Guam

UNIFORM APPLICATION
FY 2024/2025 SUPTRS BG Only ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 10/02/2023 10.52.14 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

NOT FINAL

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State Unique Entity Identification

Unique Entity ID	KMXQJ59F1RK4

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	
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

NOT FINAL

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

NOT FINAL

State Information

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

Fiscal Year 2024

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**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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 19 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, as applicable, with 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 Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
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 [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: 04/19/2021 Expires: 04/30/2024

Footnotes:

SAMHSA
Office of Financial Resources, Division of Grants Management
Center for Substance Abuse Treatment, Division of States and Community Systems
Center for Substance Abuse Prevention, Division of Primary Prevention
Center for Mental Health Services, Division of State and Community Systems Development

Request for No Cost Extension (NCE) for COVID-19 Supplemental Funding

COVID-19 Award Issue Date: 3/11/21 **Approved Expenditure Period:** 3/15/21 through 3/14/23

Instructions: *Current MHBG and SABG grantees may request a No Cost Extension (NCE) for the FY 21 COVID-19 Supplemental Funding Award for an additional expenditure period of up to twelve (12) months, through March 14, 2024. Grantees are required to complete the information below for the proposed use of funds using the NCE, and agree to implement this NCE in accordance with:*

- *the March 11, 2021 Notice of Award (NoA) Terms and Conditions for the MHBG COVID-19 Supplemental Funding or the SABG COVID-19 Supplemental Funding;*
- *the March 11, 2021 COVID-19 Supplemental Funding Guidance Letter to the SSA Directors and the SMHCs from Tom Coderre, then Acting Assistant Secretary for Mental Health and Substance Use; and*
- *the grantee's SAMHSA currently approved MHBG COVID-19 Supplemental Funding Plan, or SABG COVID-19 Supplemental Funding Plan, as previously communicated to the grantee by the CMHS or CSAT State Project Officer.*

Grantees are requested to submit this **Request for No Cost Extension (NCE) for COVID-19 Supplemental Funding** *to their CMHS or CSAT State Project Officer by email as a Word document or PDF file, and to upload this NCE Request as an Attachment in WebBGAS in the FY 23 MHBG Plan, or in the FY 23 SABG Plan. Upon written notification of a grantee's intention to file a NCE Request, the CMHS or CSAT State Project Officer will be requested to create and send the grantee a Revision Request in the FY 23 MHBG Plan or FY 23 SABG Plan in WebBGAS, with instructions for uploading the NCE Request as an Attachment in the FY 23 MHBG Plan or the FY 23 SABG Plan. Separate NCE Requests are required for approval for either a MHBG NCE Request or a SABG NCE Request. Grantees are requested to complete and submit the NCE Request, as instructed above, no later than Friday, September 9, 2022, at 12:00 midnight EST. Further information about this process may be requested from your CMHS, CSAT, or CSAP State Project Officer. Thank you.*

Check One Only (✓): _____Request for NCE for FY 21 **MHBG** COVID-19 Supplemental Funding
_✓__Request for NCE for FY 21 **SABG** COVID-19 Supplemental Funding

A. Name of MHBG or **SABG Grantee Organization**	Guam Behavioral Health and Wellness Center		
B. Date of Submission of NCE Request	9/6/2022	C. Length of Time Requested (in Months) for NCE (12 Mo. Max. through 3/14/24)	12 months (through 3/14/2024)

D. Name and Title of Grantee Finance Official	Maria Teresa Lozada Administrative Officer

Approving This NCE Request			
E. Name and Title of Grantee Program Official Approving This NCE Request	Theresa C. Arriola GBHWC, Director		
F. Name and Title of Other Grantee Official Approving This NCE Request	Athena Duenas Substance Abuse Program Supervisor GBHWC		
G. COVID-19 Award Total $ Amount Issued in NoA of 3/11/2021	$ 1,072,119.00	H. COVID-19 Award Total $ Amount Expended as of NCE Request Date Above	$ 342,220.83
I. COVID-19 Award Total $ Amount Planned to be Expended through 3/14/2023	$ 227,455.35	J. COVID-19 Award Total $ Amount Requested for NCE	$ 421,512.08

K. Please provide a brief listing of your grantee actual itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that have been completed with your current COVID -19 Supplemental Funding, through the date of your submission of your NCE Request.

2021 SUBSTANCE ABUSE PREVENTION & TREATMENT (SAPT) FY21/22

GRANT 1B08T1083531-01

Period

3/15/2021-9/30/2021

Account No.

5101H212310SE115

		Appropriation	Expenditure	Available Balance
Salaries	111	$ 487,728.00	$ -	$ 487,728.00
Benefits	113	$ 260,154.00	$ -	$ 260,154.00
Contractual (2SUV Lease)	230	$ 188,574.64	$ 11,296.13	$ 168,586.27
Supplies	240	$ 76,162.36	$ 956.00	$ 70,077.01
Equipment	250	$ 50,000.00	$ 12,925.00	$ 28,723.00
Miscellaneous	290	$ 9,500.00		$ 9,500.00
Total		**$ 1,072,119.00**	**$ 25,177.13**	**$ 1,024,768.28**

2021 SUBSTANCE ABUSE PREVENTION & TREATMENT (SAPT) FY21/22

GRANT 1B08T1083531-01

Period

10/01/2021 - 8/16/2021

Account No.

5101H212310SE115

		Appropriation	Expenditure	Available Balance
Salaries	111	$ 463,817.00	$ 117,410.12	$ 346,406.88
Benefits	113	$ 248,198.00	$ 46,085.49	$ 202,112.51
Contractual (2SUV Lease)	230	$ 148,574.64	$ 39,115.08	$ 109,459.56
Supplies	240	$ 71,062.36	$ 7,301.82	$ 58,631.19
Equipment	250	$ 55,100.00	$ 53,890.00	$ 1,210.00
Miscellaneous	290	$ 85,367.00	$ 50,241.20	$ 35,125.80
				$ -
Total		**$ 1,072,119.00**	**$ 314,043.71**	**$ 752,945.94**

L. Please provide a brief listing of your grantee estimated itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that are planned to be completed with your current COVID -19 Supplemental Funding, from the date of this Request through the end of the current expenditure period of March 14, 2023.

10/1/2022 – 3/14/2023

Personnel		
Technical Assistance Coordinator	Treatment x 2	$ 40,762.00
Technical Assistance Coordinator	Prevention x 1	$ 21,153.50
Key Family Contact Coordinator	Treatment x 2 Prevention x 1	$ 54,091.00
Fringe Benefits		
Technical Assistance Coordinator	Treatment x 2	$ 17,133.84
Technical Assistance Coordinator	Prevention x 1	$ 22,800.81
Key Family Contact Coordinator	Treatment x 2 Prevention x 1	$ 23,493.48
Contractual		
Office rental space	Treatment	$ 26,070.72
Other		
Data Entry Intern	Prevention	$ 4,950.00
Peer support stipend	Treatment	$ 16,000.00
Participant/Consumer incentive	Treatment	$ 1,000.00
		$ 227,455.35

M. Please provide a brief summary of the challenges that your program has experienced in fully expending the current COVID-19 Supplemental Funding by March 14, 2023, and what steps the grantee will be implementing to ensure that approved NCE COVID-19 Supplemental Funding will be fully expended by the end of the NCE period of expenditure requested above.

Two of the major issues that contributed to our inability to fully expend the supplemental funding as initially planned are listed below. Identified with each are our approach in the coming FY during the NCE to address and eliminate these delays.

1) **Staff recruitment** – considering the impact of COVID-related lockdowns and disruptions to daily operations in the Government of Guam, it was challenging to immediately hire personnel in FYs 2020-2021. These positions were eventually filled, with the exception of a Data Entry Clerk, and onboard staff will continue their employment through March 14, 2023 using the NCE of COVID Emergency supplemental fund. The position for the Data Entry Clerk is currently in the recruitment process through GBHWC's HR Division.
2) **Procurement** – while procurement was always a hurdle for GBHWC, the pandemic had caused even greater delays to this government function. Previously budgeted items were not expended fully because it was awarded much later than expected, such as the contract with TOHGE. Since there is a contract already in place with this partner, continuing to subgrant the funds should no longer be an issue moving forward. Likewise, instead of budgeting year-long for equipment lease and supplies purchase, we shortened the expected timeframe to account for months needed for procurement.

N. Please provide a brief listing of your grantee planned itemized expenditures for your COVID-19 Supplemental Funding approved projects, activities, and purchases, that are requested to be supported with the No Cost Extension for the COVID-19 Supplemental Funding amount that is identified above, for the NCE expenditure period that is identified above. All planned expenditures that are requested to be supported in an approved NCE must be fully within the current scope of the grantee's SAMHSA currently approved MHBG COVID-19 Supplemental Funding Plan or currently approved SABG COVID-19 Supplemental Funding Plan.

3/15/2023 – 3/14/2024

Personnel		
Technical Assistance Coordinator	Treatment x 2	$ 81,524.00
Key Family Contact Coordinator	Treatment x 2 Prevention x 1	$ 108,182.00
Fringe Benefits		
Technical Assistance Coordinator	Treatment x 2	$ 34,267.68
Key Family Contact Coordinator	Treatment x 2 Prevention x 1	$ 46,986.97
Equipment		
Lease for Mini-van	Treatment/Prevention	$ 25,550.00
Supplies		
Mifi device	Treatment x 1 Prevention x 1	$ 3,960.00
Contractual		
Office rental space	Treatment	$ 52,141.44
TOHGE Peer Support Training	Treatment	$ 25,000.00
Other		

Data Entry Intern	Prevention	$ 9,900.00
Peer support stipend	Treatment	$ 32,000.00
Participant/Consumer incentive	Treatment	$ 2,000.00
		$ 421,512.08

O. Please provide any other relevant information about the current use of this COVID-19 Supplemental Funding, with actual itemized expenditures, and/or the proposed use of this COVID-19 Supplemental Funding, with estimated itemized expenditures, through a SAMHSA approved NCE for projects, activities, and purchases approved for expenditure under this funding.

Most of the proposed budgeted items are the same expenditures from the previously submitted/approved project and budget narratives, with the exception of these updates (costs account for 10/1/2022 – 3/14/2024):

Personnel		
Key Family Contact Coordinator	Prevention x 1	$ 54,091.00
Fringe Benefits		
Key Family Contact Coordinator	Prevention x 1	$ 23,493.48

An additional Key Family Coordinator (employee name: Alexa Mata) will be sustained using this NCE funds. Hired personnel, Alexa Mata, previously funded under the SABG COVID Mitigation Funds set to be fully expended by 9/30/2022, will continue to oversee the in-house COVID testing and vaccination clinic for GBHWC consumers, as well as the Nicotine Cessation Clinic, an auxiliary service to be offered for GBHWC consumers in FY 2023.

Equipment		
Lease for Mini-van	Treatment/Prevention	$ 25,550.00

The two vehicles purchased under the COVID Emergency supplemental funds are currently used for community-based mobile crisis response and transportation for consumers. An issue that arose is its distinct government vehicle tag that becomes counterproductive when needed for more discreet/unmarked trips. To address this, we propose to rent a privately tagged vehicle for the duration of the NCE. Aside from more discreet transportation for consumers, this van will also be utilized during undercover inspections funded by the SAPT Block Grant.

End of NCE Request. Thank you.

UFISINAN I MAGA'HÅGA
OFFICE OF THE GOVERNOR

LOURDES A. LEON GUERRERO
MAGA'HÅGA • GOVERNOR

JOSHUA F. TENORIO
SIGUNDO MAGA'LÅHI • LIEUTENANT GOVERNOR

M'd 07/30 @ 11:19
GBHWC-DOH
07/30/19-19

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 8/20/19.

RICARDO J. BORDALLO GOVERNOR'S COMPLEX · HAGÅTÑA, GUAM 96910
P.O. BOX 2950 · HAGÅTÑA, GUAM 96932

Other Attachments:

OMB Control Number 0945-0008
Exp. Date: 12/31/2022

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSURANCE OF COMPLIANCE

Under the Paperwork Reduction Act of 1995, as amended, and 5 C.F.R. § 1320.5(b)(2)(i), persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The OMB control number for this collection is 0945-0008. In lieu of completing this hard copy form and mailing it in, the Applicant may provide this assurance via the U.S. Department of Health and Human Services' Assurance of Compliance online portal at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf.

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, SECTION 1557 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND FEDERAL CONSCIENCE AND ANTI-DISCRIMINATION LAWS

*With respect to compliance with 45 C.F.R. Part 88, the signatory is providing assurance of compliance with such Part to the extent it is in effect during the term of the award. Consistent with applicable court orders, the version of Part 88 in effect as of December 2, 2019, is found at 76 Fed. Reg. 9,976-77 (February 23, 2011).

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, as amended (codified at 42 U.S.C. § 2000d *et seq.*), 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, as amended (codified at 29 U.S.C. § 794), 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, as amended (codified at 20 U.S.C. § 1681 *et seq.*), 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, as amended (codified at 42 U.S.C. § 6101 *et seq.*), 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 Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18116), 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.

6. As applicable, the Church Amendments, as amended (codified at 42 U.S.C. § 300a-7), the Coats-Snowe Amendment (codified at 42 U.S.C. § 238n), the Weldon Amendment (*e.g.*, Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019, Div. B., sec. 507(d), Pub. L. No. 115-245, 132 Stat. 2981, 3118 (Sept. 28, 2018), as extended by the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Pub. L. No. 116-59, Div. A., sec. 101(8), 133 Stat. 1093, 1094 (Sept. 27, 2019)), Section 1553 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18113), and Section 1303(b)(4) of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18023(b)(4)), and other Federal conscience and anti-discrimination laws, including but not limited to those listed at https://www.hhs.gov/conscience/conscience-protections, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 88), to the end that the rights of conscience are protected and associated discrimination and coercion are prohibited, in any program or activity for which the Applicant receives Federal financial assistance or other Federal funds from the Department for which the Federal conscience and anti-discrimination laws and 45 C.F.R. Part 88 apply.

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 person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

4/4/22
Date

Signature of Authorized Official

Director – Theresa C. Arriola
Name and Title of Authorized Official (please print or type)

Guam Behavioral Health & Wellness Center
Name of Agency Receiving/Requesting Funding

790 Gov. Carlos G. Camacho Rd.
Street Address

Tamuning, Guam 96924
City, State, Zip Code

Please mail form to:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W. Room 509F
Washington, D.C. 20201

The Applicant may provide this assurance via the U.S. Department of Health and Human Services' Assurance of Compliance online portal at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf in lieu of mailing it to the address provided.

HHS Form 690 (Last updated 11/2019)

OMB Number: 4040-0007
Expiration Date: 01/31/2019

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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 cost) 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 standards 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 19 statutes or regulations specified in Appendix A of OPM's Standards 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 nondiscrimination 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 Titles 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, as applicable, with 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 wetlands 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 (Clean 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 Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

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.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
[redacted]	[redacted]
APPLICANT ORGANIZATION	DATE SUBMITTED
[redacted]	[redacted]

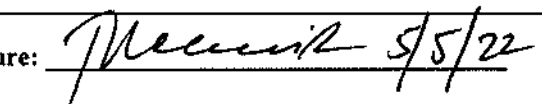
Standard Form 424B (Rev. 7-97) Back

Approved by OMB
0348-0046

Disclosure of Lobbying Activities

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. **Type of Federal Action:** a. contract __b__ b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	2. **Status of Federal Action:** a. bid/offer/application ___b__ b. initial award c. post-award	3. **Report Type:** a. initial filing ___a__ b. material change **For material change only:** Year _____ quarter _____ Date of last report _____

4. **Name and Address of Reporting Entity:** ____ Prime _____ Subawardee Tier_____, if Known: **Guam Behavioral Health & Wellness Center** **790 Governor Carlos Camacho Road** **Tamuning, Guam 96913** **Congressional District,** *if known*:	5. **If Reporting Entity in No. 4 is Subawardee,** Enter Name and Address of Prime: **Congressional District,** *if known*:
6. **Federal Department/Agency:** **Department of Health & Human Services** **Substance Abuse & Mental Health Services Administration**	7. **Federal Program Name/Description:** **FY2022 Grants to Expand Substance Abuse Treatment Capacity in Adult & Family Treatment Drug Courts** CFDA Number, *if applicable*: _____
8. **Federal Action Number,** *if known:*	9. **Award Amount,** *if known:* **$ 400,000/year for 5 years**
10. a. **Name and Address of Lobbying Registrant** *(if individual, last name, first name, MI):* N/A	b. **Individuals Performing Services** *(including address if different from No. 10a)* *(last name, first name, MI):* N/A
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:**  **Print Name: THERESA C. ARRIOLA** **Title: DIRECTOR** **Telephone No.: 671-647-1901 Date: May 4, 2022**
Federal Use Only	**Authorized for Local Reproduction** **Standard Form - LLL (Rev. 7-97)**

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

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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 (description of the current prevention system's attention to individuals in need of substance use primary 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. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

NOT FINAL

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

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary 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. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Overview of the State/Jurisdiction

Guam, "where America's day begins," 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 the Pacific, as well as Asia, because of its air links (Figure 2). This plays a significant part in the movement of tobacco, alcohol, and illicit drugs into the island.

The island has a land area of 549 sq. km., roughly three times the size of Washington, DC. The terrain is of volcanic origin, surrounded by coral reefs. The climate is tropical marine, with little seasonal temperature variation. There are frequent squalls during the rainy season and, occasionally, potentially very destructive typhoons from June to December.

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 island's 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.

Currently, the Democratic Party holds 9 seats while the Republican Party holds 6. Guam also elects one nonvoting delegate to the US House of Representatives to serve a two-year term. The current representative, Congressman James Moylan, belongs to the Republican Party. The judicial branch was revamped to create the Unified Judiciary of Guam, consistent with the Organic Act. Guam has the District Court of Guam (federal) and the Supreme Court of Guam and the Superior Court of Guam (local).

Guam's economy relies heavily upon federal support, military spending, and tourism. The COVID-19 pandemic severely impacted tourism revenues. However, continued national defense spending and the infusion of emergency funds from the Total Coronavirus Aid, Relief, and Economic Security (CARES) Act and COVID-19 programs helped to soften the blow to the island's economy. In 2020, there were 42,312 households in Guam, excluding people in military housing units. Median household income was $58,289 (Table 3). About 11% of Guam's households lived on $14,999 or less per year. The poorest of the poor comprised nearly 4% of all households on

Key Population Indicators

Population (2020 census): 153,836
Sex: Males – 78,271
Females – 75,565
Ethnic groups: CHamoru – 33%
Filipino – 29%
Chuukese – 7%
Caucasian – 7%
Age structure: 38% under 25 years
Median age: 29 years
Birth rate: 20 births/1000
Death rate: 6/1,000
Life expectancy: Male: 73.6 years
Female: 78.6 years
Unemployment rate: 19.4%
Families below poverty: 17%
Household mean income: $74,309
Mobile phones in use: 190,200
Internet users: 81% of population

NOT FINAL

Guam and lived on less than $3000 per year. In contrast, 15.8% of households made more than $125,000 per year.

According to the 2020 Census, Guam's total population is 153,836. Males slightly outnumber females, comprising 51% of the total population. Nearly 38% of the population is under the age of 25 years. Guam's population is multi-ethnic/multi-racial. CHamorus remain the largest ethnic group, making up 33% of the island's population. This represents a decrease by 3 percentage points from 2010. Filipinos are the second largest group, comprising 29% of the total, up from 26% in 2010. The Chuukese and Whites each comprise 7% of the population. Majority of Guam residents identify themselves as being of one ethnic origin or race.

The ethnic diversity is reflected in the languages spoken at home. Data from the 2020 census on this issue is not yet available. Based on the 2010 census, twenty percent of the population over 5 years 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.

Overview of State Behavioral Health System

Single State Authority for Behavioral Health Services in Guam

Guam Behavioral Health and Wellness Center (GBHWC) serves as the single state authority (SSA) for public behavioral health services and substance misuse prevention and treatment services for the U.S. Territory of Guam (Public Law 17-21). As a line agency under the Government of Guam, GBHWC is headed by a Director and Deputy Director who appointed cabinet members of the Governor. GBHWC's existence and roles are defined in 10 GCA 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.

As an agency, GBHWC envisions a healthy island, committed to promoting and improving the behavioral health and well-being of its community. Its mission is to create a safe environment where it can provide culturally respectful, quality behavioral health services that support and strengthen the well-being of the persons it serves, their families and the community as a whole. In accordance to Guam Public Law 17-21, GBHWC, through its over 300 staff, aims:

- 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 behavioral health assistance in an efficient and effective manner in order to minimize community disruption and strengthen the quality of personal, family and community life; and
- 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.

GBHWC has three major divisions: Clinical Services Division, Child & Adolescent Services Division, and the Nursing Services Division. Through its Clinical Services Division, GBHWC is provides behavioral health care for consumers suffering mental disorders, emotional disturbances, behavioral problems, and familial dysfunction, drug and alcohol use disorders and co-occurring disorders. The Clinical Services Division is comprised of seven (7) services which include: Adult Counseling Services Branch, Crisis Intervention Services, Medical Records Services, Drug and Alcohol Treatment Services (New Beginnings), Prevention and Training (PEACE Office), Day Treatment Services, and Residential Services.

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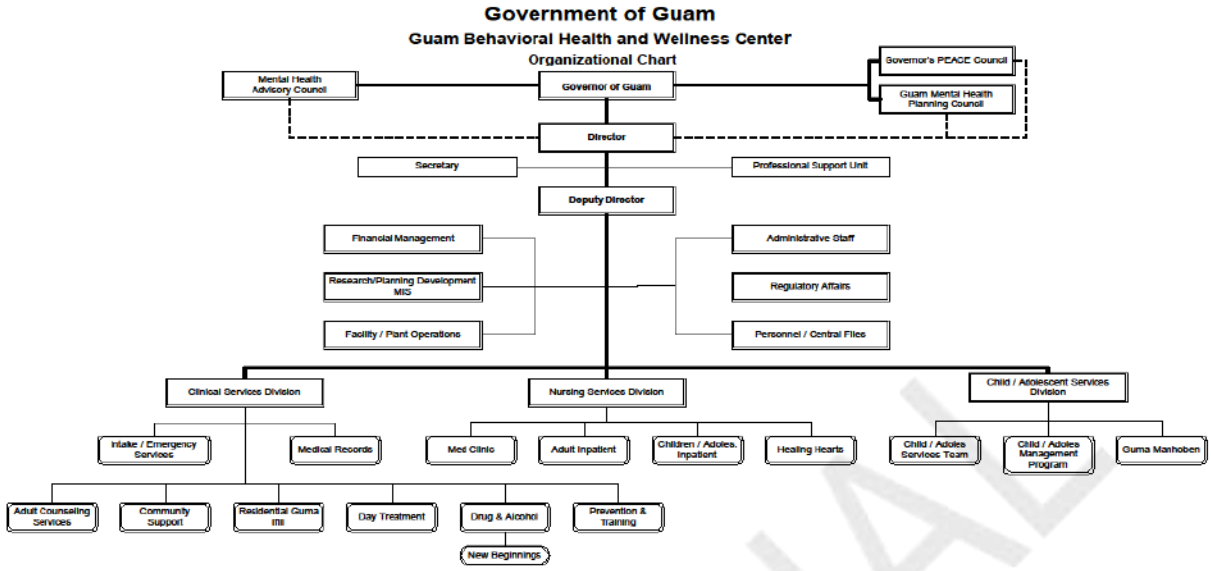

GBHWC is an accredited organization by the Commission on Accreditation of Rehabilitation Facilities (CARF), most recently receiving it in June 2021 from its previous accreditation in June 2017. An organization receiving a three-year CARF accreditation signifies completing a rigorous peer review process, demonstrating to a team of surveyors its commitment to offering programs and services that are measurable, accountable, and of the highest quality. The most recent CARF survey stated:

> *"(GBHWC) demonstrated substantial conformance to the standards. It is evident that (the agency) provides valuable service that positively impacts the lives of the persons served. Stakeholders express satisfaction with the commitment of the organization's leadership and personnel to improve outcomes of services. GBHWC has a highly engaged leadership team that is committed to conformance to all of the CARF standards in its programs. This was evidenced by the preparation of documents that were available in an exceptionally organized matter, which were arranged according to CARF standards, prior to the onset of the survey."*

The three year accreditation includes the following programs:

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

SUD Prevention and Early Intervention System in Guam

As the SSA, GBHWC provides leadership in obtaining state and federal funding to support comprehensive prevention services in Guam. GBHWC's Prevention and Training Branch (PEACE Office) provides both direct and indirect 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 PEACE Office monitors GBHWC's prevention systems and processes as part of an ongoing quality control assessment of the agency's prevention service delivery. In addition, the PEACE Office manages the various prevention funding (local and federal) 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, the SAMHSA

Substance Abuse Prevention and Treatment Block Grant funds and SAMHSA discretionary grant funding for specific initiatives.

GBHWC works in collaboration with other partner agencies and community-based organizations to develop, implement and assess prevention policies and programs. The PEACE Office is currently supported by the Governor's Prevention Education and Community Empowerment (PEACE) Council - a multi-sectoral, state-level advisory group representative of the three branches of government and key prevention stakeholders from the private sector, including cultural, faith-based, and nongovernmental/community-based organizations. The Council's composition reflects the ethnic and cultural make-up of the Guam community and provides direction and guidance for prevention priorities and approaches. On the other hand, Guam's State Epidemiological Outcomes Workgroup (SEOW) serves as a technical working group that supports GBHWC with local data on substance misuse consumption and consequences, suicide epidemiology, and selected mental health indicators.

The P&T Branch employs a community-based participatory approach to strategic planning. The first PEACE Strategic Prevention Framework-State Incentive Grant (SPF/SIG), Guam Comprehensive Strategic Plan (2006-2009) focused on prevention of tobacco use and harmful alcohol use, reduction in underage drinking and substance misuse-related problems and enhancement of community capacity and infrastructure for prevention. The State Prevention Enhancement (SPE) Plan 2014-2018 expanded prevention goals to include preventing/reducing consequences of underage drinking and adult problem drinking, preventing suicides and attempted suicides among populations at risk, including military families and LGBTQ youth, reducing prescription drug misuse and abuse, preventing substance misuse and mental illness (promote positive mental health), enhancing policy and augmenting funding to support needed services for behavioral health system improvements in Guam, and strengthening behavioral health workforce development initiatives.

In 2019, the Branch created a new strategic plan for 2020-2024 which focuses the prevention system in Guam to impact the five key areas of work:

- Substance misuse prevention
- Suicide prevention
- Mental health promotion
- Community outreach and empowerment
- Sustainability of the prevention system

SUD Treatment and Recovery System in Guam

GBHWC's Drug and Alcohol Treatment Branch provides directs services including American Society of Addiction Medicine (ASAM) Levels of Care:

- Level 0.5 Brief Intervention/Education
- Level I Outpatient
- Level II Intensive Outpatient
- Level 3.5 Women's Residential Program (PPPW)
- Level 3.7 Withdrawal Management
- Level 0.7 aftercare (Social Support) program.

Evidence Based Treatment Models are provided in the levels of care:

- Matrix Model
- Driving with CARE (DWI/DUI) program (DWC)
- Dialectical Behavioral Therapy for SUD (DBT-S)
- Moral Reconnation Therapy (MRT)
- Helping Men/Women Recovery (SUD-TRAUMA) Program
- Women's Way to 12-Steps

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- Dual Diagnosis Recovery Counseling (DDRC)
- Motivational Interviewing (MI)
- WRAP-Wellness Recovery Action Planning
- Contingency Management

The program also provides treatment services in the Department of Corrections (DOC). Currently providing treatment in the Residential Substance Abuse Treatment (RSAT) program at DOC. We also provide ASAM levels of care (Level 1 & 2) and the above Evidence Based Programs in DOC.

Recovery Oriented Systems of Care (ROSC) program with works with individuals who have completed the 6-month Residential Substance Abuse Treatment (RSAT) program in the Department of Corrections and are released to the community to continue in Social Support Services. The ROSC is the aftercare program for the RSAT program.

All persons served are provided person centered treatment plans and Intensive case management. Peer Support is also provided as needed. The Drug & Alcohol also started the Peer Support Program in 2011. The program has grown and flourished since then. Peer support is provided in group treatment, individual sessions, and treatment planning when needed. We currently employ 23 Certified Peer Recovery Specialists who provide peer mentorship and education, advocacy, and wellness recovery support.

The Drug & Alcohol Program also contracts with non-profit providers for ASAM Level of Care:

- Salvation Army Lighthouse Recovery Center:
    - level I Outpatient
    - II Intensive Outpatient
    - III.2-D Social Detoxification
    - III Residential for adult Men
- Sanctuary Incorporated:
    - level I Outpatient
    - II Intensive Outpatient
    - III.2-D Social Detoxification
    - III.5 Residential for adolescents
- TOHGE Peer Recovery Organization:
    - 24-Hour Warmline-Recovery Coaching
    - Warm Hand-off
    - Recovery Support Services

Community-Based Participatory Planning for SUPTRS Block Grant

For years, the annual SEOW reports have served as a resource for GBHWC in its assessment of community needs, prioritization of primary prevention efforts and evaluation of impact on the population's substance use behaviors and perceptions. With local data driving all of Guam's primary prevention efforts, grassroots and elected leaders and non-profit organizations can align and involve themselves with strategies championed by the government agency. But prevention efforts do not exist in a vacuum and prevention can never maximize its impact on the community if other segments in the behavioral health continuum of services are developed in silos.

In line with its commitment to creating a safe environment where it provides culturally respectful and high-quality behavioral health services to support and strengthen its consumers as well as their families and the general community, and with guidance from the Pacific Southwest Prevention and Addiction TTCs, on July 2023, GBHWC's New Beginnings and PEACE office collaborated with peer recovery community organization, Tohge Inc., in reviewing the current infrastructure of substance use prevention, treatment and recovery

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services in Guam. More importantly, this group of seventy-five service providers and stakeholders throughout the behavioral health continuum assessed how well these services in Guam respond to the needs and challenges reflected on SEOW's data report.

A collaborative effort among SUD prevention, treatment and recovery service providers brought upon the SUPTRS BG plan for FYs 2024-2027

Here are the strengths and opportunities highlighted by the community members who participated during the gathering:

History of established, effective programs for SUPTR in Guam

Considering our relatively smaller population, GBHWC's position as the Single State Authority for behavioral health services meant that the agency is also in charge of establishing and sustaining the infrastructure of SUPTR services for the entire island community. GBHWC always looked to leverage other funding sources, local and federal, to identify, support and sustain services that have the highest likelihood of effectiveness. Through its staff and subcontracted service providers, these services have been adapted in practice to fit the profiles and needs of the people receiving them more appropriately. This iterative process of creating best practices for services on island has attracted individuals to engage with and commit to prevention and treatment services.

Effective private-public partnerships

As enacted in P.L. 17-21, GBHWC encourages the development of privately funded community-based programs for mental health, drug, and alcohol abuse, in particular those programs that employ qualified local residents. This practice has worked well to serve Guam's diverse populations because grassroots organizations are able to seek training, hire skilled SUPTRS practitioners, and apply for resources to offer services to subpopulations who are already within their reach. These private-public partnerships have allowed SUPTR services in Guam to be community-driven while evidence-based, as monitored by GBHWC as the SSA.

Access to field expertise in the national and cultural levels

GBHWC takes advantage of training and technical assistance provided by SAMHSA and other funders to continuously improve the quality and breadth of SUPTR services in Guam. This includes the Pacific Southwest TTCs for Prevention and Treatment, NASADAD and the Opioid Resource Network. It is our standard practice to not only receive these trainings, but also organize a local network of facilitators to be trained as trainers, specifically those are already familiar or are part of the communities and populations we serve. This contributes to our practice of adapting evidence-based programs within fidelity. Now that GBHWC will

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embark in guiding the development of a multi-sector SUPTR coalition, we will also activate technical assistance available through CADCA to later get recognized as a Drug-Free Community.

Access to Resources to Help Improve Infrastructure: Political support, Federal funding, Certification for Skills Training

Guam's leadership in all sectors of the government understands the impact of substance misuse and addiction in our community. This has led to political backing for initiatives and efforts that aim to curb the rates of substance use across the population. Some examples include the increase of minimum legal consumption age for tobacco and alcohol, the infusion of funds to expand the treatment services for substance dependence, and willingness to integrate behavioral health services with law enforcement and rehabilitation. As a US territory, our access to federal funding, both formulary and discretionary, that supplement our limited local resources enables GBHWC to enhance these services that our leaders support.

GBHWC is an active member of the Pacific Behavioral Health Collaborating Council, which oversees the regional and international certification for Prevention Specialist, Substance Abuse Counselors and Peer Recovery Specialist. Leadership from throughout the region is supportive of work advancement and development in the field, therefore resources are prioritized and made accessible to individuals willing to invest their time and efforts to get certified.

Highly Skilled and Fully Committed Service Providers

Lastly and probably most important of our strengths in the SUPTR community is the commitment and passion that drive our service providers to continue doing the valuable work that we do. In our small community, most, if not all of us, have been personally impacted by substance misuse and addiction. This passion to make a difference or change the trajectory of experiences in our families and throughout the community in our island home resonates in our shared outcomes.

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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 systems, 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 behavioral health system, including for 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. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. 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 with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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Overview of the Guam Epidemiological Profile on Substance Use

Guam's SEOW collates data from the various agencies that have surveillance systems tracking prevalence and consequences of alcohol, tobacco, and other substance use, as well as suicide, and mental health indicators. Two key data sources are the Behavioral Risk Factor Surveillance System (BRFSS) for population data amongst adults 18 years and older, and the Youth Risk Behavior Surveillance System (YRBSS) for youth data. In analyzing these data, the SEOW assesses (1) magnitude, (2) trend, (3) comparison to the national standard and (4) difference across groups (equity). Whenever possible, data is disaggregated by sex, age group, income, education, and ethnicity/racial group. As much as possible, ethnicity categories are reflective of the various ethnic groups that make up the Guam population.

During the community gathering to develop the SUPTRS Block Grant Plan for FYs 2024-2027, SEOW Lead Epidemiologist, Dr. Annette David, guided the group in identifying and understanding substance use and mental health concerns in the population. Here are the key findings that the group deciphered, as reported by the Guam SEOW in its latest Epi Profile update. These results were utilized to guide the selection of priorities and the development of block grant objectives and strategies.

Tobacco and E-cigarettes

- Tobacco consumption remains higher in Guam than in the US, for both adults and youth.
- Smoking is declining, but Guam still has one of the highest smoking prevalence rates across the various States and Territories.
- Males smoke more than females. Adult female smoking in Guam is similar to male smoking in the US. CHamoru adults have the highest smoking prevalence.
- Smokeless tobacco use among adults is more than double the US rate, and smokeless tobacco use among Guam youth is triple the US rate. Micronesians have the highest rates of smokeless tobacco consumption.
- Electronic cigarette use, or "vaping" is high among our youth: More than one in three (35.2%) high school students and middle school students (34.6%) reported current use. Among adults, vaping rose markedly between 2018 and 2019.

- Tobacco use has 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.
- Tobacco control policies are closely associated with reductions in smoking prevalence and smokeless tobacco use.

Alcohol

- Current alcohol use, binge drinking, and heavy drinking are lower among Guam adults compared to the US rates.
- 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. However, current alcohol use has risen in 2019.
- Unlike tobacco, and binge drinking among adults, there is no difference in binge drinking rates across the sexes for Guam youth. Micronesian youth have the highest binge drinking prevalence.
- Liver cancer, which is directly related to alcohol use, has risen in rank as a major cause of cancer death.
- Alcohol-related arrests comprised 8.1% of all arrests cleared in 2020.
- Alcohol control policies appear to be related to declines in adult and youth binge drinking.

Other Substances

- In 2021, 12.6% of Guam adults reported using marijuana within the past 30 days. Adult males were more likely to report current marijuana use than adult females.
- Current marijuana use among youth in Guam is markedly higher than among adults. One in 4 high school students in Guam is a current user of marijuana. Current and lifetime marijuana use among Guam students are higher than the US median.
- In 2021, 10.2% of adults reported illicit drug use other than marijuana.
- Less than 2% of adults reported taking prescription drugs that were not prescribed for them.
- About 6% of Guam high school students report having tried methamphetamines. Nearly 14% reported using synthetic marijuana. About 15.5% reported taking a prescription pain medication without a doctor's prescription.
- In 2019, about 36% of high school youth reported they had been offered, sold, or given an illicit drug on school property.

Suicide

- The age-adjusted 2021 suicide rate in Guam is 21.2 per 100,000. While this decreased from 2020, it remains higher than the US rate of 14.1 per 100,000.
- Suicide deaths in Guam occurred predominantly among younger people. From 2009 to 2021, nearly half (47%) of all suicides occurred in those under 30 years of age.
- Chuukese and CHamorus have the highest ethnicity-specific suicide rates.
- 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.

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Mental Illness

- About one-third of Guam adults reported one or more mental health symptoms in the past 30 days.
- Almost 10% of Guam adults reported being told they had depression in 2021.
- Reporting sadness or hopelessness was higher among youth in Guam compared to their US counterparts. Girls were more likely to report persistent sadness than boys. The prevalence of these symptoms is rising over time.

Gaps and Challenges within the System

Aside from looking at environmental factors and epidemiological data on substance use, the community planning group also looked into the gaps and challenges within Guam's SUPTR services:

Limited-Term Funding Leads to Instability and Inconsistency

While discretionary funds allow GBHWC to expand SUPTR services directly offered by the agency or through subgrantees and subcontractors, the time limitations in these funds also hinder the program's maximized sustainability. For example, the mobile crisis response offered alongside law enforcement officers garnered positive feedback from service providers and recipients alike. However, it had to be halted due to federal funds ending and not having enough local funds to cover the entire service provided. Not only does the lack of sustainability for services contribute to inconsistency of programs, but it also impacts the staff who are trained to offer them. Without resources for competitive and sufficient salaries and benefits, staff turnover tends to be high in the SUPTR field, with staff leaving their agencies, bringing with them the knowledge, skills and abilities they have developed while facilitating the programs.

Treatment and Recovery are Not Captured in the Epidemiology Report

The annual Epi report published by the Guam SEOW is historically considered a foundation for Guam's prevention services, and recently it has also been used in informing priorities for all other behavioral and public health services. All data reported here are representative of the population and can speak to the common risks, behaviors and perceptions among youth and adults. However, it has not yet reported data relevant to treatment and recovery from substance use disorders. While data currently received from the Office of the Chief Medical Examiner (OCME) informs data on suicide death, the SEOW has not received similar data profiles on deaths related to substance use and overdose. The OCME is scheduled to start releasing an annual report at the end of 2023. Hopefully this reports will be available to the SEOW so that it can fill these gaps in its report.

Current Services must Catch Up to Evolving Needs: New Drug Trends, New Approaches for Therapy, Telehealth

Especially after the pandemic, SUPTR services have evolved to maximize outreach despite the physical distance among community members. This has benefited the community, especially those who have limited access to transportation. However, it may have caused unintentional disadvantages to those who may have no access to reliable Internet connection. Identifying and eliminating these disparities should be taken into consideration as we assess and improve the SUPTR services in Guam.

Guam also receives federal funding that may not completely align with current priorities in our local population. GBHWC should examine more closely if and how these funding sources could truly benefit the community instead of having it disrupt or hinder services that could positively impact our SUPTR priorities.

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Limited Opportunities for Advancement in the Workforce

Recently salary adjustments were given to Government of Guam workers, including those who are in the field of SUPTR services. This shift in salaries created a considerable difference between those in the government and in the private, non-profit organizations. In addition, because there are not many identified job titles for SUPTR-specific roles, it becomes difficult for workers to leverage their skills and training to advance in the workforce or receive additional compensation. For SUPTRS providers who are earning barely a living wage, the increasing cost of living drive them to consider other job opportunities elsewhere, oftentimes outside of the SUPTRS field.

GBHWC's Roles in the SUPTRS System

As the SSA, GBHWC's role is to maintain a strong infrastructure for all SUPTR services in Guam. However, as a government agency, the community also looks to GBHWC as a direct service provider to provide freely accessible, all-encompassing services for behavioral healthcare. While it has worked for most cases wherein GBHWC is able to make swift referrals of individuals to community-based service providers, this dual-position had also created a barrier in building trust and competence for services offered outside of GBHWC. When it comes to funding, GBHWC also had found itself in competition for grant opportunities – local and federal – with community-based partners. This conflict hinders opportunities for prolonged collaboration and integration of our services.

Proposed Solutions and Public Comments

We recognize that the funds provided by the SUPTRS block grant are not enough to address all unmet needs and service gaps for SUPTR in Guam. Therefore, GBHWC proposes to utilize these funds to improve the infrastructure that guides all these services. The proposed SUPTRS block grant plan, co-written with our SUPTRS community in Guam has an overall goal ***to improve Guam's substance use prevention, treatment, and recovery workforce***, and ***to sustain services that are evidence-informed and community-driven***. As the government agency overseeing these services in Guam, GBHWC is taking the lead in ensuring successful completion of these objectives: policy amendments to increase resources invested for substance use prevention, treatment and recovery; a systems-focused approach to establish standards for quality, accessibility and consistency of services; programs to address social determinants of health especially for subpopulations who are disproportionately at higher risk for substance misuse and addiction; and a coalition of service providers, consumers and stakeholders who will lead the research, development and evaluation of home-grown interventions in behavioral health practice.

The goals, objectives and proposed activities included in Guam's SUPTR block grant plan was presented to the following groups of stakeholders for feedback and discussion:

- SUPTRS Coalition meeting – September 18, 2023 (attended by ~20 participants)
- PEACE Council meeting – September 21, 2023 (attended by ~25 participants)
- Annual Conference on SUDs among Pacific Islanders – September 27, 2023 (attended by ~200 participants)

Aside from sharing their agreement and support to the planned initiatives in FYs 2024 and 2025, the groups also provided feedback that are shown below:

- There were key behavioral health services that may not be specific only to SUPTR but have been beneficial in the safe response to persons who may be affected by drug use. Particularly, the mobile crisis response service that was offered through the CARES Act funds allowed peers

recovery specialists to respond alongside law enforcement to individuals who may be actively in or have history with drug use. The stakeholders shared that such services should be part of the core services offered by GBHWC as the SSA for behavioral health services.

- There should be a stronger push for environmental strategies such as shifting social norms around substances, breaking the stigma against addiction and people in recovery, and policy advocacy that better support and sustain the SUPTR infrastructure. The coalition that is included in these proposed objectives should address them in their strategies; GBHWC should consider these activities as allowable expenses.
- While some of the proposed objectives are ambitious, GBHWC and the coalition pursuing them may be able to break them into smaller milestones. For example, in line with establishing a one-stop SUPTR Center, the coalition may work towards a website first then eventually an actual office space in the future when resources have been identified.

As we develop the objectives and indicators for this iteration of the State Plan, GBHWC recognizes that we are not able to capture and address all these strategies in the immediate two years. However, the feedback will be shared to our partners and will be integrated into further planning and implementation of SUPTR services in Guam.

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Workforce recruitment and retention

Priority Type: SUP, SUT, SUR, BHCS

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

Goal of the priority area:

Guam to sustain a highly-skilled workforce in SUPTR, that is representative of the populations it serves

Strategies to attain the goal:

Collaborate with the Pacific Southwest PTTC and ATTC to offer pertinent training courses to prepare individuals for the application and exam by the end of the FY. Cover the cost associated with the application and exam process through the PBHCC and IC&RC.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of CPS certified prevention practitioners in Guam

Baseline Measurement: 1 of 10 staff is currently certified

First-year target/outcome measurement: All 10 staff will receive their certification

Second-year target/outcome measurement: At least 10 staff and subsgrantees will sustain/receive their certification

Data Source:

PBHCC log of regional and international (reciprocity) certifications

Description of Data:

The inventory of prevention practitioners on Guam who successfully received and renewed their certification

Data issues/caveats that affect outcome measures:

The required hours to be eligible to apply may take at least a full year to complete.
IC&RC exams need to be scheduled in person, which may limit the timeframe allowed for individuals to receive required number of hours for the application.

Indicator #: 2

Indicator: Number of College-Level Prevention Fellows

Baseline Measurement: 0 as of FY 2023

First-year target/outcome measurement: Develop the prevention fellowship program, to include identifying a list of resources to supply them

Second-year target/outcome measurement: At least 1 college student will complete the year-long fellowship

Data Source:

HR and admin record at Guam Behavioral Health and Wellness Center

Description of Data:

The student interns who are processed into the GBHWC Prevention and Training Branch must compile all trainings completed

Data issues/caveats that affect outcome measures:

NOT FINAL

As of FY 2023, there is no set program yet for the Prevention Fellowship

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Indicator #: 3

Indicator: Number of SUPTR job titles recognized by the Government of Guam

Baseline Measurement: 1 currently established - Chemical Treatment Dependency Specialist (CTDS)

First-year target/outcome measurement: Develop a proposed list of position and job descriptions to cover SUPTR services

Second-year target/outcome measurement: Establish these positions to be recognized by the Government of Guam

Data Source:

Department of Administration (DOA) Human Resources

Description of Data:

Government of Guam job titles and pay grade

Data issues/caveats that affect outcome measures:

There are no prior record for positions pertaining to Prevention and Recovery services

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Indicator #: 4

Indicator: Number of Participants in the program each year

Baseline Measurement: 10 participants in the SUD Counseling Program

First-year target/outcome measurement: Participants will have 50% of the required courses for certification complete

Second-year target/outcome measurement: Participants will have completed 100% of the certification program.

Data Source:

Guam Community College Enrollment

Description of Data:

The number of participants enrolled in the SUD Certificate Program at the Guam Community College

Data issues/caveats that affect outcome measures:

Participants will complete the GCC program within the first year but the supervised work experience in the field will take 2 yeas or more to achieve SUD certification.

Indicator #: 5

Indicator: Number of participants in the program each year 2

Baseline Measurement: 2 participants in the program taking the required courses

First-year target/outcome measurement: Participants will have 50% of the reuirements for certification completed

Second-year target/outcome measurement: Participants will have completed 100% of the requirements for certification

Data Source:

The program data clerk an program coordinator

Description of Data:

Data on the number of participants in this specific program that will be provided by the SSA

Data issues/caveats that affect outcome measures:

Not too many clinicians are interested in this particular certification

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Priority #: 2

Priority Area: Culturally relevant programs

Priority Type: SUP, SUT, SUR, BHCS

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

Goal of the priority area:

Guam to implement evidence-informed and community-driven SUPTR services

Strategies to attain the goal:

Expand the SEOW Profile to include SUPTR data that are representative of the population. Mobilize various SUPTR service providers subcontracted by GBHWC to collaborate and establish a coalition. Provide training, technical assistance and support in their coalition building.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of active members in the Governor's PEACE Advisory Council

Baseline Measurement: At least 20% of the members attend the bi-annual meeting

First-year target/outcome measurement: 75% of the members participate in the bi-annual meeting and the quarterly subcommittee meetings

Second-year target/outcome measurement: 75% of the members participate in the bi-annual meeting and the quarterly subcommittee meetings

Data Source:

GBHWC Prevention and Training Branch records

Description of Data:

The attendance record for PEACE Council member meetings, to include minutes of the meeting and resources shared

Data issues/caveats that affect outcome measures:

As of FY 2023, all members may need to be re-sworn or re-appointed, pending the confirmation of the Governor's office

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Indicator #: 2

Indicator: Number of indicators relevant to treatment and recovery data in the SEOW profile

Baseline Measurement: 0

First-year target/outcome measurement: Integrate at least 2 indicators, to include data gathered from GBHWC EHR

Second-year target/outcome measurement: Integrate a total of 4 indicators, to include data gathered from GBHWC, local hospital intake, and CME data

Data Source:

SEOW list of indicators

Description of Data:

This list of indicators are gathered by the Lead Analyst and Lead Epidemiologist to inform the full Epidemiological Profile reported annually

Data issues/caveats that affect outcome measures:

These data sources are currently not collected or made available by the identified sources. A formal agreement between agencies may need to occur prior to receiving the data.

Indicator #: 3

NOT FINAL

Indicator: Number of SUPTR coalitions in Guam

Baseline Measurement: 0

First-year target/outcome measurement: At least 1 organization will serve to identify, review and facilitate SUPTR services in Guam

Second-year target/outcome measurement: At least 1 organization will be recognized as a Drug-Free Coalition by CADCA

Data Source:

GBHWC subgrantee records

Description of Data:

GBHWC will tally the partners it subgrants or subcontracts its SUPTR funds to, and monitor each of their progress in coalition development

Data issues/caveats that affect outcome measures:

There is 1 recognized coalition in Guam, but is only focused on substance use prevention

---

Indicator #: 4

Indicator: Number of CSAP strategies implemented by community-based organizations

Baseline Measurement: In FY 2023, 2 alternative, 1 education

First-year target/outcome measurement: Increase to at least 4 strategies, to include community-based processes

Second-year target/outcome measurement: Increase to at least 5 strategies, to include environmental

Data Source:

GBHWC Prevention and Training subgrantee logs

Description of Data:

The branch will oversee a record of the programs funded by SUPTRS block grant, including the number of strategies implemented

Data issues/caveats that affect outcome measures:

N/A

Indicator #: 5

Indicator: Number of participants in the SUD/Co-Occuring disorder treatment program each year

Baseline Measurement: 10 participants in the program each quarter

First-year target/outcome measurement: 25 participants will complete the treatment program

Second-year target/outcome measurement: 50 participants will complete the treatment program

Data Source:

Data clerk and SABG program coordinator

Description of Data:

The AWARDs EHR collects monthly and quarterly programs data elements for consumers receiving services

Data issues/caveats that affect outcome measures:

The AWARDs and EHR data collects the data and number of consumers in the program, continue working with the consumers and the outcomes (effectiveness of the program) Performance indicators collected for our QIP

Indicator #: 6

Indicator: Increase the number of consumers receiving this service

NOT FINAL

Baseline Measurement: FY 2020, 200 Consumers recevied education, testing and early intervention services for AIDS/HIV/STI

First-year target/outcome measurement: 1,000 consumers will received education, testing and early intervention services for AIDS/HIV/STI

Second-year target/outcome measurement: 1,200 education, testing and early intervention services for AIDS/HIV/STI

Data Source:

SUD treatment programs and Guam DPHSS

Description of Data:

Data collected by the treatment providers and Guam DPHSS to provide data on the number of consumers provided education, testing and early intervention services for AIDS/HIV/STI

Data issues/caveats that affect outcome measures:

This service is voluntary and not all consumers will choose to participate

---

Indicator #: 7

Indicator: Increase the number of consumers (women and children) receiving this service

Baseline Measurement: In FY 2020, 10 pregnant women and 12 women with children were provided access to prenatal and primary care services

First-year target/outcome measurement: 20 pregnant women will receive prenatal services and 20 women with children will receive primary care services while in SUD treatment

Second-year target/outcome measurement: 20 pregnant women will receive prenatal services and 20 women with children will receive primary care services while in SUD treatment

Data Source:

AWARDs EHR

Description of Data:

Data collected quarterly in the EHR

Data issues/caveats that affect outcome measures:

Data will be collected at intake, at 6 months into SUD treatment and at discharge

---

Indicator #: 8

Indicator: Increase the number of consumers receiving this service

Baseline Measurement: In FY 2020, 100 individuals received SBIRT

First-year target/outcome measurement: 200 individuals to receive SBIRT and SUD treatment

Second-year target/outcome measurement: 200 individuals to receive SBIRT and SUD treatment

Data Source:

Data Clerk and Peer Recovery Organization data collection

Description of Data:

The number of individuals who received and SBIRT and the outcome, referral to treatment and completion of SUD treatment

Data issues/caveats that affect outcome measures:

Not all those who received SBIRT will follow through with the referral

---

Indicator #: 9

NOT FINAL

Indicator: Number of participants in the program each year

Baseline Measurement: None

First-year target/outcome measurement: 10 participants in the program

Second-year target/outcome measurement: 10 participants to complete the program

Data Source:

Data collected on AWARDs EHR

Description of Data:

Data will be collected through the SSA EHR

Data issues/caveats that affect outcome measures:

First time project and outcomes may vary

Indicator #: 10

Indicator: Program identifie or developed

Baseline Measurement: None

First-year target/outcome measurement: Identify work group members and start the process of identifying or developing the treatment model

Second-year target/outcome measurement: 10 participants to complete the program

Data Source:

Work group outcomes and EHR on consumer data

Description of Data:

Data collected qualitatively by the work group and data collected from the EHR on consumers in the program and the completion

Data issues/caveats that affect outcome measures:

Not all consumers may complete the program, survey for those who complete may change the outcome

---

Indicator #: 11

Indicator: Increase the number of consumers receiving this service

Baseline Measurement: None

First-year target/outcome measurement: 25 participants will complete the treatment program

Second-year target/outcome measurement: 50 participants will complete the treatment program

Data Source:

Data clerk and program coordinator

Description of Data:

Data collected on the Nutrition and wellness program and outcomes

Data issues/caveats that affect outcome measures:

None

Indicator #: 12

Indicator: The development of an advisory group

Baseline Measurement: Create a culturally relevant intervention program

NOT FINAL

First-year target/outcome measurement: Identify members of the treatment advisory group

Second-year target/outcome measurement: Start the development group of the culturally relevant intervention SUD

Data Source:

Member of the advisory group

Description of Data:

Advisory group will be instrumental in implementing the culturally relevant intervention program

Data issues/caveats that affect outcome measures:

First time project and outcomes may change

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Footnotes:

NOT FINAL

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 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$984,451.75		$0.00	$0.00	$2,011,524.00	$0.00	$0.00		$942,367.29	$683,429.86
a. Pregnant Women and Women with Dependent Children[c]	$25,000.00								$13,181.38	$0.00
b. Recovery Support Services	$111,021.25								$68,364.20	$56,152.92
c. All Other	$848,430.50				$2,011,524.00				$860,821.71	$627,276.94
2. Primary Prevention[d]	$260,671.00		$0.00	$0.00	$100,000.00	$0.00	$0.00		$129,471.71	$197,070.14
a. Substance Use Primary Prevention	$260,671.00				$100,000.00				$129,471.71	$197,070.14
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00								$0.00	$0.00
6. Early Intervention Services for HIV	$0.00								$0.00	$0.00
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$58,230.25								$280.00	$45,421.00
11. Crisis Services (5 percent set-aside)										
12. Total	**$1,303,353.00**	**$0.00**	**$0.00**	**$0.00**	**$2,111,524.00**	**$0.00**	**$0.00**	**$0.00**	**$1,072,119.00**	**$925,921.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:
Planning period start date: 10/1/2023 - 9/30/2025

NOT FINAL

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	100	20
2. Women with Dependent Children	200	120
3. Individuals with a co-occurring M/SUD	500	100
4. Persons who inject drugs	100	48
5. Persons experiencing homelessness	100	49

NOT FINAL

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

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$436,715.25	$874,003.09	$627,276.94
2 . Substance Use Primary Prevention	$130,335.50	$129,471.71	$197,070.14
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Recovery Support Services[5]	$55,510.63	$68,364.20	$56,152.92
6 . Administration (SSA Level Only)	$29,115.13	$280.00	$45,421.00
7. Total	**$651,676.51**	**$1,072,119.00**	**$925,921.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

NOT FINAL

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions 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 use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report 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 required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services 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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the 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 SUPTRS BG 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 will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

NOT FINAL

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$22,292		$21,041
	Selected			
	Indicated			
	Unspecified			
	Total	**$22,292**	**$0**	**$21,041**
2. Education	Universal			
	Selected	$5,592		
	Indicated			$1,041
	Unspecified			
	Total	**$5,592**	**$0**	**$1,041**
3. Alternatives	Universal	$7,500		
	Selected	$5,200		
	Indicated			
	Unspecified			
	Total	**$12,700**	**$0**	**$0**
4. Problem Identification and Referral	Universal			$700
	Selected	$5,592		$5,500
	Indicated	$5,200		
	Unspecified			
	Total	**$10,792**	**$0**	**$6,200**
	Universal	$9,800		$21,381

NOT FINAL

	Selected			$10,000
5. Community-Based Processes	Indicated			
	Unspecified	$39,200	$2,583,555	$37,077
	Total	**$49,000**	**$2,583,555**	**$68,458**
6. Environmental	Universal	$14,700		$13,060
	Selected			
	Indicated			
	Unspecified	$500		$52,343
	Total	**$15,200**	**$0**	**$65,403**
7. Section 1926 (Synar)-Tobacco	Universal			
	Selected			
	Indicated			
	Unspecified	$14,762		
	Total	**$14,762**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$130,337**	**$2,583,555**	**$162,144**
Total SUPTRS BG Award[3]		**$651,677**	**$1,072,119**	**$925,921**
Planned Primary Prevention Percentage		**20.00 %**	**240.98 %**	**17.51 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$39,292		$35,141
Universal Indirect	$15,000		$21,041
Selected	$16,383		$15,500
Indicated	$5,200		$1,041
Column Total	**$75,875**	**$0**	**$72,724**
Total SUPTRS BG Award[3]	**$651,677**	**$1,072,119**	**$925,921**
Planned Primary Prevention Percentage	**11.64 %**	**0.00 %**	**7.85 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

Unspecified targets (not included in this table) are identified as audiences for some Prevention strategies

NOT FINAL

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☐	☐
Tobacco	☑	☑	☑
Marijuana	☑	☐	☐
Prescription Drugs	☐	☐	☐
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☑	☐	☐
Fentanyl	☐	☐	☐
Prioritized Populations			
Students in College	☑	☐	☐
Military Families	☐	☐	☐
LGBTQI+	☑	☐	☐
American Indians/Alaska Natives	☐	☐	☐
African American	☐	☐	☐

NOT FINAL

Hispanic	☐	☐	☐
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☑	☑	☑
Asian	☑	☑	☑
Rural	☑	☑	☑
Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Footnotes:

NOT FINAL

Planning Tables

Table 6 Non-Direct-Services/System Development

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$5,000.00	$460.50	$2,899.85	$39,306.40	$51,633.47
2. Infrastructure Support	$97,824.00	$9,000.00	$6,700.00	$35,221.36	
3. Partnerships, community outreach, and needs assessment	$32,014.00	$74,000.00	$2,000.00	$8,161.00	$107,854.77
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00	$12,300.00		$1,726.22	$3,060.00
5. Quality Assurance and Improvement	$13,874.00		$9,100.00		$19,230.77
6. Research and Evaluation	$13,874.00	$14,300.00		$184,773.92	$62,342.81
7. Training and Education	$35,658.50	$17,500.00	$18,488.00	$3,102.06	$10,719.56
8. Total	**$198,244.50**	**$127,560.50**	**$39,187.85**	**$272,290.96**	**$254,841.38**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

We have improved our intake and registration process for assist consumers with better access to treatment. Policies are in place for providing integrated services for individuals with co-occurring individuals. Policies are in place for priority populations (PWID, PPPW, HIV,).

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

The billing process has not started in the SUD program. We are currently working on creating the system.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

All our consumers are provided assistance with enrolling for benefits. Consumers are encouraged to seek primary heath care. Peer Support is provided to assist consumers with accessing health care.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

Intensive case management is provided to coordinate care for each consumer. Peer Support assists with the case management and care coordination. Peer Support also provides transport when needed, to ensure consumers are receiving services.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Integrated services are provided for each individual with a co-occurring disorder, we have a social work section who assists specifically with the case management and medication management. The SUD counselors are trained to provide services for this population.

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

More training in this area.

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Footnotes:

NOT FINAL

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], 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 orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., 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 **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are 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[5]. 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[6]. 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, LGBTQI+ 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. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

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

[6] **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?

NOT FINAL

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?

The state currently has interpreters that assist in our treatment programs to provide the needed services for ESL consumers. CLAS training is provided throughout each fiscal year for all staff.
As outlined in our state plan, we plan to build a Coalition that will also have a an advisory group to develop culturally appropriate intervention. We will build a treatment model that is culturally appropriate in the Pacific Jurisdictions.

Please indicate areas of technical assistance needed related to this section

TA will be required for this new activity.

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NOT FINAL

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. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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 for the efficacy and value of various mental and substance use prevention, SUD 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/NASEM 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 (EBPRC) 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 EBPRC 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 used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was 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."[6] SAMHSA and other HHS federal partners, including the 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 innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] 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)**[8] 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. Each 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, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] 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

[3] 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 use disorder and Mental Health Services Administration.

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

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

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

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

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 focused 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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NOT FINAL

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary 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 SUPTRS BG. 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:

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?

   Contracts include clause on pass-through of restrictions from grantors to subgrantees.

   Please indicate areas of technical assistance needed related to this section

   Not at this time

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NOT FINAL

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:

NOT FINAL

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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.

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)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] 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)

- **a)** [ ] Children (under age 12)
- **b)** [x] Youth (ages 12-17)

NOT FINAL

c) [x] Young adults/college age (ages 18-26)

d) [x] Adults (ages 27-54)

e) [x] Older adults (age 55 and above)

f) [x] Cultural/ethnic minorities

g) [x] Sexual/gender minorities

h) [ ] Rural communities

i) [ ] Others (please list)

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

a) [ ] Archival indicators (Please list)

b) [ ] National survey on Drug Use and Health (NSDUH)

c) [x] Behavioral Risk Factor Surveillance System (BRFSS)

d) [x] Youth Risk Behavioral Surveillance System (YRBS)

e) [ ] Monitoring the Future

f) [ ] Communities that Care

g) [ ] State - developed survey instrument

h) [ ] Others (please list)

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

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

b) If no, (please explain) how SUPTRS BG funds are allocated:

While not considered a stand-alone evidence-based workgroup, the Governor's Advisory Council for Prevention Education and Community Empowerment (PEACE) is representative of the 12 sectors of community that the CADCA describes for an ideal coalition. The GBHWC Prevention branch works closely with the PEACE Advisory Council in their review of strategic plans, program launch schedules and evaluation reports for all primary prevention efforts funded by the SUPTRS BG and other SAMHSA grants. Additionally, the branch uses the annual Epi report from Guam SEOW to inform all program plans and budget allocations.

Moving forward, the branch will work with the PEACE Council to revive its evidence-based workgroup as an active

NOT FINAL

subcommittee who can work alongside branch staff in needs assessment and program planning.

6. Does your state integrate the National CLAS standards into the assessment step? (●) Yes ( ) No

a) If yes, please explain in the box below.

All staff are trained in the CLAS standards, as required by the agency. The practice of these standards are integrated as essential functions in the assessment process for primary prevention strategies.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The PEACE Council will also include a subcommittee on sustainability that will work with the branch staff in identifying means to sustain initiatives outside of the SUPTRS block grant, to include capacity and resource building through community partners and coalitions.

b) If no, please explain in the box below.

NOT FINAL

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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 Planning

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

a) If yes, please describe.

Guam prevention practitioners submit for the Certification Prevention Specialist to the Pacific Behavioral Health Collaborating Councill (PBHCC), which is the certifying board for the Pacific region that is also recognized by the IC&RC.

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

a) If yes, please describe mechanism used.

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

a) If yes, please describe mechanism used.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

All staff are trained in the CLAS standards, as required by the agency. The practice of these standards are integrated as essential functions in the capacity building process for primary prevention strategies.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The PEACE Council will include a subcommittee on sustainability that will work with the branch staff in identifying means to sustain initiatives outside of the SUPTRS block grant, to include capacity and resource building through community partners and coalitions.

b) If no, please explain in the box below.

NOT FINAL

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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 Processes*** 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 primary 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.

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

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

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component (i.e., National CLAS Standards)
- **g)** [x] Sustainability component
- **h)** [ ] Other (please list):

NOT FINAL

i) ☐ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG 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 SUPTRS BG primary prevention funds? ○ Yes ◉ No

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

N/A

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ◉ Yes ○ No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ○ Yes ◉ No

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

N/A

8. Does your state integrate the National CLAS Standards into the planning step? ◉ Yes ○ No

a) If yes, please explain in the box below.

All staff are trained in the CLAS standards, as required by the agency. The practice of these standards are integrated as essential functions in the planning process for primary prevention strategies.

b) If no, please explain in the box below.

N/A

9. Does your state integrate sustainability into the planning step? ○ Yes ○ No

a) If yes, please explain in the box below.

The PEACE Council will include a subcommittee on sustainability that will work with the branch staff in identifying means to sustain initiatives outside of the SUPTRS block grant, to include planning, through community partners and coalitions.

b) If no, please explain in the box below.

N/A

NOT FINAL

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not 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 primary 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 SUPTRS BG 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.

Implementation

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

- **a)** [x] 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)** [x] The SSA funds community coalitions to provide prevention services.
- **h)** [x] The SSA funds individual programs that are not part of a larger community effort.
- **i)** [x] 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 SUPTRS BG primary prevention dollars

NOT FINAL

in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

All funded initiatives (directly implemented by SSA staff, subgranted to coalition or programs implemented by a subcontracted agency) will be required to distribute prevention education materials and information. Literature (brochures, social media posts, web content, etc) will be reviewed for accuracy and reliability of information shared.

b) Education:

c) Alternatives:

Throughout the year, at least 2 alternative activities will be supported by the SUPTRS grant, each to target youth and adult audiences. The youth event will likely be an after-school or summer program that encourages peer mentorship and leadership among middle to high school kids. The adult event will be a health and wellness fest that offers information, demonstration and access to holistic activities that promote substance use prevention and positive coping strategies.

d) Problem Identification and Referral:

All youth programs supported by the SUPTRS grant will encourage the use of universal assessments to identify and potentially intervene with at risk behavior or mental health concerns. Tools and skills will be provided to facilitators to safely and appropriately refer potential concerns to services.

e) Community-Based Processes:

GBHWC will work alongside community coalitions that are starting up or sustaining their efforts in substance use prevention efforts. The team will provide technical assistance, especially in the use of the SPF process. Aside from training, we will also encourage certification of coalition and subgrantee staff as certified prevention specialist.

f) Environmental:

The subgranted coalition will be required to implement an environmental strategy, either focusing in administrative policy, legislation or social norms.

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

a) If yes, please describe.

The Prevention set-aside is managed solely by the agency's prevention branch that also oversees all prevention initiatives funded by various sources, local and federal. All programs and strategies funded by the SUPTR set-aside are also closely monitored by designated staff to ensure no supplanting of funds and duplication of efforts. Lastly, the supervisor and financial officer manage financial distribution for prevention efforts and aims to correct any potential unallowable or misuse of such funds.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

All staff are trained in the CLAS standards, as required by the agency. The practice of these standards are integrated as essential functions in the implementation process for primary prevention strategies.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

The PEACE Council will include a subcommittee on sustainability that will work with the branch staff in identifying means to sustain initiatives outside of the SUPTRS block grant, to include implementation, through community partners and coalitions.

b) If no, please explain in the box below

NOT FINAL

Narratve Question

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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 primary 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.

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

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ 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 SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served

NOT FINAL

b) ☐ Implementation fidelity

c) ☑ Participant satisfaction

d) ☑ Number of evidence based programs/practices/policies implemented

e) ☑ Attendance

f) ☑ Demographic information

g) ☐ Other (please describe):

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

a) ☑ 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☑ Heavy use

c) ☑ Binge use

d) ☑ Perception of harm

e) ☑ Disapproval of use

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

g) ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

Based on the CLAS standards, the agency will ensure appropriate representation of the populations in our community in the reach of our programs. Based on epi data, we exert more effort in reaching subpopulations that experience disparities and increased risks for substance misuse. Lastly, we work with the community in offering prevention services -- cultural ambassadors are key to our successful outreach and implementation.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ○ Yes ◉ No

a) If yes, please describe in the box below.

b) If no, please explain in the box below.

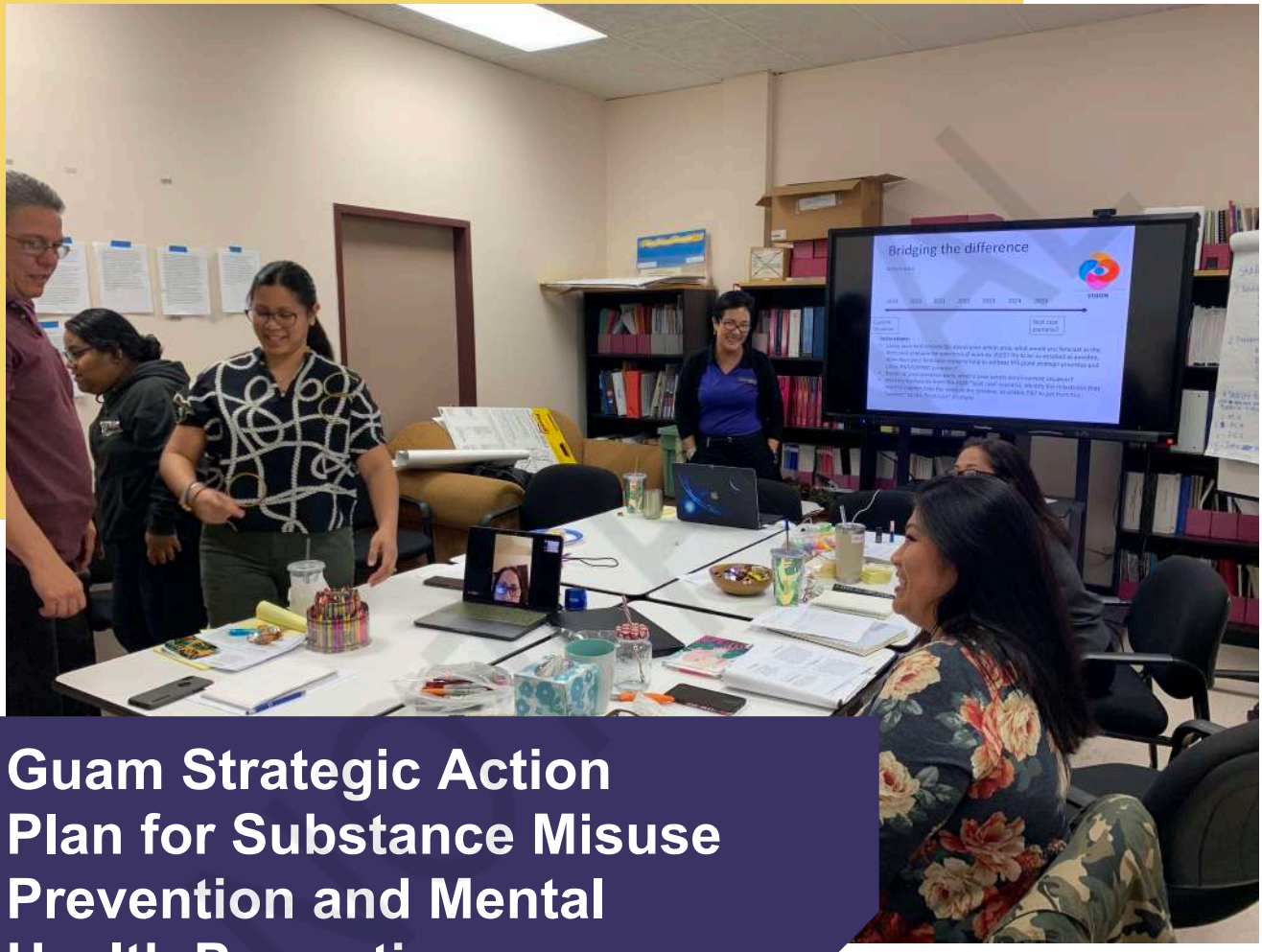
We have yet to establish a sound implementation plan, however this year we will focus on accomplishing a needs assessment that will be the baseline of our evaluation. A staff members will be hired to closely monitor these indicators. TA will also be requested in FY 24 from SAMHSA to guide our agency in proper evaluation planning and sustainability.

NOT FINAL

Footnotes:

NOT FINAL

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER



Guam Strategic Action Plan for Substance Misuse Prevention and Mental Health Promotion FY 2020 thru FY 2024

Guam Behavioral Health and Wellness Center, Prevention & Training Branch

Website: www.gbhwc.guam.gov

Tel: (671) 647-1901
Fax: (671) 649-6948

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FOREWORD

Prevention works.

The forefront of Guam's infrastructure for behavioral health services heavily focuses on treatment, rehabilitation and community reintegration for persons living with mental illness and substance dependence. However what most do not see is the foundation of Prevention services that protect and promote the mental health of our entire island community.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes Prevention activities as integral strategies to educate and support individuals and communities to prevent the use and misuse of drugs and the development of substance use disorders. As many of us can attest, substance use and mental disorders can make daily activities difficult. It may impair a person's ability to work, interact with others – even family and close friends – and fulfill major life functions. Mental illnesses and substance use disorders are among the top conditions that cause disability in the United States, including in our island home. Therefore, the active effort of championing Prevention activities in the government and private sectors, in the community and in our homes to prevent mental illnesses and substance use disorders is critical to uplift the overall health of our people.

As we thrive in this new normal we created living through the COVID-19 pandemic, promoting positive mental health and preventing substance misuse in our community has become more pronounced than ever. We support and applaud the Guam Behavioral Health and Wellness Center's Prevention and Training Branch in leading this initiative. Through the strategies laid out in this **Guam Strategic Action Plan for Substance Misuse Prevention and Mental Health Promotion,** despite delays caused by uncontrolled factors, our people will continue to have access to tools and opportunities to completely recover and take care of themselves.

We urge you to join us in this journey towards a healthy island, committed to promoting and improving the behavioral health and well-being of each other. *Biba Prevention!*

Approved and Endorsed By:

Theresa C. Arriola
Director, GBHWC

Lourdes A. Leon Guerrero
Governor of Guam

PEACE stands for Prevention Education and Community Empowerment. To attain its vision, the PEACE office identifies valuable key stakeholders within the community, and partners with them in planning and carrying out culturally relevant, community-involved prevention initiatives.

BACKGROUND

Guam Behavioral Health and Wellness Center envisions a healthy island, committed to promoting and improving the behavioral health and well-being of our community.

While Guam has made strides in reducing tobacco use among youth and adults, and harmful alcohol use rates among youth, tobacco and harmful alcohol use continue to be higher in Guam compared to the United States, and the prevalence of suicide and its attendant mental health risk factors are significantly elevated. The distribution of risk demonstrates significant inequity across socio-economic groups.

The Guam State Epidemiological Outcomes Workgroup (SEOW) reviewed local substance misuse and suicide data and used an incremental process that weighted magnitude (high prevalence), burden, vulnerability (high risk, low protective factors), capacity and the presence or absence of other programs and funding support to identify prevention priorities and high-need groups. Underage drinking, tobacco use and suicide prevention emerged as the priorities. Examination of data disaggregated for ethnicity, age, and sex revealed that Chamorro and other Micronesian youth and young adults are at highest risk for increased vulnerability (high prevalence of risk factors), actual consumption and health and social consequences. Increased use and lower perception of harm were correlated with lower income and education levels.

NOT FINAL

"…it made me realize that we (Prevention &Training branch) make such a difference in many lives by the coordination and provision of prevention services."

NOT FINAL

Guam Behavioral Health and Wellness Center's Prevention and Training Branch (P&T) currently receives support from local and multiple federal grant sources, but these various funding sources have different priorities, and are time-limited. Thus far, implementation of the various activities under these diverse grants has occurred largely independently of each other.

Funding sources for P&T:

- Local funding - Focus on Life Suicide Prevention (FOL)
- Federal funding
  - Partnerships for Success grant (PFS)
  - Garrett Lee Smith State/Tribal Youth Suicide Prevention grant (Guam Focus on Life)
  - Substance Abuse Prevention and Treatment block grant (SAPT)
  - State Tobacco Enforcement (FDA)

Prevention priorities:

- Substance misuse prevention
- Mental health promotion
- Suicide prevention
- Wellness promotion (staff)

Moreover, staff turnaround has been considerable at the Branch and within the GBHWC. Some staff, including interns, are new to prevention practice. Continuous development of the skills set of the current P&T team is necessary. At present, transitions in the prevention field and staff loss and turnover contributed to limited clarity about duties, roles and expectations for each individual staff member. Identified staffing gaps include the need for health educators and a mental health training coordinator. There was consensus on the need to create a safe and healthy working environment where:

- Decision making is transparent and participatory;
- Open communication is fostered;
- Individual roles and team expectations (including contractors, partners and sub-grantees) are clearly delineated;
- Staff skills and competencies are periodically upgraded; and,
- Organizational structure is explicitly defined.

Previously, P&T was guided by the 2014-2018 State Prevention Enhancement (SPE) Comprehensive Strategic Plan and the 2016-2020 Suicide Prevention, Early Intervention, Postvention and Referrals Plan for Guam. The team identified the need

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and opportunity to embark on a new strategic planning process, consolidating the various prevention priorities into one integrated plan, the Guam Strategic Plan for Substance Misuse Prevention and Mental Health Promotion (referred to in the remaining document as the Guam Strategic Plan). This plan will direct the targeted application for P&T's grant funding.

The development of this Guam Strategic Plan for Substance Misuse Prevention and Mental Health Promotion (FY 2020 thru FY 2024) was funded by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Prevention and Treatment (SAPT) Block Grant.

In March 2020, the Governor of Guam's Executive Order (EO) No. 2020-05 mandated island wide social isolation and clarified the status of non-essential Government of Guam operations. During this time, community gatherings were limited, procurement for new services and changes to contracts were paused and non-essential employees were required to home-quarantine and Guam was placed in Pandemic Condition of Readiness 1 (PCOR 1) (the strictest measure for Pandemic Condition of Readiness).

This EO was in effect until June 1, 2020 when Government of Guam agencies were allowed to reopen. However, Guam went back into PCOR 1 in August 2020, limiting once more non-essential operation among local and private agencies. These limitations delayed timelines for staff operations and the completion and endorsement of this strategic action plan.

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METHODOLOGY

This Guam Strategic Plan for Substance Misuse Prevention and Mental Health Promotion (FY 2020 thru FY 2024) contains the vision and strategic directions for strengthening prevention in Guam, with a particular emphasis on tobacco and alcohol control, substance misuse and suicide prevention and mental health promotion for the next five years. The 2014-2018 State Prevention Enhancement (SPE) Comprehensive Strategic Plan, the 2016-2020 Suicide Prevention, Early Intervention, Postvention and Referrals Plan for Guam, and the 2018 PEACE Partnerships for Success grant provide the foundation for this Guam Strategic Plan. The Guam Strategic Plan is designed to be in line with the priorities of the United States Substance Abuse and Mental Health Services Administration (SAMHSA) Strategic Plan 2019-2023, SAMHSA Center for Substance Abuse Prevention (CSAP) community grants, the World Health Organization (WHO) Regional Strategy to Reduce Alcohol-Related Harm, the WHO Regional Strategy for Tobacco Control 2019-2023, the WHO Regional Strategy for Mental Health Promotion, and Guam's Non-Communicable Disease Strategic Plan for 2019-2023.

Prevention and Training (P&T) staff undertook a 3-day retreat to reflect upon the branch's previous work and future directions and collaboratively delineated the new vision, goals, strategic objectives and actions for the next five years. With the help of consultant Dr. Annette M. David from Health Partners, LLC, the P & T team created and wrote the plan and disseminated it to a broader stakeholder audience for public review and comment. Due to the island being placed in PCOR 1 as a direct result of the global pandemic, the Guam Strategic Plan was finalized by incorporating relevant feedback from the Prevention Education and Community Empowerment (PEACE) Advisory Council in early 2021. The Guam Behavioral Health and Wellness Center (GBHWC) and the PEACE Advisory Council approved the final plan on May 5, 2021. The Office of the Governor officially endorsed the final plan on _____, 2021.

"…prevention is essential. Creating more community support will reinforce our island's commitment to making informed decisions towards a healthier future."

NOT FINAL

PRINCIPLES

In developing this strategic action plan, these overarching principles are recognized:

- **Using existing evidence while nurturing new evidence**

  Sufficient local data exists to guide the initial actions in the Guam Strategic Plan in addressing tobacco, alcohol and other drug use, suicide and mental health. However, evidence gaps persist, particularly in evaluated programs and interventions developed and implemented for and by Pacific Islanders. Thus, the P&T team recognizes the value in fully utilizing the existing data for effective action while exploring and documenting potential new evidence for action within our community of Pacific islanders.

- **Fostering multisectoral collaboration, partnerships and networking at all levels**

  Effective prevention necessitates multisectoral participation, strong partnerships and networking. The P&T staff recognize the vital need to engage with other government agencies, higher learning institutions, faith-based organizations, the PEACE Council and political leaders to fully address the comprehensive nature of prevention. At the societal level, the team needs to work collaboratively with relevant community stakeholders and individuals for effective education and community mobilization to support prevention policies and programs**.** Effective collaboration is also necessary at the national, regional and global levels, to accelerate capacity building and leverage these networks to support the work in Guam. Mechanisms to foster these types of creative partnerships are essential for successful implementation of the Guam Strategic Plan.

- **Guam's prevention stakeholders are the driving force to the success of the Action Plan**

  The process that underpins this Plan of Action is an iterative one; that is, it continues the Strategic Prevention Framework (SPF) which includes assessment, capacity building, planning, implementation, and evaluation, while ensuring that sustainability and cultural competence are integrated in each step. Stakeholders are included in the planning, implementation and evaluation of the strategies and interventions. The Plan of Action also recognizes that community groups and partners are at different stages of capacity for prevention. Thus, partners and sub-grantees may need

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additional training and technical assistance that allows them to gradually build up prevention capacity and resources. Fundamental to this Plan is the aspiration to create a “Prevention Resource Center” as the embodiment of a prevention “learning community” that would facilitate the diffusion of lessons learned, and potentially create a pool of island-wide prevention technical assistance resources.

- **Tailoring prevention practice to acknowledge both strengths and needs of the diverse cultures in Guam, with specific inclusion of its vulnerable populations**

  Local culture, language preferences and other unique characteristics of specific populations are taken into consideration when designing the approaches and formats for implementation. Prevention interventions should be made as inclusive and accessible as possible for the vulnerable populations in our island community. The P&T team intends to incorporate the principles of Culturally and Linguistically Appropriate Services (CLAS) promoted by the Office of Minority Services (OMH) of the US Centers for Disease Control and Prevention (CDC), to include the practice of cultural humility as prevention professionals.

- **Strengthening local prevention infrastructure that thrives through the changes in the field**

  Shifts in federal leadership in the past years have impacted resources prioritized for prevention initiatives in Guam. The P & T recognizes this Action Plan as an opportunity to increase the self-sufficiency of Guam’s prevention infrastructure, so that it can better withstand current and future changes in its environment. Key to this shift is the re-commitment of local support and funding to programs, staff and resources maintained within the Guam Behavioral Health and Wellness Center.

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- **Recognizing and addressing social inequity and the social determinants of tobacco, alcohol and other drug use and suicide**

  Finally, this Plan of Action requires P&T staff and their partners to systematically address social inequities that directly or indirectly impact on tobacco, alcohol and other drug consumption and exposure to suicide and other mental health risk factors. Incorporating a perspective that considers gender, ethnicity, religion, culture and other socio-economic determinants is critical, if Guam's community is to build capacity to resolve the fundamental causes of poor health and elevated risks among those groups with increased vulnerabilities to substance misuse and poor mental health, and the adverse health effects accompanying these.

"…throughout my almost 15 years in Prevention/PEACE, when people approach me and tell me that I made an impact in their lives---my passion cup overflows for our work!"

NOT FINAL

VISION, MISSION AND GOALS

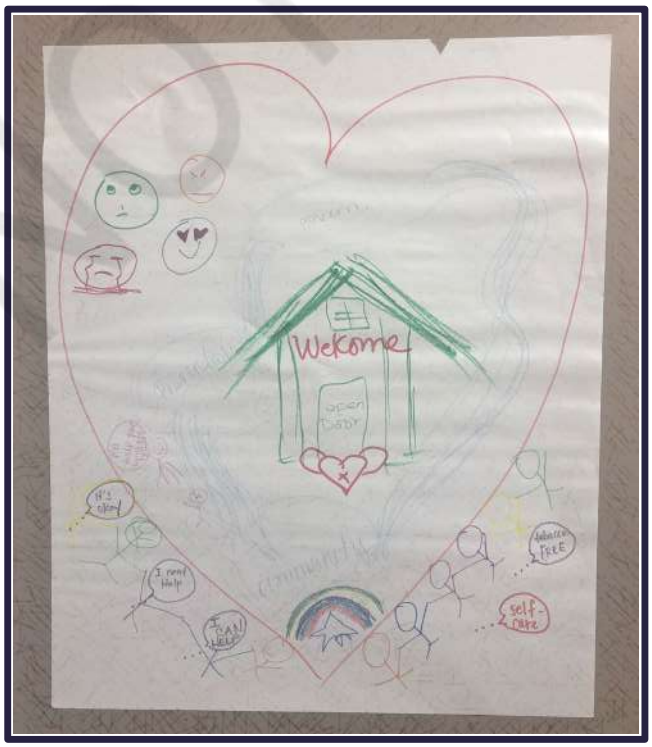
Vision:

We envision an island community where prevention and the value of Inafa' Maolek (pronounced e-na-fah-mao-lek) to make the island good by restoring harmony is a priority. There is island-wide support for prevention. It is normal and natural for people who need help to seek help, and people who can help are willing to give help. There is no gap between prevention and treatment. Prevention services are fully guided by cultural values. Everyone has access to behavioral health services and care.

Families, individuals and the community choose to be alcohol, tobacco and other drug free. There are no substance use related crimes.

There are no suicides in Guam. Our people are liberated from the stigma of mental health issues, suicidal thoughts and substance use addiction.

Prevention professionals model health, wellness and selfcare every day.



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Mission

Our mission is to engage and empower our community so that prevention is elevated to a priority while promoting evidence-informed interventions to prevent and reduce tobacco, alcohol, other drug use and suicides, and to enhance mental wellness.

Goals

We have established five goals for the next five years that address five key areas of work:

Key area of work	GOAL: By 2024
Sustainability of the prevention system	85% of prevention programs, including suicide prevention, substance misuse prevention, mental health promotion will be locally funded.
Community outreach and empowerment	A fully functional GBHWC Prevention and Training structure will be established that will operate as a community resource center for building community capacity.
Alcohol, tobacco and other drug misuse prevention	Substance use rates will have been reduced by 50% from baseline.
Suicide prevention	No suicide deaths will occur among individuals who seek and receive behavioral health services from GBHWC.
Mental health promotion	Mental health promotion activities and holistic services will be included in the GovGuam Worksite Wellness program.

"…(P&T) showed compassion at my most vulnerable moment--this quality is needed when in the business of saving lives."

NOT FINAL

SPECIFIC GOALS, OBJECTIVES AND ACTIONS

STRATEGIC ACTION AREA: Sustainability

GOAL 1

By 2024, 85% of prevention programs, including suicide prevention, substance misuse prevention, and mental health promotion will be locally funded.

Strategy: Link tobacco, alcohol and marijuana taxes, licensing fees and penalties to prevention funding

Baseline: In 2019, ~15% of prevention programs are locally funded

SPECIFIC OBJECTIVES:

1.1 By 2020, the Alcohol Prevention Team (NCD Consortium) will be fully operational.
Baseline: currently inactive

1.2 By 2021, alcohol taxes will be increased by at least 300%.
Baseline: malted beverages – 7 cents/12 ounces, distilled spirits -$18/gallon, wine - $4.95/wine gallon

1.3 By 2022, law passed to appropriate tobacco, alcohol and marijuana taxes, licensing fees and penalties to GBHWC Prevention and Training.
Baseline: no appropriations for prevention from alcohol and marijuana taxes

NOT FINAL

Specific Objective 1.1: By 2020, the Alcohol Prevention team (NCD Consortium) will be fully operational. *Baseline:* currently inactive			
Activity	**Responsible party**	**Time frame**	**Outcome Product Result**
DESIGNATE a P&T staff who will lead the APT within the NCD Consortium.	P&T staff	1st Q 2020	APT Chairperson identified
Recruit additional members for the APT	Designee/Chair	2-3 Q, 2020	Membership list
Review NCD Alcohol prevention and control priorities in NCD Strategic Plan	APT	2-3 Q, 2020	
Align APT goals, objectives and strategic actions with state strategic plan	APT	4 Q 2020	APT workplan adopted by P&T
Implement strategic actions in workplan	APT	2020-2024	

NOT FINAL

Specific Objective 1.3: By 2022, law passed to appropriate tobacco, alcohol, and marijuana taxes, licensing fees and penalties to Prevention.
Baseline: no appropriations for prevention from alcohol and marijuana taxes

Activity	Responsible party	Time frame	Outcome Product Result
Identify existing laws related to GBHWC Prevention and Training appropriations	P&T	1-2 Q, 2020	Inventory of existing laws
Map GBHWC Prevention and Training funding and resource needs and existing local allotments	P&T	1-2 Q, 2020	Budget gap analysis
Present budget gap to GBHWC leadership and ensure inclusion in overall GBHWC budget for presentation at annual budget hearing	P&T Supervisor	3-4 Q, 2020	P&T budget within GBHWC budget increased
Coordinate and provide data to prevention champions in legislature to assist them in identifying additional appropriations to cover the prevention budget gap	P&T	4 Q, 2020; 1 Q, 2021	
Provide information to legislature for potential sources for additional revenue for prevention through taxation of alcohol, tobacco, and marijuana	P&T	2 Q-4Q; 2021	Additional revenue to prevention

NOT FINAL

STRATEGIC ACTION AREA: Community empowerment

GOAL 2

By 2024, A fully functional community prevention resource center structure will be operated by GBHWC Prevention and Training branch for building community capacity to carry out and sustain prevention programs. This resource center will include, but not limited to, training rooms for community trainings, Council meetings, prevention planning and access to prevention resources for community members.

Strategy: Ensure P&T's inclusion in GBHWC Expansion Plan

Baseline: In 2019, no physical space allotted to P&T for community capacity building and education activities.

SPECIFIC OBJECTIVES:

2.1 By 2020, the GBHWC expansion plan will include the creation of a community prevention resource center operated by Prevention and Training branch.

Baseline: P & T not explicitly allotted a portion of the expansion plan

2.2 By 2023, the P&T Prevention Center will be built.

Baseline: none

2.3 By 2024, the P&T Prevention Center will be operational.

Baseline: none

Specific Objectives:
2.1 By 2020, the GBHWC expansion will include Prevention and Training branch.
2.2 By 2023, the P&T Prevention Center will be built.
2.3 By 2024, the P&T Prevention Center will be operational.

Activity	Responsible party	Time frame	Outcome Product Result
Ensure P&T community prevention resource center is included in GBHWC expansion planning	P&T Supervisor	1 Q, 2020	
Conduct mapping of current and future prevention program functions, funding and resources to determine future infrastructure needs	P&T	1-2 Q, 2020	Infrastructure recommendations

NOT FINAL

Incorporate P&T recommendations into overall expansion plan and timeline	P&T supervisor	2020-2024	
Continuously monitor/ follow-up with expansion progress plan	P&T supervisor	2020-2024	Prevention Resource Center

NOT FINAL

STRATEGIC ACTION AREA: Substance misuse prevention

GOAL 3

By 2024, substance use rates will have been reduced by 50% from baseline.

Strategies:

- Strengthen enforcement of existing ATOD laws and policies
- Expand alcohol-free public places to de-normalize alcohol use in public
- Fully implement the Partnerships for Success (PFS) project plan

Baseline: (insert 2019 rates here)

SPECIFIC OBJECTIVES:

3.1 By 2024, enforcement of tobacco and alcohol laws will be strengthened.

3.1.a By 2024, there will be zero Synar violations.
Baseline: 2019 Synar retail violation rate - 12.1%

3.1.b By 2023, GDOE will reduce its alcohol and tobacco related offenses by 10%
Baseline: tobacco-related offenses (2019); alcohol-related offenses (2019)

3.2 By 2022, public parks and beaches will be alcohol free.
Baseline: In 2019, ___ out of ____ parks and beaches are designated as alcohol-free

3.3 By 2023, GDOE middle and high school students in PFS-participating schools will have an increased perception of harm towards tobacco, alcohol and nicotine by 10%.
Baseline: Baseline figures will be determined by PEACE PFS sub-grantees during their required school-based needs assessment at select GDOE school sites in FY2020. The following indicators for attitudes and perceptions on youth substance use will be collected and monitored:

- Perceived availability of alcohol, electronic vapor products, marijuana and other drugs to youth
- Peer disapproval of underage use of alcohol, electronic vapor products, alcohol, marijuana and other drugs

NOT FINAL

- Parental disapproval of underage use of alcohol, electronic vapor products, alcohol, marijuana and other drugs
- Perceived risk of harm of alcohol, electronic vapor products, alcohol, marijuana and other drug use.

3.4 By 2023, GDOE will increase its in-school early intervention screening/assessment among students by 10%, to identify and refer youth with increased risk for alcohol, tobacco and nicotine use to appropriate behavioral health care services.

Baseline: As of date, GDOE does not utilize a universal, evidence-based process for screening, brief intervention and referral for capturing students with increased risk for substance use.

NOT FINAL

Specific Objective 3.1: By 2024, enforcement of tobacco and alcohol laws will be strengthened.
3.1.a: By 2024, there will be zero Synar violations.
Baseline: 2019 Synar retail violation rate - 12.1%
3.1.b: By 2023, GDOE will reduce its alcohol and tobacco related offenses by 10%
Baseline: tobacco-related offenses (2019); alcohol-related offenses (2019)

Activity	Responsible party	Time frame	Outcome Product Result
Re-establish PEACE Council	P&T	1-2 Q, 2020	PEACE Council
Create ATOD Prevention Taskforce to address enforcement	P&T; PEACE Council	1 Q, 2021	Taskforce
Conduct education outreach for tobacco and alcohol vendors	P&T; SAPT Partners	2020-2024	
Re-strategize Synar inspections	P&T; SAPT	2 Q, 2020	Revised protocol
Implement and evaluate new Synar protocol to increase frequency of inspections	P&T; SAPT	2021-2024	Decreased Synar violations
Implement PEACE Partnerships for Success grant (PFS) action plan	P&T; PFS project director	2020-2023	Reduced Alcohol and Tobacco offenses in GDOE

NOT FINAL

Specific Objective 3.2: By 2022, public parks, sports facilities and beaches will be alcohol free.
Baseline: In 2019, Public Law designates that up to 15% of parks and beaches are designated as alcohol-free.

Activity	Responsible party	Time frame	Outcome Product Result
Conduct environmental scan with SAPT partners to document visually the adverse impact of alcohol use in parks, sports facilities and beaches (Photovoice)	P&T; SAPT partners; RCUOG/Cooperative Extension; APT	1- 4 Q, 2021	Findings/report
Conduct policy and literature review of states with existing alcohol-free parks, sports facilities and beaches	P&T; RCUOG/Cooperative Extension Taskforce	1-4 Q, 2021	Findings/report
Present environmental scan findings to Parks & Rec	P&T; SAPT partners, APT	1 Q, 2022	Presentation/meeting
Collaborate with Parks & Rec to expand alcohol-free zone policies to 100%	P&T; Parks & Rec, APT	2022-2024	MOU
Implement and enforce alcohol-free zone policy	Parks & Rec	2022-2024	
Monitor and evaluate policy through periodic environmental scan (photovoice)	P&T; SAPT partners; RCUOG/Cooperative Extension; APT	2022-2024	Annual Report

Specific Objective 3.3: By 2023, GDOE middle school students will have an increased perception of harm towards tobacco, alcohol and marijuana by 10%.
Baseline: Baseline figures will be determined by PEACE PFS sub-grantees during their required school-based needs assessment at select GDOE school sites in FY2020. The following indicators for attitudes and perceptions on youth substance use will be collected and monitored:

- *Perceived availability of alcohol, electronic vapor products, marijuana and other drugs to youth*
- *Peer disapproval of underage use of alcohol, electronic vapor products, alcohol, marijuana and other drugs*

NOT FINAL

• *Parental disapproval of underage use of alcohol, electronic vapor products, alcohol, marijuana and other drugs* • *Perceived risk of harm of alcohol, electronic vapor products, alcohol, marijuana and other drug use*			
Activity	**Responsible party**	**Time frame**	**Outcome Product Result**
Implement PEACE PFS action steps (Please refer to PEACE PFS action plan.)	P&T; PFS Staff	2020-2023	Progress report

Specific Objective 3.4: By 2023, GDOE will increase its in-school early intervention screening/assessment among students by 10%, to identify and refer youth with increased risk for alcohol, tobacco and nicotine use to appropriate behavioral health care services. Baseline: As of date, GDOE does not utilize a universal, evidence-based process for screening, brief intervention and referral for capturing students with increased risk for substance use			
Activity	**Responsible party**	**Time frame**	**Outcome Product Result**
Implement PEACE PFS action steps (Please refer to PEACE PFS action plan.)	P&T; PFS Staff	2020-2023	Progress report

STRATEGIC ACTION AREA: Suicide prevention

GOAL 4

By 2024, no suicide deaths will occur among individuals who seek and receive behavioral health services from GBHWC.

Baseline: 2018 crude suicide rate – 26.6/100,000

Strategy: Fully implement the Zero Suicide Framework in GBHWC and provide Mental Health First Aid Trainings to local prevention partners and community NGO's.

SPECIFIC OBJECTIVE:

4.1 By 2024, the Zero Suicide framework will be fully implemented.

Baseline: In 2019, implementation of the Zero Suicide framework has not yet started.

NOT FINAL

Specific Objective 4.1: By 2024, the Zero Suicide framework will be fully implemented in primary and behavioral health care providers. *Baseline:* In 2019, Zero Suicide framework has not been adopted.			
Activity	**Responsible party**	**Time frame**	**Outcome Product Result**
Seek technical assistance in Zero Suicide Framework (ZSF) from PTTC and other partners	P&T	1 Q, 2020	
Introduce and mobilize support for ZSF among divisions of GBWHC	P&T	2-3 Q, 2020	
Adopt zero suicide framework within GBHWC	P&T; GBHWC	2021	
Revise MOU between community healthcare providers and GBHWC to include adoption of ZSF, program evaluation, and community outreach & training	P&T	2021	MOU
Establish Suicide Prevention taskforce within the PEACE Council to liaise with external partners	P&T	1 Q, 2023	Taskforce
Develop MOU between DPHSS and GBHWC to implement ZSF	P&T	2 Q, 2023	MOU
Develop MOU between ED and GBHWC to implement ZSF	P&T	2 Q, 2023	MOU
Continue Suicide prevention trainings (START, ASIST, safeTALK, Connect, Grief Talk)	P&T	2020-2024	

STRATEGIC ACTION AREA: Mental health promotion

GOAL 5

By 2024, mental health promotion activities and holistic services will be included in the GovGuam Worksite Wellness program.

Baseline: 2019 – Worksite Wellness consists of physical wellness activities only

Strategy: Expand Worksite Wellness to include mental health promotion and overall behavioral and physical wellness.

SPECIFIC OBJECTIVE:

NOT FINAL

5.1 By 2023, an Executive Order to expand Worksite Wellness activities to include mental health promotion, overall wellness and selfcare activities will be issued.

5.2 By 2023, The Executive Order will identify the Worksite Wellness to be monitored and evaluated by both GBHWC and DPHSS.

Baseline: 2019 – none

Specific Objective 5.1: By 2023, an Executive Order to expand Worksite Wellness activities to include mental health promotion will be issued.
Baseline: 2019 – none

Activity	Responsible party	Time frame	Outcome Product Result
Review Worksite wellness executive order to identify wellness activities that relate to mental health	P&T Staff, GBHWC Health Coach	3-4 Q, 2021	List of mental health activities
Present mental health promotion as part of an NCD priority for wellness	P&T	4 Q, 2021	presentation
Collaborate with DPHSS, Worksite wellness committee and health coaches to revise current executive order and incorporate mental health promotion activities into Worksite wellness options	P&T	1-4 Q, 2022	Executive order
Provide TA in monitoring and evaluating mental health activities reported as part of worksite wellness	P&T; DPHSS	2023-2024	Findings/report

NOT FINAL

THE WAY FORWARD

This Guam Strategic Plan for Substance Misuse Prevention and Mental Health Promotion (FY 2020 thru FY 2024) builds on the previous Strategic Prevention Framework and former P&T action plans to provide the strategic guidance to the branch and its partners and stakeholders in their efforts to promote the policy and program interventions for achieving a resilient community freed from substance misuse, suicide and other mental health issues.

The Guam Strategic Plan emphasizes evidence-based, collaborative and participatory approaches towards preventing/controlling current and emerging substance misuse and mental health risks with a view towards reducing health inequities among the diverse groups that comprise our island community. Its objectives are aligned with or complement other existing strategic action plans, such as those of SAMHSA, existing P&T grants, and relevant NCD community action plans while actions address specific prevention priorities and issues.

We realize that there are formidable barriers, but we are optimistic about the impact and potential achievements when our community is mobilized to act strategically in advocating for our vision and goals. We intend to monitor progress periodically and agree that our Guam strategic plan is a “living” document that may need to change as we go through the next five years. We will learn as we go.

Ultimately, Guam’s development rests upon the health and well-being of its people. We anticipate that this Guam Strategic Plan will empower P&T, GBHWC and its community partners to focus on pivotal issues, use resources judiciously, build on ongoing efforts, prevent overlap, learn from each other’s experiences and expand institutional and individual capacities to ensure a community that is free from substance misuse and suicide and empowered to promote mental health with the Guam Behavioral Health and Wellness Center taking the lead for this action plan. By doing so, a future of sustainable development for all of us in this island community can be assured.

NOT FINAL

REFERENCE:

CDC: Center for Disease Control

CLAS: Culturally and Linguistically Appropriate Services

CME: Chief Medical Examiner

ED: Emergency Departments

FDA: Food and Drug Administration

FOL: Focus on Life (Grant)

GBHWC: Guam Behavioral Health and Wellness Center

MOU: Memorandum of Understanding

NCD: Non-communicable Diseases

OMH: Office of Minority Services

P&T: Prevention and Training Branch

PEACE: Prevention Education and Community Empowerment

PFS: Partnership for Success (Grant)

SAMHSA: Substance Abuse and Mental Health Services Administration

SAPT: Substance Abuse Prevention and Treatment (Block Grant)

SEOW: Guam State Epidemiological Outcomes Workgroup

SPE: State Prevention Enhancement

SPF: Strategic Prevention Framework

WHO: World Health Organization

ZSF: Zero Suicide Framework

NOT FINAL

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

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/residential)	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:

i)	Prioritized services for veterans?	Yes / No
ii)	Adolescents?	Yes / No
iii)	Older Adults?	Yes / No

NOT FINAL

Criterion 2

NOT FINAL

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.

Our SUD outpatient programs are CARF Accredited since 2017. We currently have a robust PWWDC outpatient & residential services that is monitored often by the SUD Program supervisor to ensure all provisions of required supportive services are provided.

NOT FINAL

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, if applicable	○ 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, LGBTQI+, 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 seThe 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 ● Yes ○ No

NOT FINAL

HIV in areas that have the greatest need for such services and monitoring such service delivery?

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 SUPTRS BG 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 SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

NOT FINAL

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)** MOUD — (●) 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

NOT FINAL

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 including 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.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

1. Salvation Army Light House Recovery Center
2. TOHGE Corporation
3. Sanctuary Incorporated

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) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

NOT FINAL

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 opportunity 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) Performance-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

NOT FINAL

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.

If the answer is No to any of the above, please explain the reason.

NOT FINAL

Footnotes:

NOT FINAL

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 2022-FFY 2023? (●) Yes ( ) No

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

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Footnotes:

NOT FINAL

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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 and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their 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 how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, 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 with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] 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.*

[2] *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 guides 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 provide training on trauma-specific treatment and interventions for M/SUD providers?	● Yes	○ No
4.	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
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	● Yes	○ No
6.	Does the state use an evidence-based intervention to treat trauma?	● Yes	○ No

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

All staff of the state and sub-grantee (providers) SUD program are trained on trauma informed treatment. The Guam SSA provides Helping Women Recover and Helping Men Recover curriculum in the SUD treatment programs. Both curriculum are for individuals with an SUD and trauma.

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

NOT FINAL

Not at this time

Footnotes:

NOT FINAL

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

NOT FINAL

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

(●) Yes ( ) No

The collaboration with the SSA and all treatment court at the Judiciary of Guam has improved. The Drug & Alcohol program has been instrumental in the planning and implementation of the DWITC-Driving While Intoxicated Treatment Court, the Re-entry Court and the Guam Family Drug Court. The SSA is involved in the clinical staffing for all treatment courts mentioned above and for the Adult Drug Court and the Mental Health court. We also contract with the Judiciary of Guam to provide Peer Support

NOT FINAL

Services for the DWITC-Driving While Intoxicated Treatment Court, and Guam Family Drug Court.
The state is currently providing SUD treatment services in the Department of Corrections. Evidence based treatment models are provided; Matrix Model, Moral Reconnation Therapy, 12-step education & treatment.

3. 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

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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NOT FINAL

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

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 offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

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 the use of medications for substance use disorders? ○ Yes ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? ○ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

NOT FINAL

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs?

Yes No

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

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NOT FINAL

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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-intervention 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, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

The state currently implemented the 988 crisis services. The SUD program also contracts with the TOHGE Corporation to provide Peer Support in the in the community and a 24 hour warmline for individuals with and SUD to call and seek assistance with access to treatment, crisis services, warm hand off to treatment and recovery support services.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to go or to be	☐	☐	☐	☑	☐	☐

b. Briefly explain your stages of implementation selections here.

The program is implemented.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

The states crisis system is currently available. We have implemented the 988 since July 2022.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

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

None at this time.

NOT FINAL

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

None at this time.

Footnotes:

NOT FINAL

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining 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- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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, 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.

NOT FINAL

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)	Use 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.

Peer Support Specialists provide recovery coaching, transportation, and access to other recovery support services in our community.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Recovery is a person who has completed a treatment program and is in continued care services to maintain their sobriety. Recovery Support Services are services a person serviced is engaged in that supports or enhances their recovery from an SUD. Recovery Support Services is Peer Support services (Mentoring, Advocacy, education, wellness), Housing services, health care benefits & services, employment services, childcare, education services, and transportation are a few examples of Recovery Support services. TOHGE is also Guam's only Peer Ran Organization. The state contracts TOHGE to also provide peer support, transport, and other recovery support services.

5. Does the state have any activities that it would like to highlight?

Safe Ride Program: Driving home those who are too drunk to drive
24 Hour Peer Ran Warm line program (crisis and treatment services)
Warm Hand off services: to the local hospital, to treatment providers
Prevention & Education services provided in schools and the community by educated Peer Recovery Specialists

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

None at this time

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NOT FINAL

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:

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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NOT FINAL

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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.[1]. 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.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

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.[4].

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.[5].

According to data from the 2017 Report to Congress[6] 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).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]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.

[3]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.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]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**

[6] **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 of children and youth with SED? ○ Yes ○ No

b) The resilience of children and youth with SED? ○ Yes ○ No

c) The recovery of children and youth with SUD? ○ Yes ○ No

d) The 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) Health care? ○ Yes ○ No

c) Juvenile justice? ○ Yes ○ No

d) 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

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? ○ Yes ○ No

d) Does the state have an established FEP program? ○ Yes ○ No

Does the state have an established CHRP program? ○ Yes ○ No

e) Is the state providing trauma informed care? ○ Yes ○ No

NOT FINAL

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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Footnotes:

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Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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:

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

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

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Footnotes:

Aside from the SUPTRS stakeholders gathering in developing the State Plan on July 31, 2023 to August 2, 2023, GBHWC also presented the draft plan in these meetings and events:

1) SUPTRS coalition - September 18, 2023
2) PEACE Council - September 21, 2023
3) Annual Conference on SUDs among Pacific Islanders - September 27, 2023

In all these occasions, feedback were discussed among those present, and were incorporated into the final version of the State Plan submitted here. Details are included in the narratives for Steps 1 and 2.

NOT FINAL

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

The Guam Behavioral Health & Wellness Center (SSA) currently does not participate in any syringe program. We do not use SUPTR Block Funds for a Syringe Services Program (SSP).

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Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:

The Guam Behavioral Health & Wellness Center (SSA) currently does not participate in any syringe program. We do not use SUPTR Block Funds for a Syringe Services Program (SSP).

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