), PTSD program at Veteran's Affairs Vet Center, Self Advocacy In Action group, support groups, National Guard (SafeTALK, ASIST, Postvention) Other: GUARNG resiliency skills annual mandatory suicide prevention training,
Informal Supports	Education: Groups of informal supports Law Enforcement: Interpersonal relations (patrol officer through public contact), promoting student health Social Services: Group activities/positive outlets to be yourself, have fun, environment/climate to talk about suicide Other: Connecting advocate to be called for assistance when needed based on experience, personal references, friends, peers, family, FSMCC follow up with refer clients, provide safe environments through sports (individual and team), spiritual counseling, interpersonal relationships with community, positive life skills, cultural competitions
Policies	Education: Healthy Futures Fund (HFF) - $289,100 for programs that promote student health Law Enforcement: GPD Interpersonal Relationship (public contact) Social Services: Island Girl Power Family Enrichment Center facility open for others Other: Building programs in private schools
Outreach/ Awareness	Education: Outreach events (e.g. YFY Conference, Sanctuary Too Cool To Do Drugs Conference), suicide prevention at schools Social Services: Suicide prevention media campaigns, suicide awareness presentations in schools, Island Girl Power, church community, outreach program/awareness Other: Outreaches at malls (table top displays), Waves (GBHWC, sex assault, child abuse), forum,
Trainings	Education: DOE-approximately 125 personnel who have completed ASIST-SafeTALK training Healthcare: ASIST Law Enforcement: GFD-EMT trained as advocates for patients, mandatory training (Safe-Talk/ASIST/Connect) Social services: Postvention, ASIST, SafeTALK (PEACE) Other: LGBT sensitivity, suicide awareness workshops
Miscellaneous	Diversify the help to help the language barrier, education of social services, creating connections between resources (e.g. Stakeholder's Meeting)

INTERVENTION:

Theme:	Resources:
Counseling Services	Education: DOE-students, Student Procedural Assistance Manual Social Services: I'Pinangon, ISA Psychological Services, Law Enforcement: Military EAP's
Formal Groups	Healthcare: GBHWC Adult and Children's Inpatient Unit, GBHWC Crisis Intake after hours, clinical supervision or field staff Social Services: I'Famagu'on-ta, GALA, Inc.,
Gatekeepers	Education: Community events and projects (sing/dance/chant) Social Services: Self-help groups, Peer Education Program (LGBT and SA gatekeepers) Other: Church pastors, family, FSMCC Counseling families and church goers, friends, peers, screening, church pastors, Ask Care Escort, home/clinical setting
Resources	911, Crisis Hotline, ASIST, National Suicide Hotline
Trainings	Law Enforcement: Military ASIST/ACE, Healthcare: Staff training on depression screening of community-based patients, SafeTALK, ASIST Social Services: List of ASIST trained individuals (for accessibility), GUARNG 24-hour Crisis Hotline for Soldiers and families, gatekeeper trainings, Ask Care Escort

POSTVENTION:

Theme:	Resources:
Formal Supports:	Healthcare: GBHWC crisis incident debriefing, GBHWC Adult/children's inpatient units, VA (PTSD), EAP
Informal:	Family, friends, peers, support, Island Girl Power community garden, healing/therapy
Counseling/ Support Groups:	Education: DOE crisis debriefing, DOE counseling services Healthcare: GBHWC Crisis debriefing, grief and Loss counseling/support program Social Services: Survivors support group, suicide support group, clinical prevention follow up via counseling
Capacity Building/ Training:	ASIST, SafeTALK, Connect Education: DOE-approximately 46 personnel trained in Postvention

REFERRALS:

Theme:	Resources:
Counseling Services:	Healthcare: GBHWC, School and GMH referrals to GBHWC, PTSD referrals to VA and Vet Center, Policies and procedures to refer patients with risk indicators for mental health assistance/support, community program collaborations for service referral Law Enforcement: GPD Social Service: PEACE, VARO, Healing Hearts, ASIST trained, Inafa Maolek conflict resolution referrals, VARO, Hotlines (24 hours),
Informal supports	Friends, families, peers, sent to spiritual leaders, FSMCC counseling then refer to appropriate resources and organizations,
Support Groups:	Faith-based, FOL support group
Miscellaneous:	Social Services: FOL resource directory, FOL hotline, peaceguam.org resources, existing services

Current Resources

	1. First Responders	2. Youth Serving Organizations	3. Youth/Adult Serving Organizations	4. Primary/Behavioral Healthcare Providers
Training & Program Development	• GPD: Victims' Advocate • Military (Army Guard): open to all military • GPD: JIS (Juvenile) thru processing	• AmeriCorps • GREAT: Gang Resistance Education • Adult/Youth Probation	• Sanctuary AmeriCorps Program • CPS Family Preservation Services (home based support service/referral)	• Faith based trained in suicide prevention, intervention, postvention
Professional Support	• GFD, DYA: Chaplain • Military: Chaplain and psychological staff • DYA: clinical professionals	• Peer Mediation	• Consult/refer to psychological specialist in Micronesian studies • IMFT: Counseling Sessions	• Community of MH/PH professionals • Primary Care providers • Home visits by providers
Community Support	• Military: smart phone app "Guard Ready" • GFD: initial identification for services needed when responding to a crisis	• Girls Empowerment Center 14-17 • Church Youth Group	• GALA peer educators	
Cultural Factors			• Indigenous leaders	• Cultural Practices

Resources Needed From Within

	1. First Responders	2. Youth Serving Organizations	3. Youth/Adult Serving Organizations	4. Primary/Behavioral Healthcare Providers
Training & Program Development	• GPD, DYA, GFD, Military: Mandatory Training • Executive/Management Level training	• Required training for teachers, coaches, etc. • Training One-Stop	• Suicide component in parenting skills group • Resource Directory that is comprehensive and easy to find • Traditional living programs • Outreach/canvassing to homes • Helpline that is culture specific • Culturally sensitive interventions	• Trained personnel • Professional development for Medical/First Responders for high risk behaviors

	1. First Responders	2. Youth Serving Organizations	3. Youth/Adult Serving Organizations	4. Primary/Behavioral Healthcare Providers
Capacity Building & Resource Allocation	• Funding	• Funds (used for right purpose) • Capacity Building (curriculum at UOG)	• Funding • Court System: More therapists • Available private practitioners • IFAM: need more social workers • Increase community advocates • Supply interpreters for limited English plans (or CLC) • More foster homes /transition homes • Transportation for physical interventions	• Local Funding • Budget Priorities
Policy & Procedures		• Strengthen Referral Process/Follow up • Standardize Consent Policies and screen tools	• Sanctuary: policy for postvention	• Established curricula within UOG/GCC/PIU • Policies; Decision Tree
Additional Research			• Updating data and identifying priorities	• More research on needs and risk factors for Micronesian communities
Organizational Collaboration			• Reinforce involvement of families (media, DOE, parent support groups)	• CLAS
Cultural Factors	• Behavior Changing			

Supports Needed from Outside

	1. First Responders	2. Youth Serving Organizations	3. Youth/Adult Serving Organizations	4. Primary/Behavioral Healthcare Providers
Training & Program Development	• Mayors to be trained • Clergy to get trained • Senior NCO's to be trained	• Trained facilitators	• Coalition active in suicide prevention (raise awareness of services) • Support group for those who have attempted	• Professional development for other professionals (FR) for high risk behavior

	1. First Responders	2. Youth Serving Organizations	3. Youth/Adult Serving Organizations	4. Primary/Behavioral Healthcare Providers
Capacity Building & Resource Allocation		• Funds for community organizations		• Insurance support for mental health treatment (Government Insurance Negotiations) (Insurance Representatives)
Policy & Procedures	• Legislature: Strengthen and solidify policy and training • Cross agency policy (All Stakeholders)	• Standardized Consent Policies and referral forms • Policy and advocacy • Weave health into all public policies • Medical community into GBHWC	• Government policies, SOP's, funding for data collection on attempts and LGBT profile • Reassessment of current policies/resources	• Coordinated plan for all agencies with regard to suicide prevention, intervention, postvention, referrals (MOU)
Organizational Collaboration	• Community Support	• Community collaboration • Increase political support	• More community networking • More Government networking (Guam, CNMI, FSM, RMI) • Involve faith based communities • Media to help promote awareness of services	

Challenges

	1. First Responders	2. Youth Serving Organizations	3. Youth/Adult Serving Organizations	4. Primary/Behavioral Healthcare Providers
Training & Program Development	• Who gets trained to do the work that doesn't get done • Universal system of prevention			• Village outreach • Enhance wellness programs to be more holistic • Training in the villages
Capacity Building & Resource Allocation	• Lack of Funding • Money not directed for suicide prevention • Awareness of resources	• Lack of funding	• Funding (not qualified, discontinued, limited) • Lack of staff/manpower/service provider • Public/after hours transportation	• Insurance support for outreach/home visits • Under funded APS and CPS • Transportation challenge • Government budget priorities • PC providers for screening (SBIRT)
Policy & Procedures		• Legal Challenges	• Policy • Restriction on confidentiality	• Behavioral health co-ops
Additional Research				• Report back (progress challenges, what has changed)

	1. First Responders	2. Youth Serving Organizations	3. Youth/Adult Serving Organizations	4. Primary/Behavioral Healthcare Providers
Organizational Collaboration	• Lack of communication • Support from the TOP	• Political Will • Religious Resistance • Medical Profession Resistance	• Lack of knowledge/awareness	• Involve decision makers (government, senators, Mayors' Council of Guam) • Federal/Local government support of use of cultural progression
Cultural Factors	• Language barrier	• Language and cultural norms • Counter message of assisted suicide • Glamorization • Natural Disaster • Social Media	• Cultural barriers • Stigma/taboo/not acceptable	• Cultural practices/tradition for engaging community

Attachment: Stakeholder Meeting #2

Focus on Life

Garret Lee Smith Youth Suicide Prevention
2nd Stakeholders' Meeting: Policies and Protocols
Wednesday, June 24, 3015
Pacific Star Hotel, Tumon

Notes below feature participant feedback from discussions and activities.

Meeting Notes:

FOCUS: Policies & Protocols

1. **Welcome and Introductions**
    a. Participants include: GBHWC, DOE, Archdiocese of Agana, Legislature, VARO, I'Pinangon, Guam Amateur Baseball, YFYLG, Island Girl Power, Sanctuary, Inc., Inafa' Maolek, Department of Corrections, Guam Army National Guard, FSM CLAG, DPHSS, DYA, Compassionate Friends, GPD, Southern Christian Academy, Pa'a Taotao Tano
2. **Recap of 1st Stakeholder's Meeting (held March 26, 2015):**
    a. 6 participants attended last stakeholder's meeting; many new stakeholders (invited based on suggestions from previous meeting)
3. **Crisis Response and Referral Processes**
    a. GBHWC Crisis Response Team by Sylvia Quinata, Counseling Services
        i. Currently 6 teams; respond after a suicide death; Gather details and incorporate treatment based on needs of survivors of suicide
        ii. Mission: Mental health and substance abuse treatment in addition to other programs/services: **PEACE**, Healing Hearts, **Child Adolescent Services Division, Clinical Services-Community Support Services**, **Counseling Services**, New Beginnings, Drug & Alcohol Treatment, Intake, Emergency Services & Crisis Hotline, Nursing Services, **Professional Support** (psychiatry/psychology), Residential Recovery Program
        **bold includes programs that mobilize for Crisis Response Teams*
        iii. Duties of team: Mobilize to provide debriefing to individuals affected by traumatic death (including but not limited to suicide, sudden accidental death, layoff in workplace, community crisis); provide support at home, school, and/or workplace
        iv. Protocol:
            1. Call department
                a. 24-hour Crisis Hotline: 647-8833
                b. Reception desk (8a-5p): 647-5440/5325
            2. Annie Unpingco will notify GBHWC to mobilize team with I'Famagu'on-ta and PEACE
            3. Francis will contact referee
            4. Team will conduct assessment
            5. Mobilize
        v. Q & A:

1. Currently working on translators to response to non-English speaking callers; Cultural and Linguistic Services and Partners with AG's office working on written policies to include language interpreters to identify and create funded positions in government for every government service provider; open access to community
2. Crisis Hotline contracted with non-profit organization until September: system does not currently allow for call forwarding
3. Takes a lot for individual to reach out; need for outreach; "one way link" or disconnect between needs and resources; not just electronically due to access
4. Be creative about: Cultural skill of asking for help and resiliency skills; island families want to work in-house and youth rather problem solve and reach out via texting and Whatsapp; need to put outreach within the community and amongst peers due to cultural stigma; Will these communities want to talk about it?

b. GPD by Officer Michael Jay Lender
   i. Mostly respond after-the-fact; gather information and provide contacts for services; have responded prior to
   ii. Persons-In-Need of Service (PINS) case: Can put individual on involuntary 72-hour hold at GBHWC (determined based on information from referee)
   iii. No written policies or protocol for suicide
      1. Will take PINS individual to GBHWC
      2. To prepare, send GPD officers to ASIST (PEACE office) when available so that we can recognize individuals at risk for suicide and respond accordingly; trained individuals share at briefings before shift and trainings at precincts
      3. Victims Assistance services usually respond to victims of sexual assault
   iv. Q & A:
      1. Data on attempts, deaths
         a. Data under reported
         b. Anecdotally, large percentage of FSM
      2. GPD required to give individual medical attention if injured prior to being incarcerated; currently no staff psychologist due to budgetary constraints
      3. Question on voluntary psychologists/therapists: No pro-bono therapists; currently officers can only go to therapy voluntarily through insurance
         a. Available chaplains that officers can go to
         b. Recommendation: Cost-share with GFD for full-time therapist
      4. FSM ministers provide support to male and females in prison?

a. Faith-based supports provided at DOC at request of prisoners
5. Critical need to fund full-time staff psychologist to provide support for first responders
6. Officer asking participants to notify Police Chief to request for staff psychologist – include in FOL Strategic Plan

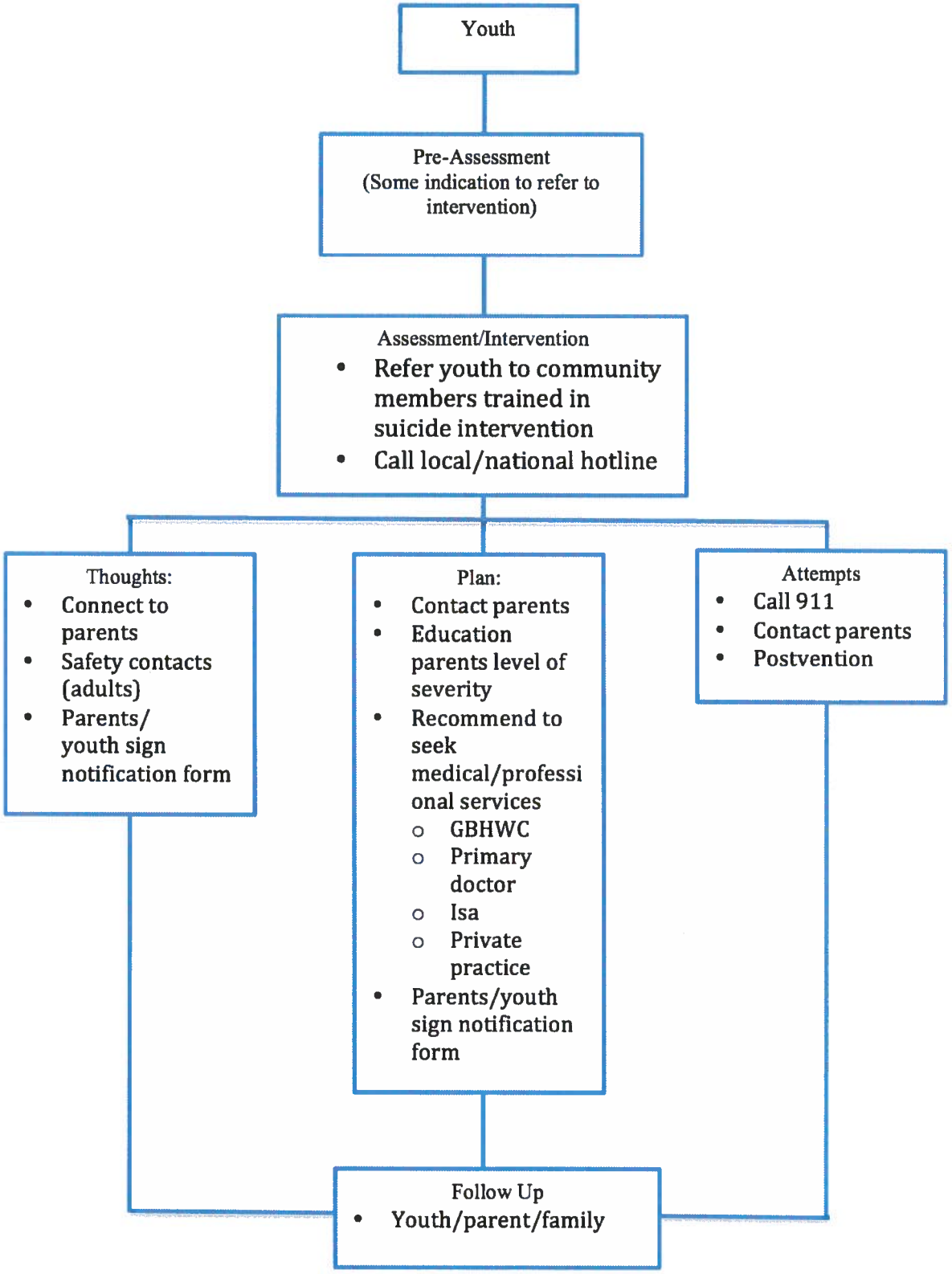
c. GDOE – Nicole, Student Support Services Division
   i. 3-school-level services provided: psychological, section 504, truancy prevention
   ii. 3 district-level services provided: standard operation procedures, liaison for GBHWC (ASIST, Safetalk, Connect trained), professional development for school counselors, administrators, staff monthly
      1. Collaborating with I'Famagu'on-ta
      2. Want to include GPD and FSM community
   iii. Student Procedural Assistance Manual (SPAM) (2011) – Chapter 14 (currently under review; see new proposed changes in GDOE ppt)
      1. Suicide Chapter Outline:
         a. Includes parts for students who are not in serious, immediate danger, those in serious, immediate danger, and relationship of the suicide intervention procedures to the child abuse and neglect referral and coordination procedures (determine if attempt related to abuse and respond accordingly with CPS)
         b. Suicide Incident Notification Forms for suicide attempts, CPS form
   iv. Q & A:
      1. Cases where parents request to not use ambulance due to costs?
         a. Response: Policy is to use ambulance, however at discretion of school administrator
      2. Issue with type of insurance especially high-deductible insurance for GovGuam employees; limiting access to necessary medical services
         a. Recommendation: Ensure every insured person has basic needs (reasonable, necessary treatment) to include coverage for reasonable number of visits (~3) to psychological /therapeutic services; include at next insurance negotiation; mental health focus
         b. These families end up going to public health services, thus overloading public health services
      3. How to manage social media: use tools on current social media outlets to reach out to youth at-risk (Facebook, Instagram, Twitter)
      4. Needs:
         a. To continue collaboration among agencies to increase response time;

b. Define "immediate danger" collectively

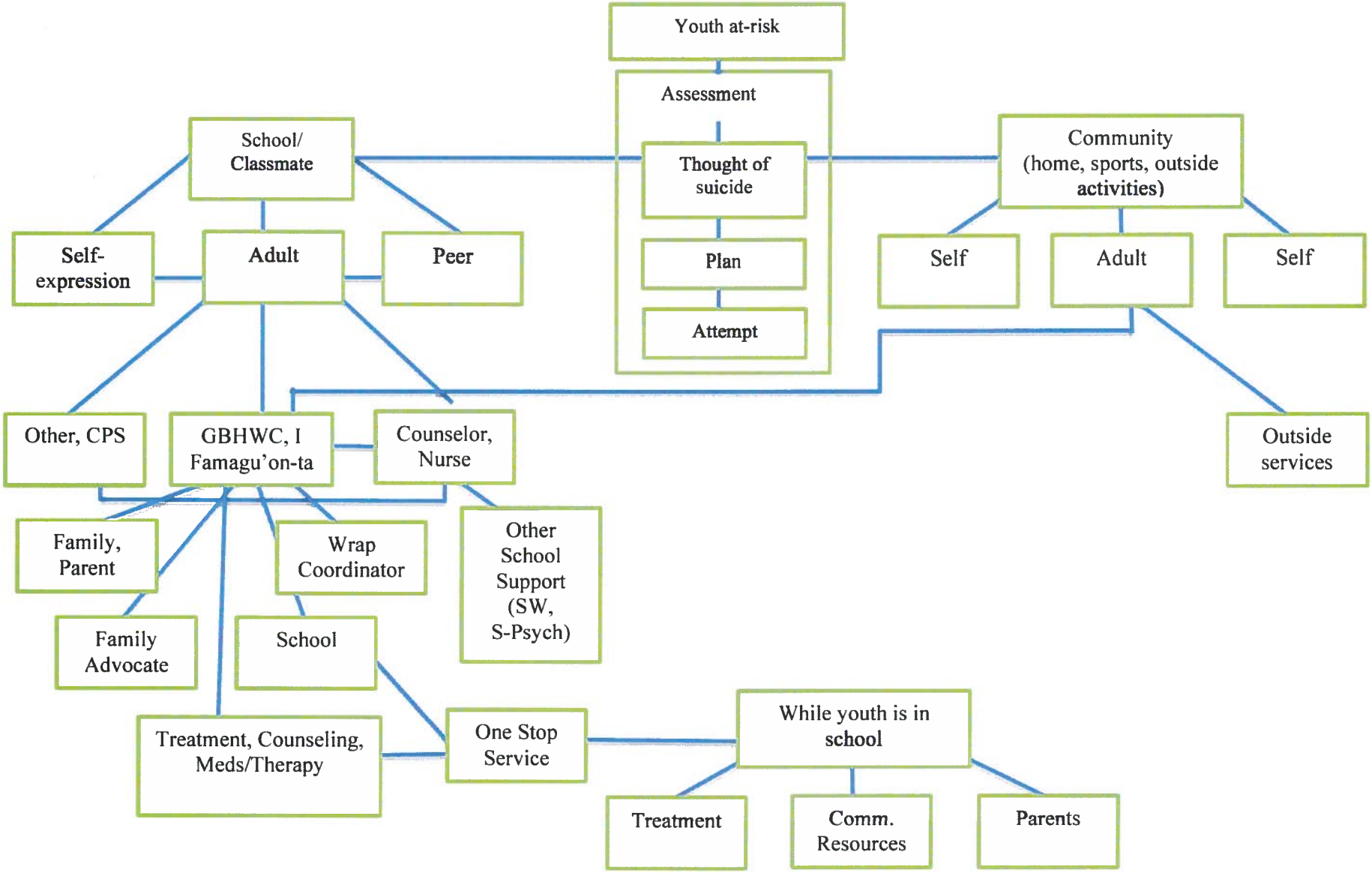
5. Suicide prevention trainings for teachers? Use staff development days?
    a. ASIST is difficult because it is 2-day training, however counselors, nurses, and teachers are working to get trained in SafeTALK, ASIST, Connect
    b. Now have DOE trainers for SafeTALK
    c. Currently trainings are not mandated; however included in Vision 2020 with focus on counselors and nurses
    d. Recommendation: Suicide prevention trainings prior to person becoming certified as a teacher or hired as a teacher with DOE; perhaps include during teacher training at UOG (e.g. bullying prevention course for soon-to-be teachers)
6. Headstart; support provided for special education at charter schools (still figuring out relationship with charter schools)

4. **Group Work: Decision Tree** *(see protocols)*
    a. Youth (Education)
    b. Youth (in community setting)
        i. Pre-assessment=somebody; Facebook post; some indication to get someone to refer to Intervention
        ii. Parent notification form: Form to assign accountability to parents and organization/community members
            1. Recommendation: Include youth on form
        iii. Healing/coping strategies for grief after suicide death: Things that are in sync with culture but do not glamorize suicide (i.e. floating lanterns with message).
        iv. Recommendation: Include youth in drafting protocol
    c. Law Enforcement/First responders: DOC & DYA
    d. Clinical service providers
5. **Flower Garden**
    a. Social media: youth education; address negative/positive effects of posts and tweets
    b. Safe-messaging
    c. Suicide safe
    d. Clay Hunt Act for dealing with suicidal veterans; what statistics, resources, and services are given to suicidal veterans?
    e. ASIST training (or other trainings) specifically for faith-based youth groups
6. **Next Steps: Pathways to action**
    a. Next meeting: July 15
        - Draft protocol for individual at-risk for suicide and work with respective organization to review/revise. Bring protocol back to 3rd Stakeholder's Meeting on 7/15

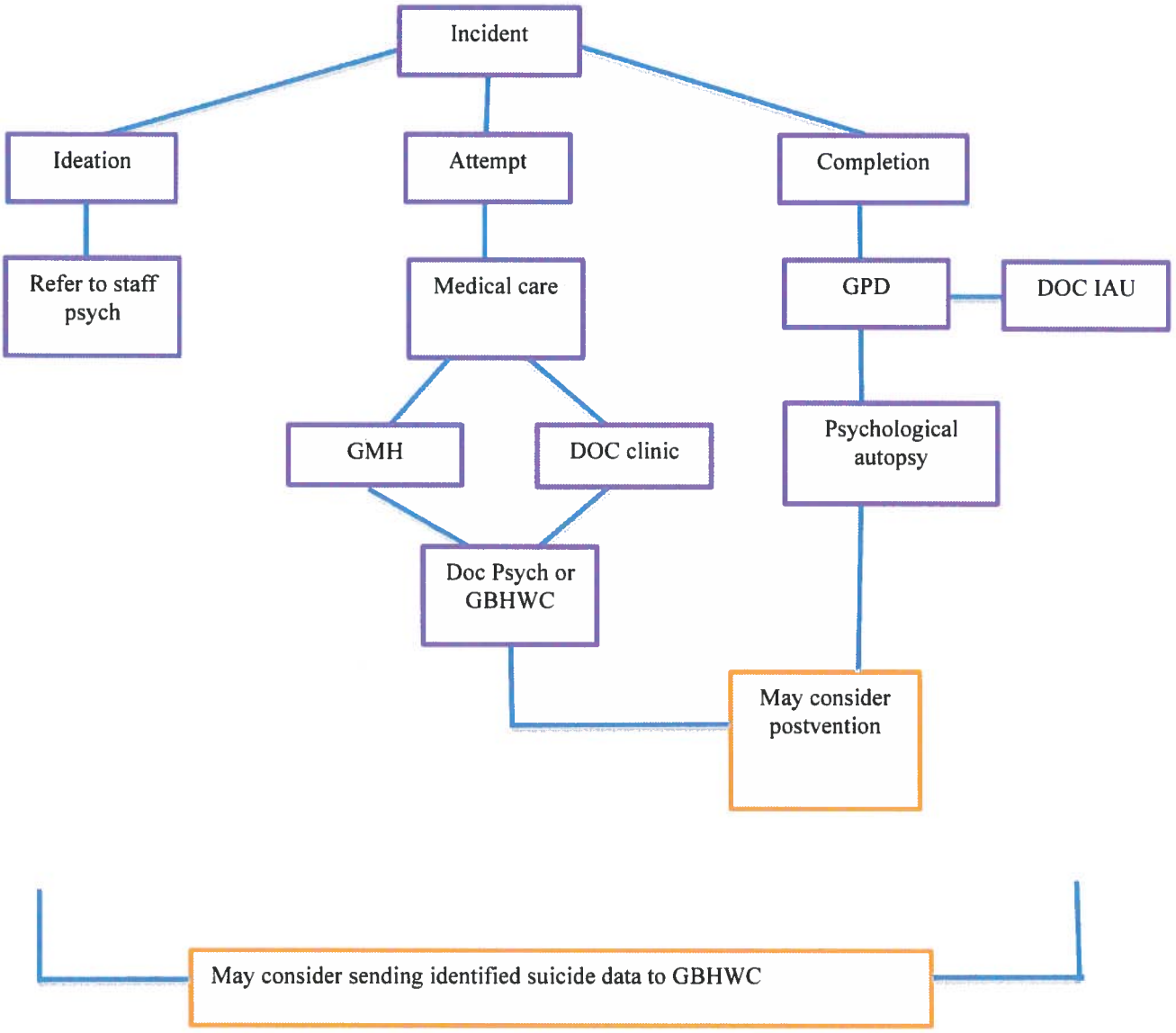
Youth-Serving (Community Setting)
Protocol



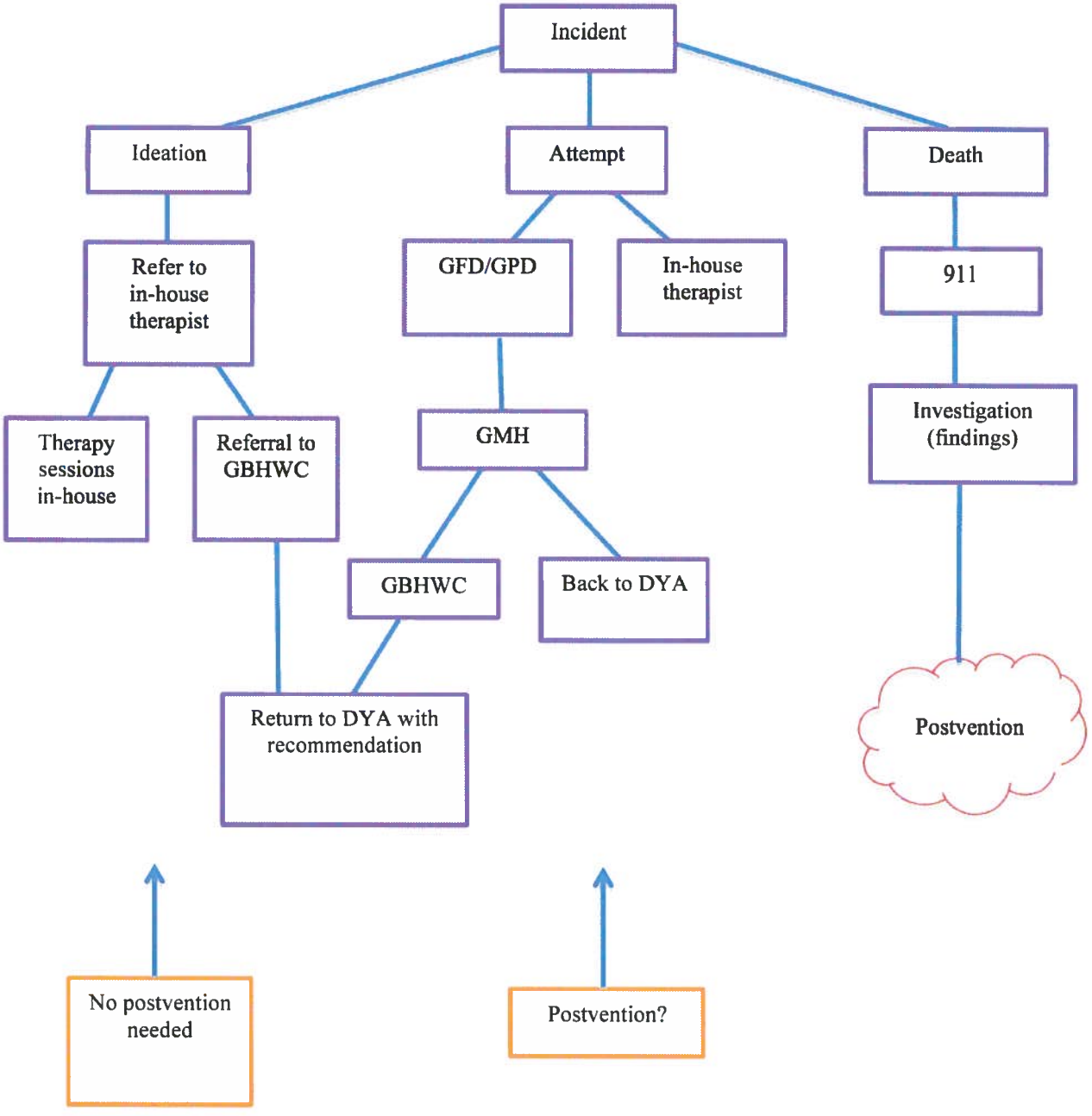
Youth-Serving (Education)
Protocol



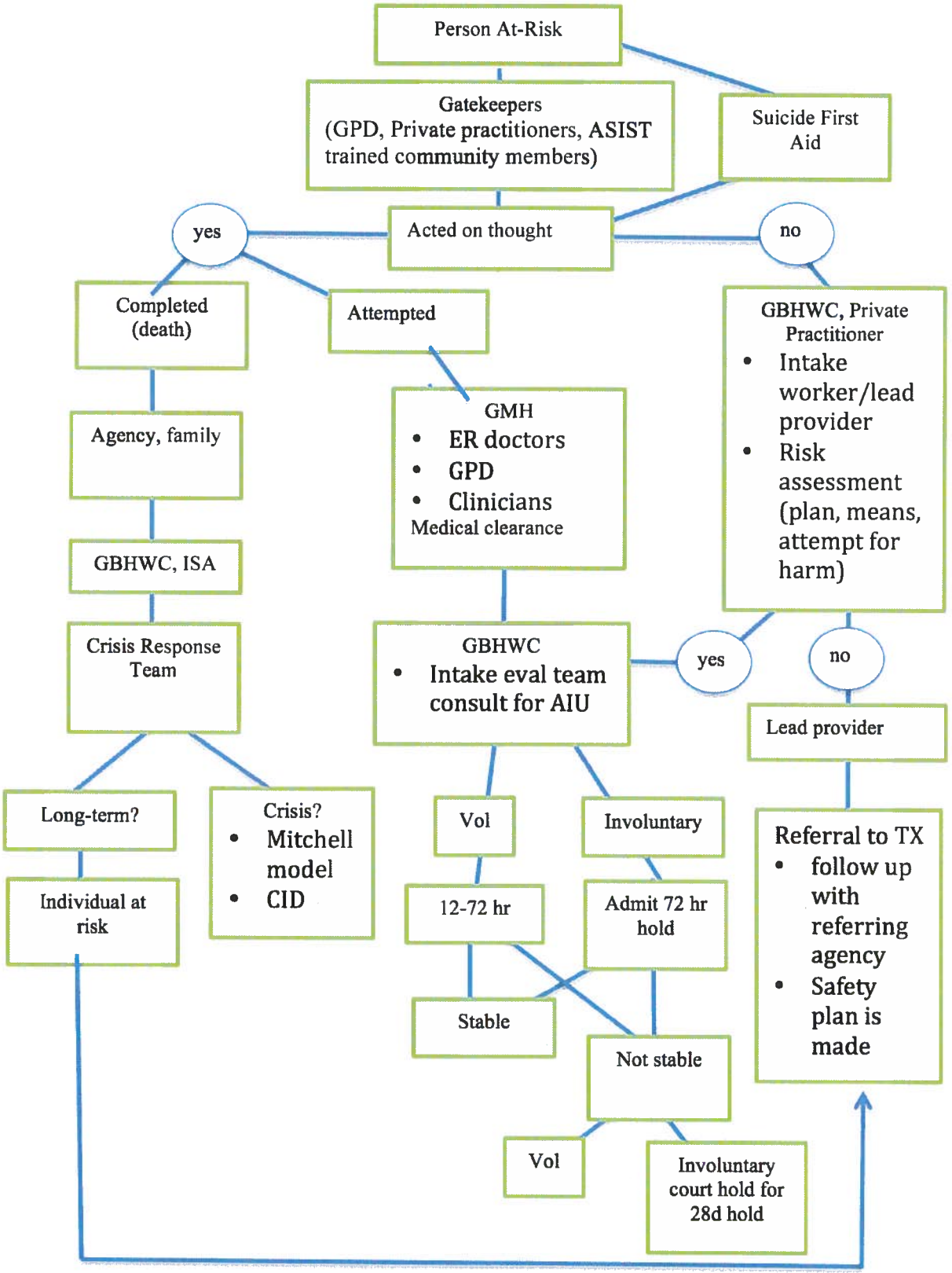
Law Enforcement/First Responders
DOC
Protocol



Law Enforcement/First Responders
DYA
Protocol



Healthcare
Protocol



Attachment: Stakeholder Meeting #3

Focus on Life
Garret Lee Smith Youth Suicide Prevention
3rd Stakeholders' Meeting: Pathways To Action

Thursday, July 30, 2015
Pacific Star Hotel, Tumon

Notes below feature participant feedback from discussions and activities.

Meeting Notes:

FOCUS: Policies & Protocols

1. **Welcome and Introductions**
   a. Participants included: GBHWC, DOE, Archdiocese of Agana, I'Pinangon, Guam Amateur Baseball, Island Girl Power, Inafa' Maolek, Guam Army National Guard, GFD , DYA, GPD, DISID, DPHSS, FSM, Pa'a Taotao Tano and Community representation.
2. **Recap of 2nd Stakeholder's Meeting (held June 24, 2015):**
   a. Review of FOL Goals and Objectives:
      1) Establish, strengthen and maintain FOL Task Force (Sub-committee of PEACE Council).
      2) Strengthen Guam's suicide-related data collection, monitoring and surveillance system.
      3) Establish and/or strengthen policies, practices and programs that support workforce development and well-being.
      4) Develop and Implement Guam's Crisis Response Team
      5) Establish, update, and/or strengthen agreements, policies and procedures for suicide prevention, intervention, postvention, and referrals among Guam's Government agencies and community organizations.
      6) Identify and earmark local funding to support and sustain Focus on Life goals and strategies.

Comments/Feedback from participants regarding FOL Goals and Objectives:

- Continue discussions regarding healthcare on Guam for Insurance FY16 coverage: healthcare package for wellbeing & seeking help services. Building upon existing wellness coverage, allow employees free mental health care for x amount of sessions before co-payment or deductibles kick in. (Reference Goal 3).
- Government of Guam Insurance negotiations team member will bring this up during negotiations meeting scheduled for July 30 for consideration in FY16 (Reference Goal 3).
- Standardized Data Collection spreadsheets and tools needed for Stakeholders across agencies and organizations (Reference Goal 2)
- DOE training policy to allow for training to include one-to-one aides and other DOE staff in direct contact with students. (Reference Goal 3)
- Government of Guam agencies and organizations to have policy

write-up for mandatory trainings (ASIST, safeTALK, Connect, Lifelines and Team Awareness) (Reference Goal 3 and Goal 5)

b. Link back to last meetings closing:
"I want..." and **"I will..."** activity:

Comments/Feedback from participants:

- "I want a system of self-care/Insurance wellness for care providers." "I will seek further support for this."~Christine Camacho, GBHWC
- "I want more resource materials." "I will contact GBHWC for additional resources."~Dr. Hope Cristobal, Private Practice
- "I want to update my agency's SOP's (SPAM)." "I will forward for draft for feedback to stakeholders."~Nikki Monforte, GDOE
- "I want to use trainings to help students." "I will get trained in all gatekeeper trainings soon."~Austin Terlaje, Inafa Maolek
- "I want to know if there are any current suicide prevention policies within my organization." "I will check with Inafa' Maolek on our current policy."~Raeleen Pangelinan, Inafa Maolek
- "I want to get more families involved in suicide prevention for soldiers." "I am currently, and will continue, working on this in the Guam Army National Guard."~Deana Esplana, GUANG
- "I want the upcoming fire cycle to have the ASIST training incorporated into the Fire Academy." "I will have discussions for this for next cycle."~Jaque Santos, GFD
- "I want to make time to take suicide prevention trainings as a cabinet member." "I will encourage other cabinet members to make time as well and to incorporate into policies also." ~Director Servino, DISID
- "I want to bring in grassroots for trainings and awareness and sit with them to ask "How did that make you feel?" after participating in FOL trainings." "I will prioritize time to sit and chat with them after each training they attend."~Juanita Blaz, IGP

3. **Group Work: Action Plan**
Participants were placed into three (3) working groups and tasked to develop an action plan on two (2) goals (FOL Goals and Objectives) to include action step(s) person(s) responsible and timelines, .

GROUP A: Isabella Fagota (Community Representative), Juanita Blaz (Island Girl Power), Morael Escalona (I' Pinangon), Dr. Patricia Taimanglo (Department of Corrections), Darleen Caasi (I' Pinangon), Austin Terlaje (Inafa Maolek), Remy Malig (GBHWC/P&T), Renee Mesa (Island Girl Power), Debbie Duenas (GBHWC/P&T)

Assigned with Goals 1 and 2:

1) Establish, strengthen and maintain FOL Task Force (Sub-committee

of PEACE Council).
2) Strengthen Guam's suicide-related data collection, monitoring and surveillance system.

Group B: Ben Servino (DISID), Tim Santos (GPD), Jacques Santos (GFD), Brad Hewitt (GABA), Sylvia Quinata (GBHWC), Christine Camacho (GBHWC), Mark Perez (DOC), George Hauk (FSM), Vicente Villoria (IGP), Michelle Sasamoto (GBHWC/P&T)

Assigned with Goals 3 and 4:

3) Establish and/or strengthen policies, practices and programs that support workforce development and well-being.
4) Develop and Implement Guam's Crisis Response Team

Group C: Nikki Monforte (DOE), Rowena Torres-Morada (GBHWC/I Famaguonta), Lila Lujan (Archdiocese of Agana/BBMCS), Rebecca Respicio (DYA), Melissa San Nicolas (DPHSS), Therese Arriola (Pa'a Taotao Tano), Dr. Hope Cristobal (Private Practice), Deana Esplana (Guam Army National Guard), Rosemarie Camacho (Guam Army National Guard), Raeleen Pangelinan, Helene Paulino (GBHWC/P&T)

Assigned with Goals 5 and 6:

5) Establish, update, and/or strengthen agreements, policies and procedures for suicide prevention, intervention, postvention, and referrals among Guam's Government agencies and community organizations.
6) Identify and earmark local funding to support and sustain Focus on Life goals and strategies.

4. **Group Work: Group Presentations**

Group A:
Goal 1: Establish, strengthen and maintain FOL Task Force (Sub-committee of PEACE Council).

Action Steps	Who is responsible?	Projected Timelines
Develop Task Force: Bringing in partners that deal with the target population which is males (18-30 y/o Chuukese, Chamorro and Japanese tourists.	Partners (to be comprised of representation from): GPD, GFD, DOE, DOL, AHRD, GHURA, GCC, UOG, NCD, Judicial Court System (Probation Office), Medical Practitioners, Shelters / Recovery Centers, Life Coaches, Youth programs, Wellness Programs, Healthcare service providers,*Survivors of Suicide. *Insurance Providers *Faith-based, *Cultural Groups *Worksite Wellness Coaches, *Guam Memorial Hospital	3 Months to develop Task Force and Data Collection Template: **October 2015**

Group A:
Goal 2: Strengthen Guam's suicide-related data collection, monitoring and surveillance system.

Action Steps	Who is responsible?	Projected Timelines

Develop & Implement suicide-related Data Collection, Monitoring, and reporting system (change from surveillance system): Have a Biopsychosocial Database (standardized) using an electronic template: flexible to each agency's terminology. Database to be updated quarterly (at the least). Designated persons in charge to be receiver of data collection will: • Remind agencies to update template. • Analyze and disseminate information/data. • Provide qualitative and quantitative data with cultural perceptions on suicide to be more sensitive.	Designated Person(s) in charge to be Receiver of Data: **GBHWC**	3 Months to develop Task Force and Data Collection Template: **October 2015**

Data template to be organized into sections: 1) Behavioral: Isa, Latte Treatment, GBHWC, Rays of Hope, Private Practices, I' Pinangon 2) Medical: *Guam Memorial Hospital, GBHWC, GMC, Private Practice, DPHSS, Veterans Clinic. 3) Law Enforcement/Correctional: DYA, DOC, GPD, Probation 4) Judicial: Courts, AG's Office, Guam Legal Services, OPG 5) Educational: DOE, UOG, GCC, JP Torres, Special Education, Charter Schools 6) Community: Mayors' Council, Non Profit Organizations, Sanctuary, LGBT Community, IGP, Service Providers 7) Faith-based: Catholic Services, Oasis Empowerment, Lighthouse Recovery, Salvation Army 8) Military: Air Force, Army, National Guard, Navy, Marines, Veterans.	Designated Person(s) in charge to be Receiver of Data and create date template: **GBHWC**	3 Months to develop Task Force and Data Collection Template: **October 2015**

Group B:
Goal 3: Establish and/or strengthen policies, practices and programs that support workforce development and well-being.

Action Steps	Who is responsible?	Projected Timelines
1) Meet with Director or Agency Head to inform of program regarding suicide workgroup (GBHWC, GPD, GFD, etc.) 2) Present packet as draft form • Identify roles • Revision of existing policies/trainings • Review and revise existing policies and trainings 3) Develop presentation to Cabinet Members 4) Meeting of Cabinet Members (Director Servino (DISID) and Director Vega (GBHWC) 5) Review of internal policies and MOU's - Identify challenges, find common ground, draft MOU and finalize draft.	Director Servino and Dr. Vega with GBHWC Prevention and Training to make presentation to Government Cabinet Members. Meeting of Cabinet Members. Stakeholders to review internal policies and MOU's	Develop presentation Draft: **August 17, 2015 (GBHWC P&T)** Meeting: **August 28, 2015** Review of policies and MOU's: **August 12, 2015**

FOL, NCD, One Nation, Wellness: Campaign Leveraging existing worksite wellness campaign. Example: Cards with benefits, discounts to include gym, restaurants, spas, salons theatres etc. from NCD, Guam Chambers, Rotary and GHRA.	POC: Nash Guerrero (GBHWC), Pat Luces (DPHSS)	**By January 2015**
Trainings, events, outreaches, insurance negotiations meetings for individual counseling sessions with reasonable co-payments.	Director Servino (DISID)	**Next Fiscal Year**
Gatekeeper trainings to be incorporated into policies for new hires and existing law enforcement academies.	POC's: Tim Santos (GPD), Mark Perez (DOC), Jaques Santos (GFD).	**August 12, 2015**
Employee Assistance Program (EAP) Internal policies surrounding trauma or grief support/proposal to law makers.	PEACE Council, Director Vega (GBHWC), Senator Dennis Rodriguez and Senator Frank Aguon	**December 2015**

Group B:

6) Goal 4: Develop and Implement Guam's Crisis Response Team.

Action Steps	Who is responsible?	Projected Timelines
Task Force: Action I: Identify roles/agency Lead and Teams to respond to crisis, traumas and grief. Provide directory/roster and POC's for the following: GPD/CAPE, GFD (dispatch), GBHWC, GMH, DPHSS, DOE, Military (NG), Mayors', Cultural groups, Clergy, UOG (Isa Psychological), Community organizations, Gatekeepers and Volunteers.	Task Force	**By 2nd Task Force Meeting**
Action 2: Determine what is needed. Logistics, Supplies and materials, Transportation, Communication devices, Headquarters, Policy/Procedures.	Task Force	**By 2nd Task Force Meeting**
Action 3: Define type of responses.	Task Force	**By 2nd Task Force Meeting**
Crisis Response Team Who? What? When? Where? How?		**By 2nd Task Force Meeting**

Group C:
Goal 5: Establish, update, and/or strengthen agreements, policies and procedures for suicide prevention, intervention, postvention, and referrals among Guam's Government agencies and community organizations.

Action Steps	Who is responsible?	Projected Timelines
Develop a standard framework for suicide policies and procedures/agreements across Government of Guam agencies, community organizations and system of care councils. Ask for P&P's/Agreements from GovGuam agencies. Obtain Executive Order for suicide P&P's/Agreements and invitation to NGO's and Private Sector. Identify components for suicide standard framework (definition, gatekeeper trainings, referral systems, tools, screening, funding, etc.) Law: GPD, GFD, DYA, DOC, Courts. Health: DPHSS, GBHWC, GMH, DISID. Education: DOE, UOG, GCC Legislative: Speaker, Vice Speaker and Chair of Health. Community: NGO's, Media, Private sector (Insurance companies, Private schools and Private clinics.	Director Ben Servino Government Representative and GBHWC GBHWC to Chair	**August 2015** Cabinet Meeting **6 months** **12 months**

Write and adopt a standard framework document and specific agency policy and procedures. Provide Public Awareness Campaign.	GBHWC and All Agencies	**24 months**
Expansion and implementation among all government agencies.	GBHWC and Task Force	**By 4 years**
Provide updates and evaluations.	GBHWC and Task Force	**By 5 years**

Group C:
Goal 6: Identify and earmark local funding to support and sustain Focus on Life goals and strategies. Goal 6 folded in Goal 5

Action Steps	Who is responsible?	Projected Timelines
Finalize standard GovGuam policy on suicide in writing and identify funding needed to sustain establish policy and procedures.	GBHWC Prevention Branch	**3 months**

5. Next Steps/Closing

A. Nikki Monforte to send draft SPAM electronically for stakeholders to review and provide feedback.
B. I want... I will... (to be reported at next Task Force Meeting)

FOL 1st Task Force Meeting to be announced.

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	( ) Yes (•) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The SSA made sure there are provisions in the contract with the NGO (Non Government Organization) to ensure that pregnant women are admitted to treatment within 48 hours. The NGO must comply with the scope of service to ensure pregnant women are admitted to treatment within 48 hours. SSA has had the same NGO providing substance treatment for women since FY 2005 and there is not one complaint regarding a pregnant woman not getting services in a timely manner. The SSA also monitors the NGO through site visits or by scheduled program reviews. Thus far, pregnant women needing services were always admitted in treatment within the 48 hours' time span.

Guam always had low numbers of pregnant women coming into treatment. Should there be a time where residential services are full the SSA will work with the NGO on an alternative for the pregnant woman in need. Guam is a small island where families are still closely knit no matter what severe difficulties they are going through. To provide intensive case management and to look for extended family has been an option for shelter as the pregnant woman receives substance abuse treatment on outpatient basis.

The Drug and Alcohol Supervisor is responsible to monitor the NGO contracted to serve women who are pregnant and women with dependents. Monitoring is done at least quarterly. The NGO must provide quarterly report that shows how many pregnant women were served or women with dependents. Thus far, its been low numbers for those women in treatment who are pregnant. The Supervisor communicates on a regular basis with the Director of the NGO on a monthly basis by phone call or via face to face meeting in the Community Substance Abuse Development Group. Issues in regards to pregnant women and other treatment issues are discussed for resolution. The Drug and Alcohol Supervisor and his staff would also conduct a program review at least once a year with follow-ups. The review is going over the scope of services to ensure that NGO contracted has been provided the services on a continual basis and at fidelity level. There is only one program on Guam, namely the Oasis Empowerment Center on a residential basis.

The contracted NGO has its on policies that require each PWID, PP, and PWWDC to apply for welfare and health care benefits with the Department of Public Health and Human Services (DPHSS). The consumers (PWWDC, PP, PWID) are taken to DPHSS upon entry in to the Substance Abuse treatment program so that they will receive benefits, and primary health care and prenatal care as soon possible.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	○ Yes ◉ No
b)	14-120 day performance requirement with provision of interim services	○ Yes ◉ No
c)	Outreach activities	◉ Yes ○ No
d)	Syringe services programs	○ Yes ◉ No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	◉ Yes ○ No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	◉ Yes ○ No
b)	Automatic reminder system associated with 14-120 day performance requirement	○ Yes ◉ No
c)	Use of peer recovery supports to maintain contact and support	◉ Yes ○ No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	◉ Yes ○ No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The SSA made sure there are provisions in the contract with the NGO to ensure that PWID are admitted to treatment within 24 hours. The NGO must comply with the scope of service to ensure PWID are admitted to treatment within 48 hours. GBHWC has had the same NGO providing substance treatment since FY 2005 and there is not one complaint regarding a PWID not getting services in a timely manner. The SSA also monitors the NGO through site visits or by scheduled program reviews. Thus far, PWID needing services were always admitted in treatment within the 24 hours or less time span.
The SSA provides semi-annual evaluations on each contracted provider to determine if the provider is meeting the quality and safety standards set by the SSA through the Contracts. PWID and PWWDC are priority populations for admissions to any SUD programs on Guam.
The current programs in the state have been compliant with this policy.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	◉ Yes ○ No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	◉ Yes ○ No
c)	Established co-located SUD professionals within FQHCs	◉ Yes ○ No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

SSA consumers are referred to the Department of Public Health and Social Services for TB clearance and treatment when needed. At present these services are free to the consumers.
SSA consumers and consumers of contracted providers are referred to the Department of Public Health and Social Services and must present their TB clearance upon admission to the programs.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	(•) Yes ( ) No
b)	Establishment or expansion of tele-health and social media support services	(•) Yes ( ) No
c)	Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS	(•) Yes ( ) No

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?	(•) Yes ( ) No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	( ) Yes (•) No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	( ) Yes (•) No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (•) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (•) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (•) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (•) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (•) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (•) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (•) Yes ( ) No
  - **ii)** Tele-Health — (•) Yes ( ) No
  - **iii)** Social Media Outreach — (•) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (•) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (•) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (•) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (•) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (•) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (•) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — (•) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — (•) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (•) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (•) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (•) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (•) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

The SSA and its 3 contracted Providers undergo an independent peer review annually to assess the quality and appropriateness of treatment services delivered and identify areas and plans for improvement.

SSA-GBHWC New Beginnings Program- Outpatient SUD treatment program for men and women

Salvation Army Lighthouse Recovery Center SUD Treatment facility for Men

Oasis Empowerment Center- SUD treatment facility for Women

Sanctuary Incorporated - Treatment Facility for YOUTH

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) [x] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [ ] Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing (●) Yes ( ) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Preformance-based accountability (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services (●) Yes ( ) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) Mental Health TTC? (●) Yes ( ) No

c) Addiction TTC? (●) Yes ( ) No

d) State Targeted Response TTC? (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment (●) Yes ( ) No

b) Professional Development (●) Yes ( ) No

c) Coordination of Various Activities and Services (●) Yes ( ) No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

gbhwc.guam.gov

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? ○ Yes ○ No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1.	Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?	(•) Yes ( ) No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	( ) Yes (•) No
3.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	(•) Yes ( ) No
4.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	(•) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight.

Starting the Men Do Recovery Curriculum.

Please indicate areas of technical assistance needed related to this section.

TA for Trauma assessment tools

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1.	Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?	○ Yes ○ No
2.	Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?	○ Yes ○ No
3.	Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?	○ Yes ○ No
4.	Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?	○ Yes ○ No
5.	Does the state have any activities related to this section that you would like to highlight? Please indicate areas of technical assistance needed related to this section.	

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

The SSA will be opening the inpatient Level III.7 for withdrawal management that will provide MAT, Intensive Case Management and other evidence-based treatment.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☐ Psychiatric Advance Directives
- **c)** ☐ Family Engagement
- **d)** ☐ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☐ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☐ Crisis Residential/Respite
- **d)** ☐ Crisis Intervention Team/Law Enforcement
- **e)** ☐ Mobile Crisis Outreach
- **f)** ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☐ Peer Support/Peer Bridgers
- **b)** ☐ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☐ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☐ Follow-up crisis engagement with families and involved community members

f) ☐ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The SSA has a Mental Health Child and Adolescent program that provides services for Children with an SMI or and SED. The children and families are provided individual therapy and family therapy. It is a WRAP Around System of Care Approach. We refer families to this program for a more integrated approach.
The adult substance use program provides DDRC (Dual Diagnosis Recovery Counseling and DBT-S (Dialectical Behavioral Therapy for Substance Users). These programs provide individuals with tools and skills to assist with relapse prevention and mental health prevention plan.
The Peer support staff assist consumers needing more assistance in navigating our systems here on Guam. Family members also play a crucial role in developing the treatment plan if necessary and in assisting the consumer in navigating the various systems on Island, to include primary health care, behavioral health, employment services, education and housing.
Our current Family Education Program is very successful in educating both the consumer and the family on addiction, treatment and recovery. It is a 12 week program that recommends the consumer attend the program with their supportive loved ones. Program has also started Strengthening Families for all consumers and their families. Learning new ways to develop a more positive relationship.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
The GBHWC in collaboration with Department of Corrections and the Bureau of Statistics and Plans implemented a project called “Recovery Oriented Systems of Care.” The purpose of this project is to work with two categories of clients. One, it is for those incarcerated and completed the 6 months Residential Substance Abuse Treatment (RSAT) in Guam’s prison system. Upon completion, they will have aftercare/continued care with the ROSC program for another 6 months or more. The second category of clients are those incarcerated with substance issues and were released back into the community.

The ROSC project adopted the SAMHSA definition for recovery, “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” Some of the objectives of ROSC is to assist clients to engage and maintain recovery support systems including but not limited to stable housing, reliable transportation, access to healthcare or education, gainful employment, self-help groups, faith based support, and etc.…

The ROSC project is staffed with two Peer Specialists and one Social Worker II. The Peer Specialists provide mentoring and share their experience, hope, and strength. When clients have a crisis or experience a trigger they have the option to call their peer specialist. A peer specialist is a person who has one year or more in sobriety and has the compassion to help new people in recovery. The two Peer Specialists have over 12 years of sobriety and have skills in establishing rapport and developing therapeutic alliance. The peer specialists are also available 24 hours a day for their clients. Certified substance abuse counselors and psychiatrists are also available depending on the needs that clients want to work on. In the last cycle from the Dept. of Corrections, there were 11 people who started aftercare/continued care. After 6 months, all clients completed their program and were connected to the recovery support systems that they worked on. Clients were also tested for alcohol and drugs on a weekly basis and for the 6 months all remained with negative test results for any substance. All of the clients were employed or in school and were on track with their recovery plans.

Each year ROSC works with 40 to 50 clients. GBHWC hopes to expand these services as funding becomes available. GBHWC sees the value of helping criminal justice clients’ transition back into the community and for them to enjoy quality of life just as we do. Today, there are many former clients of ROSC living a clean and sober life and are grateful for the supportive efforts that ROSC provided for them. GBHWC will continue this program and look for more funding to expand its services so more clients can be served at any given time.

Every SUD consumer develops a service plan with their primary provider and peer specialists. The peer specialists assist the consumer in navigating the necessary programs and resources to reach goals and attain objectives. The recovery Support services available for SUD consumers consist of education and employment services, housing and treatment services, as well as benefits, welfare, and universal health insurance and primary or prenatal care. Peer specialists guide consumers through the agencies and resources in order to attain these support services.

5. Does the state have any activities that it would like to highlight?

The SSA has started the Strengthening Families Program and it has become a motivating factor for families in the M/SUD

programs.

Please indicate areas of technical assistance needed related to this section.

Technical assistance in capturing program effectiveness.

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes ○ No
Home and community based services.	○ Yes ○ No
Peer support services.	○ Yes ○ No
Employment services.	○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? ( ) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ( ) Yes (●) No

b) Costs? ( ) Yes (●) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? ( ) Yes (●) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Sonia Aldan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		790 Gov. Carlos Camacho Road Tamuning GU, 96913 PH: 671-477-3132	
Jermaine Alerta	State Employees	Guam Developmental Disabilities Council (GDDC)	130 University Dr. Mangilao GU, 96913 PH: 671-732-9127	jermaine.alerta@gddc.guam.gov
Esther Gina Arca	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		790 Gov. Carlos Camacho Rd Tamuning GU, 96913 PH: 671-929-5808	ginaarca@yahoo.com
Theresa Arriola	State Employees	Guam Behavioral Health and Wellness Center	790 Gov. Carlos Camacho Road Tamuning GU, 96913 PH: 671-647-1901	theresa.arriola@gbhwc.guam.gov
Jennifer Borja	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 326545 Hagatna GU, 96910 PH: 671-727-6297	jenaborja@yahoo.com
Nadine Cepeda	State Employees	Guam Department of Education	500 Mariner Ave. Barrigada GU, 96913 PH: 671-300-1624	ntcepeda@gdoe.net
Ann Chan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		146 Kayon Gaogao Dededo GU, 96913	
Maj Manny Chong	State Employees	Guam Police Department	13-16A Mariner Ave Tiyan GU, 96913 PH: 671-475-8512	manny.chong@gpd.guam.gov
Charity Doe-Stephen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		790 Gov. Carlos Camacho Rd Tamuning GU, PH: 671-777-3811	stephenchar143@yahoo.com
			790 Gov.Carlos G.	

Athena Duenas	State Employees	Guam Behavioral Health and Wellness Center	Camacho Road Tamuning GU, 96913 PH: 671-475-5443	athena.duenas@gbhwc.guam.gov
Vanessa Estella	State Employees	Guam Housing & Urban Renewal Authority (GHURA)	117 Bien Venida Ave. Sinajana GU, 96910 PH: 671-477-9851	vestella@ghura.org
Linda Flynn	State Employees	Guam Behavioral Health and Wellness Center	790 Gov. Carlos Camacho Road Tamuning GU, 96913 PH: 671-477-9081	linda.flynn@gbhwc.guam.gov
Carla Gibson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7 Columbus Circle Santa Rita GU, 96915 PH: 671-788-0742	carla.gibson77@icloud.com
James Guerrero	State Employees	Superior Court of Guam	Guam Judiciary Center Hagatna GU, 96910 PH: 671-475-3314	jcguerrero@guamcourts.org
Brian Hahn	Persons in recovery from or providing treatment for or advocating for SUD services		790 Gov. Carlos G. Camacho Road Tamuning GU, 96913 PH: 671-971-0917	brian_hahn10@ymail.com
Phyliss Leon Guerrero	State Employees	Department of Integrated Services for Individuals with Disabilities	238 Archbishop Flores St. Hagatna GU, 96910 PH: 671-475-4643	phyliss.leonguerrero@dsid.guam.gov
Joelle Mendiola	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		790 Gov. Carlos Camacho Road Tamuning GU, 96913 PH: 671-647-5337	
Lourdes Mendiola	Parents of children with SED/SUD		238 Tumon Heights Rd Tamuning GU, 96913 PH: 671-649-2761	loubasmend@gmail.com
Helene Paulino	State Employees	Guam Public Health and Social Services	123 Chalan Kareta Mangilao GU, 96913 PH: 671-478-5402	helene.paulino@dphss.guam.gov
Regis Jude Reyes	Persons in recovery from or providing treatment for or advocating for SUD services		PO Box 8345 Tamuning GU, 96913 PH: 671-864-8687	regisreyes@gmail.com
Tomasa Techaira	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PO Box 3265 Hagatna GU, 96913 PH: 671-788-9990	gloria.onguam@gmail.com

*Council members should be listed only once by type of membership and Agency/organization represented.

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Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**21**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	8	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**11**	**52.38%**
State Employees	10	
Providers	0	
Vacancies	0	
Total State Employees & Providers	**10**	**47.62%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	11	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	10	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**21**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	○ Yes ◉ No
b)	Posting of the plan on the web for public comment?	◉ Yes ○ No
	If yes, provide URL: https://gbhwc.guam.gov	
c)	Other (e.g. public service announcements, print media)	○ Yes ◉ No

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Footnotes: