# American Samoa

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

## COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/15/2023 - Expires 06/30/2026
(generated on 09/10/2024 9.18.08 PM)

## Center for Mental Health Services
## Division of State and Community Systems Development

# State Information

## State Information

### Plan Year

Start Year 2024

End Year 2025

### State Unique Entity Identification

Unique Entity ID JWV8MLNBAGC9

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

Agency Name DEPARTMENT OF HEALTH

Organizational Unit BEHAVIORAL HEALTH SERVICES DIVISION

Mailing Address PO BOX 5666

City PAGO PAGO

Zip Code 96799

### II. Contact Person for the Grantee of the Block Grant

First Name MOTUSA TUILEAMA

Last Name NUA

Agency Name DEPARTMENT OF HEALTH

Mailing Address PO BOX 5666

City PAGO PAGO

Zip Code 96799

Telephone 684-633-4606

Fax

Email Address tuinua@doh.as

### III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

### IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

## V. Date Submitted

| | |
|---|---|
| Submission Date | 9/1/2023 11:47:45 PM |
| Revision Date | 7/3/2024 1:22:26 PM |

## VI. Contact Person Responsible for Application Submission


| | |
|---|---|
| First Name | TALALUPELELE |
| Last Name | FISO |
| Telephone | (684) 699-6380 |
| Fax | |
| Email Address | talalupelele.fiso@doh.as |


OMB No. 0930-0168 Approved: 06/15/2023 Expires: 06/30/2026

**Footnotes:**

FY2024 BSCA Plan uploaded in the Attachments tab.

11/14/2023: Revised FY 2024 BSCA Plan uploaded in Attachments tab

## American Samoa Government Department of Health
## Behavioral Health Services Division
## FY2024 BIPARTISAN SAFER COMMUNITIES ACT (BSCA) PLAN

The American Samoa Department of Health (ASDOH) through its Behavioral Health Services Division (BHSD) administers the Mental Health Block Grant for the territory and will also be administering the Bipartisan Safer Communities Act (BSCA) funding. The following plan details how BHSD proposes to utilize this funding in FY2024 to support mental health crisis emergency preparedness and response efforts targeting adult individuals with a Severe Mental Illness (SMI) and young individuals with a Serious Emotional Disturbance.

<u>BHSD proposes to utilize the BSCA funding of $11,346 to develop a Territorial Mental Health Crisis Emergency Preparedness Plan, which will include protocols and response procedures for a mental health crisis emergency.</u>

### TERRITORIAL MENTAL HEALTH CRISIS EMERGENCY PREPAREDNESS PLAN

The BSCA funding will allow BHSD to coordinate with key mental health stakeholders and service providers in the territory in the development of the first Mental Health Crisis Emergency Preparedness Plan for American Samoa. Key mental health stakeholders and crisis emergency response agencies in the territory are: American Samoa Medical Center Authority (public hospital), Department of Health, Department of Human and Social Services, Department of Public Safety, Emergency Medical Services, and non-profit behavioral/mental health service providers. Coordination activities will include meetings of stakeholders, training and guidance on the structuring and development of the emergency preparedness plan, and plans for sharing the plan with all mental health service providers in the territory.

American Samoa has a territorial disaster emergency response operational manual which involves governmental department and agencies and assigns responsibilities across the Emergency Support Functions (ESFs). Unfortunately, American Samoa does not have a similar plan in place for how to respond to mental health crisis emergencies. A few crisis response agencies have existing written Memorandum of Agreements documenting the procedures for crisis emergency response although many key mental health stakeholders operate on verbal agreements or operate individually in silos. As American Samoa continues to work on officially opening a certified 988 Lifeline crisis center for the territory, the development of a territorial mental health crisis emergency plan will help to formalize the already existing crisis response protocols and coordination between mental health service providers. It is also the intent of this plan to strengthen the collaboration of mental health crisis emergency response at the state (governmental) and community levels by involving behavioral/mental health non-profit organizations based in the community.

ASDOH as the SSA will provide oversight to this project or activity with the purpose of meeting the following goals:

- Improve coordination and collaboration across territory's mental health service providers.
- Establish Memorandum of Agreements to formally document coordination across mental health services providers when responding to a mental health crisis emergency
- Offer training/guidance to territory's mental health service providers on crisis emergency preparedness and planning.
- Develop and create the Territorial Mental Health Crisis Emergency Plan

Below is the proposed budget for the use of the FY 2024 BSCA funding allocated to American Samoa:

**BUDGET or UTILIZATION OF FUNDS**

| | |
|---|---|
| Total BSCA funding for American Samoa | **$11,346** |
| COSTS: | |
| Stakeholders Meetings | $10,000 |

- Venue costs
- Meeting supplies and materials
- Training supplies and materials

| | |
|---|---|
| Administrative/Oversight costs | $ 1,346 |

- Fuel to travel to meetings
- Printing costs for handouts and written materials

**American Samoa Government Department of Health**
**Behavioral Health Services Division**
**FY2024 BIPARTISAN SAFER COMMUNITIES ACT (BSCA) PLAN**

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|---|---|
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| COSTS: | |
| Stakeholders Meetings<br>• Venue costs<br>• Meeting supplies and materials<br>• Training supplies and materials | $10,000 |
| Early Serious Mental Illness (10%)<br>• Crisis Response Plan education/outreach materials for ESMI clients and family members<br>• Education outreach costs | $ 1,346 |

## 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
Community Mental Health Services 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 1911 | Formula Grants to States | 42 USC § 300x |
| Section 1912 | State Plan for Comprehensive Community Mental Health Services for Certain Individuals | 42 USC § 300x-1 |
| Section 1913 | Certain Agreements | 42 USC § 300x-2 |
| Section 1914 | State Mental Health Planning Council | 42 USC § 300x-3 |
| Section 1915 | Additional Provisions | 42 USC § 300x-4 |
| Section 1916 | Restrictions on Use of Payments | 42 USC § 300x-5 |
| Section 1917 | Application for Grant | 42 USC § 300x-6 |
| Section 1920 | Early Serious Mental Illness | 42 USC § 300x-9 |
| Section 1920 | Crisis Services | 42 USC § 300x-9 |
| **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 Costal 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 Clear 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 182by:

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 Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: MOTUSA TUILEAMA NUA

Signature of CEO or Designee[1]: ____________________

Title: DIRECTOR

Date Signed: ____________________

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 06/15/2023 Expires: 06/30/2026

**Footnotes:**

**OFFICE OF THE GOVERNOR**
**AMERICAN SAMOA GOVERNMENT**

Serial No.: 701 – 22

December 22, 2022

Miriam Delphin-Rittman
Assistant Secretary
Mental Health and Substance Use
Substance Abuse and Mental Health Administration 5600 Fishers Lane
Rockville, MD. 20857

Subject: Designation of Single State Authority for substance abuse and mental health

Dear Assistant Secretary Delphin-Rittman:

Effective January 1, 2023, I have designated the Department of Health (DOH) as the Single State Authority (SSA) for substance abuse and mental health prevention and treatment services for the Territory of American Samoa. The DOH assumes this role from the Department of Human and Social Services (DHSS) at the start of the second quarter of the fiscal year.

Moreover, effective January 1, 2023, I have designated DOH Director Motusa Tuileama Nua to serve as the Governor's Designee and Authorized Signature on federally mandated Certificates, Assurances, and Funding Agreements for SAMHSA Federal block and discretionary grant applications for American Samoa, as well as for all existing Federal programs related to DOH. I have entrusted members of my Cabinet with the responsibility for program and policy development, performance management, fiscal accountability, and compliance with Federal rules and regulations governing federal funds received to support the delivery of programs and services.

Notwithstanding, all new Federal programs must bear my signature to ensure proper alignment of program intent to the policies of y administration. Further, this delegation of authority is specific to the terms and conditions for the existing grants; however, if any of said terms and conditions are altered, these grant amendments will require my signature.

Sincerely,

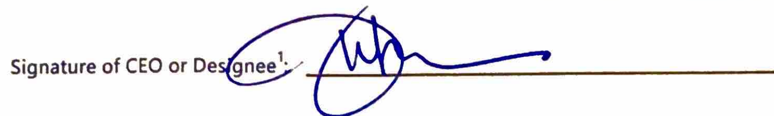
LEMANU P. S. MAUGA
Governor

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 Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: for MOTUSA TUILEAMA NUA

Signature of CEO or Designee[1]:



Title: DIRECTOR

Date Signed: 08/09/23

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

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

**Footnotes:**

## State Information

### Disclosure of Lobbying Activities

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

**Standard Form LLL (click here)**

Name

MOTUSA TUILEAMA NUA

Title

DIRECTOR

Organization

DEPARTMENT OF HEALTH

Signature: Date:

OMB No. 0930-0168 Approved: 06/15/2023 Expires: 06/30/2026

**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."

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**Footnotes:**

**Planning Step 1: Assess the strengths and organizational capacity of the service system to address the specific population(s).**

## Treatment and Prevention

The American Samoa M/SUD behavioral health system consists of three core government direct service providers: The American Samoa Department of Health (ASDOH), the American Samoa Medical Center Authority (ASMCA), and the Veterans Affairs (VA) Clinic. ASDOH and ASMCA are the two medical healthcare providers or facilities available to the public in the territory with ASMCA (also known as the Lyndon B. Johnson (LBJ) Tropical Medical Center) being the only hospital facility on the island. The VA Clinic offers medical and behavioral healthcare services to veterans and active service members.

### American Samoa Department of Health (ASDOH)

The American Samoa Department of Health (ASDOH), is the territory's Single State Agency for substance abuse and mental health prevention and treatment. ASDOH delivers community mental health services to both the adult and children population. As the SSA, ASDOH is the primary mental health treatment provider in the territory that is also recognized as the state mental health authority by law. ASDOH receives referrals from the court, ASMCA, employers, schools, government and non-government organizations, and the general public or community. ASDOH through partnership with PSMHTTC and other TA providers will commonly coordinate training opportunities for mental health treatment providers which is offered to mental health specialists and providers across the territory. Presently, all behavioral health service delivery under ASDOH is provided by the Behavioral Health Services Division (BHSD) and offered as an outpatient service only.

The BHSD workforce consists of one (1) Mental Health Physician (trained and licensed in Fiji as a Psychiatrist), one (1) Registered Nurse with Behavioral Health specialty, one (1) Clinical Services Manager with a EdD and a MAC, four (4) Masters-degree Program Managers, three (3) NAADAC licensed addictions professionals, three (3) mental health counselors, three (3) Substance Abuse Prevention Specialists, and six (6) Crisis Response Workers. BHSD utilizes technical assistance resources and support provided by PSATTC, PSMHTTC, ORN and other TA providers, to develop the behavioral health workforce skills, knowledge and application of SUD and MH treatment and prevention services.

BHSD's Treatment Services uses evidence-based SUD and MH treatment programs such as: CBT, Motivational Interviewing, Psychoeducation, SBIRT, and a combination of MET-CBT 12 and MATRIX. Prevention activities include community education and outreach programs, media campaigns, and EBP prevention programs such as SSF, RBST and Life Skills Training. ASDOH works in collaboration with ASMCA (hospital) and non-government organizations (NGOs) in case management, treatment planning, service coordination, and referral. ASDOH is the territory's sole public health agency delivering programs and services that promote, educate, protect, and address the public's health and wellness. ASDOH also oversees the territory's Community Health Centers (CHC) for over 20 years. ASDOH has extensive experience in the delivery of public health services and programs across the communities in American Samoa with a staff of physical healthcare physicians and nurses, public health program planners, and public health education and outreach specialists. BHSD collaborates with the ASDOH community health centers physicians and nurses to integrate behavioral health screening and referral for patients seen at their primary clinics. Moreover, BHSD's prevention program staff collaborate with the ASDOH public health education and outreach programs to incorporate substance abuse and mental health prevention in their outreach services.

### American Samoa Medical Center Authority (ASMCA)

ASMCA is a semi-autonomous facility and serves as the territory's only hospital. As such, they provide emergency medical care, intensive care, surgical procedures, inpatient admission for medical care, outpatient medical clinics, pharmacy, and the territory's only acute psychiatric inpatient care facility. Presently the ASMCA is utilizing the ASDOH psychiatrist/mental health physician to conduct psychiatric diagnostic assessments and respond to emergency psychiatric cases presented at the ER. ASMCA is currently working

on recruiting its own psychiatrist to avoid overworking and overwhelming the one and only psychiatrist staffed under ASDOH. Available data from ASMCA indicates an average of 150 individuals seen per month for psychiatric care (duplicated number). The ASMCA Psychiatric Clinic offers diagnostic assessments, medication-assisted treatment, care management, individual and family therapy and referral. The primary diagnoses of Serious Mental Illness (SMI) are schizophrenia and mood disorders, specifically bipolar disorder. The second most commonly treated diagnosis is co-occurring depression and substance use disorder.

Adults with a diagnosable SMI may be housed at the local behavioral health facility operated by the LBJ Medical Center, or the detention center operated by the Department of Public Safety. These individuals are routinely seen by professionals from both the SMHA and SSA and their cases are being addressed through case management meetings with all partners who have received permission in order to discuss the diagnosis, treatment plan and status of the individual or patient. Communication between the SMHA and SSA are done routinely to ensure that treatment services are provided and offered in a timely manner and wherever needed. Additionally, the SMHA and SSA continues to work collaboratively in conducting home visits and getting the services into the community should families or individuals have trouble accessing services at the facility site.

**Veterans Affairs Clinic and Outpatient Community Center**

The American Samoa VA Clinic and outpatient community center offers medical and behavioral health care to veterans and active service members. Support services are available for family members. The local VA clinic healthcare staff consists of two (2) physicians (US licensed MDs), one (1) psychologist, one (1) licensed clinical social worker, RNs, LPNs and support staff. The outpatient community center offers counseling services to veterans and active service members. Both ASDOH and ASMCA collaborate with the local VA clinic on treatment planning and case management for VA patients accessing healthcare services in the community health centers, community behavioral health or emergency medical care at the hospital. The VA clinic also contributes to territorial planning for mental health and substance use disorder treatment and prevention programs.

**Non-Governmental Organizations (NGOs)**

There are a few NGOs in the territory that provide behavioral health treatment, prevention and recovery services. The ***Christopher James Foeoletini Ledoux Foundation (The Foeoletini Foundation)*** is a 501(c)(3) nonprofit organization founded to provide recovery and response assistance for individuals and families affected by suicide crisis and SUD, specifically, the Crystal Methamphetamine (Ice) epidemic in American Samoa. The Foeoletini Foundation provides essential services to target communities of uninsured patients regardless of economic status. Other initiatives include:

- Telehealth services
- Temporary recovery houses
- Placement referrals for convicted SUD criminals
- Outreach
- Educational resources for families and communities
- Peer-to-peer support groups for individuals experiencing mental health challenges and their families

The ***Empowering Pacific Island Communities (EPIC)*** is a community-based NGO that offers a variety of programs to empower, mobilize and build capacity across the community. Through EPICS's youth support services program, it delivers counseling services for children and adolescents experiencing mental health crises and trauma. Additionally, EPIC makes referrals to other behavioral healthcare agencies for treatment and prevention.

***Catholic Social Services (CSS)*** offers a range of advocacy and social support programs for individuals in the community. CSS also makes referrals to ASDOH and other NGO behavioral health treatment providers and participates in interagency case management meetings.

## Recovery

The AS recovery support system has developed in the last few years with both government and NGO service providers collaborating in the delivery of peer support services for individuals with a SMI, SED, SUD or experiencing crisis. Through the Transformation Transfer Initiative (TTI) funding opportunity from NASMHPD, ASDOH has received several TA resources and opportunities for training for peer support service providers with a focus on crisis response and trauma in the community. ASDOH has initiated partnerships with NGOs and other partners such as the Department of Public Safety, Department of Education, and Emergency Medical Services (EMS) to provide training and planning sessions on the territorial crisis response strategic plan as well as implementation of Trauma Informed Care across behavioral health and crisis response services as well as in the community. Several community members have also expressed interest in developing SUD recovery and peer support services in collaboration with ASDOH and other peer support services in the community such as the Foeoletini Foundation. This will be the first SUD peer support community-based program to be developed and made available at the village level.

Ongoing collaborative efforts focused on recovery include case management, discharge planning, uniform referral planning, and training of recovery support providers. The local Case Review Committee or CRC (a sub-committee under the American Samoa Behavioral Health Planning and Advisory Council) meets regularly to review cases of individuals under the custody of the state to discuss their progress and any remaining or unmet behavioral health needs before a recommendation is made to the court for discharge from the ASMCA psychiatric inpatient care unit or behavioral health facility. The CRC is comprised of representatives from key agencies who play a vital role in the prevention, treatment and recovery efforts for individuals with a mental illness. These agencies are ASDOH, ASMCA, Office for the Protection and Advocacy for the Disabled (OPAD) Attorney General's Office, and the Office of the Public Defender. Follow-up visits, case management, and medication management are conducted by the SSA and other various service providers. The collaborations also extend to other non-profit agencies and peer advocates.

## Partners and Collaboration

*Department of Human and Social Services (DHSS)* DHSS is the government agency in American Samoa responsible for social services programs that include: Child Care Centers Administration, Child Welfare and Sheltering, Domestic Violence Advocacy and Women's Shelter, Family Support Services and Advocacy, Food Stamp Program, and WIC. DHSS is a major referral source for substance abuse and mental health treatment and prevention services. Individuals (adults and children) who are taken into the custody of the state are under the care and oversight of DHSS and are often referred to behavioral health treatment services.

Other partnering agencies who collaborate with ASDOH BHSD for mental health and/or substance abuse prevention activities and training opportunities are the *Department of Education, Department of Public Safety, 988 Crisis Response System, community coalitions, faith-based community and NGOs*. To address the needs of diverse populations and health disparities across the community, the SSA (ASDOH BHSD) uses these partnerships to coordinate community-based outreach activities to raise awareness about behavioral health and how the community can access services. Technical assistance or training opportunities coordinated by the SSA will continue to be available to service providers across the territory's behavioral health service delivery system in order to strengthen the capacity of the behavioral health workforce to adequately address the mental health needs of individuals.

The American Samoa Behavioral Health Advisory and Planning Council along with the Governor's Comprehensive Substance Abuse Council continue to provide support and guidance with regard to behavioral health treatment, prevention, and recovery efforts in the territory.

## 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.

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**Footnotes:**

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

In comparison to other territories (2.1 per 1000), only 1.3 out of every 1,000 individuals in American Samoa are receiving mental health services through the SSA (URS, 2016). Of note, the data that is captured through URS tables does not currently include data from other mental health care direct services providers such as the local hospital (ASMCA) and the VA clinic. The SSA URS reported data suggests that AS has a higher proportion of individuals with a diagnosable SMI serviced through the SSA when compared to the national average (90% in AS versus 71.4% nationally); however, mental health treatment services and facilities are limited to one government agency, the local hospital, and two NGOs. Furthermore, there is only one inpatient psychiatric facility housed at the local hospital and is an acute care facility with 12 beds. For an individual who is in need of long-term residential care for mental health or substance use disorder symptoms, it is not an option. For individuals with a SMI who are civilly committed, there is a residential transitional housing facility under the oversight of ASDOH, which is intended to help these individuals prepare to reenter the community and return home. However, due to their SMI diagnoses and symptoms, the likelihood of these individuals reentering the community in a reasonable time period is unlikely and all of the residents housed there have been there for the last three years when the facility was first opened.

Additionally, there has been a significant decrease in individuals with a diagnosable SMI who currently maintain stable employment decreased by approximately 10% from FY2015 to FY2016. While the national average is approximately 50%, only 14.8% of individuals with an SMI reported maintaining stable employment in 2016 (URS). In the 2018 American Samoa Hybrid Survey (collaboration between ASDOH and the previous SSA, DHSS, 1005 adults were asked a variety of questions around mental health and substance abuse. Of the 1005 adults surveyed, 36% reported experiencing trauma, 15% reported adverse childhood experiences, while less than 8% reported experiencing depression and/or anxiety symptoms. In regards to substance abuse, 26% reported consumption of alcohol in the past 30 days and less than 5% reported using prescription pain medication illegally; however, more than 70% reported agreeing with the perception of risk and harm resulting from substance use specifically 89% perceiving risk and harm with stimulant use/abuse. Despite the perception of substance use as harmful and risky, the territory is seeing an incline in cases of stimulant use from the criminal justice system as well as anecdotal reports across the community and schools.

Effective and useful data collection continues to be an area of concern. There is a lack of or nonexistent mental health and substance use disorder screening integrated into primary care clinics across the community health centers as well as at the local hospital's Emergency Room and outpatient clinics, despite training provided to local healthcare providers on the effectiveness of screening as well as evidence-based screening tools.

The integration of behavioral health care and primary care is currently not a standard of care across the territory's healthcare delivery system. The most evident barriers to implementing integrated care are a lack of knowledge of healthcare integration practices, poor communication and coordination, a severe shortage of healthcare providers, and cultural inclusiveness. Access

to care is a constant concern due to low motivation, stigma, and fear, not to mention the extremely remote residential areas on the island. The SSA's community-based BH services and the CHC Psychiatrist have minimal coordination of care for individuals referred from CHC Psychiatry to the community-based BH sites. Consequently, individuals served at the community-based BH programs are not screened for physical health conditions nor are they properly referred to the CHC when needed. At the PC, behavioral health screening is nonexistent despite it being discussed as part of patient triage. There is a lack of data and no proper tracking for referrals between the CHC Psychiatrist and PC. Anecdotally, the number of referrals from the PC to the CHC Psychiatrist is below ten (10). Currently, of the 34 general physicians staffing all seven (7) CHCs, there is only one (1) Psychiatrist and insufficient behavioral health personnel integrated into the CHC PC.

Stimulant use or misuse is on the rise on the island. Common attitudes of denial and the stigmatization of individuals with a substance use disorder makes it difficult for these individuals to seek treatment or be successful in treatment or recovery. Although there are weekly news reports of drug-related criminal activity and arrests involving stimulant use, there are also many unreported or unknown cases across the island. Local residents share their experiences on social media of homes burglarized by teenagers seeking ways to pay for drugs, drug sales out of abandoned buildings, children neglected by parents who are selling and using stimulants, and regular homes disguised as fronts for local drug schemes and operations. In an unpublished survey conducted by the American Samoa Drug Control Office in 2020, a total of 320 respondents between the ages of 13-19 were asked about their awareness and understanding of the drug problem in the territory. Of the total surveyed, 71% reported knowing at least one teenager in the community, school, or village that uses drugs; and 65% reported knowing at least one adult in the community/school/village that uses drugs. In this same survey, 52% reported that drugs are easily available on the island and about 16% reported that methamphetamine ("ice") is the preferred drug of choice.

**STEP 2**

**UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM**

In comparison to other territories (2.1 per 1000), only 1.3 out of every 1,000 individuals in American Samoa are receiving mental health services through the SSA (URS, 2016). Of note, the data that is captured through URS tables does not currently include data from other mental health care direct services providers such as the local hospital (ASMCA) and the VA clinic. The SSA URS reported data suggests that AS has a higher proportion of individuals with a diagnosable SMI serviced through the SSA when compared to the national average (90% in AS versus 71.4% nationally); however, mental health treatment services and facilities are limited to one government agency, the local hospital, and two NGOs. Furthermore, there is only one inpatient psychiatric facility housed at the local hospital and is an acute care facility with 12 beds. For an individual who is in need of long-term residential care for mental health or substance use disorder symptoms, it is not an option. For individuals with a SMI who are civilly committed, there is a residential transitional housing facility under the oversight of ASDOH, which is intended to help these individuals prepare to reenter the community and return home. However, due to their SMI diagnoses and symptoms, the likelihood of these individuals reentering the community in a reasonable time period is unlikely and all of the residents housed there have been there for the last three years when the facility was first opened.

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integrated care are a lack of knowledge of healthcare integration practices, poor communication and coordination, a severe shortage of healthcare providers, and cultural inclusiveness. Access to care is a constant concern due to low motivation, stigma, and fear, not to mention the extremely remote residential areas on the island. The SSA's community-based BH services and the CHC Psychiatrist have minimal coordination of care for individuals referred from CHC Psychiatry to the community-based BH sites. Consequently, individuals served at the community-based BH programs are not screened for physical health conditions nor are they properly referred to the CHC when needed. At the PC, behavioral health screening is nonexistent despite it being discussed as part of patient triage. There is a lack of data and no proper tracking for referrals between the CHC Psychiatrist and PC. Anecdotally, the number of referrals from the PC to the CHC Psychiatrist is below ten (10). Currently, of the 34 general physicians staffing all seven (7) CHCs, there is only one (1) Psychiatrist and insufficient behavioral health personnel integrated into the CHC PC.

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**ADDRESSING UNMET NEEDS**

DOH BHS will address unmet needs noted through the following goals and objectives:

(1) Increase access to mental health screening and assessment.
   a. Utilize the current behavioral health community sites for conducting mental health screening and assessment. The behavioral health community sites are located in easy to access residential areas where individuals in need of mental health screening and assessment can access easily.
   b. Continue coordination with the community health centers located in each district of the island for space and schedule where mental health counselor(s) can rotate through to be available for mental health screening and assessment for individuals seen at the CHCs outpatient clinics (mainly the primary clinic).

c. Continue collaboration with the main CHC in the village of Tafuna for an after hour behavioral health clinic that will allow access to mental health services after hours to cater to working individuals or families.

(2) Increase opportunities for supportive employment for individuals with a SMI

a. Network with local employment services and agencies to seek available opportunities for employment of an individual with a SMI in recovery
b. Provide training and support to current clients or individuals with a SMI/SED in recovery on employment seeking strategies and activities

(3) Increased integration of behavioral health and physical health care at the territorial CHCs.

a. Coordinate with the DOH Psychiatrist and behavioral health providers located at the Tafuna Community Health Center to develop mental health screening and assessment in the primary clinic.
b. Coordinate with the DOH Psychiatrist on opportunities to conduct training for primary care physicians and nurses on evidence based mental health screening and referral to improve integrated services.
c. Provide support to the DOH Psychiatrist and behavioral health providers located at the CHCs on other training opportunities to improve integrated services between behavioral health and primary care – training topics will include: improved communication and coordination practices, anti-stigma practices and standards and SBIRT.

## Planning Tables

### Table 1 Priority Areas and Annual Performance Indicators

**Priority #:** 1

**Priority Area:** Increase Access to Mental Health Treatment

**Priority Type:** MHS

**Population(s):** SMI, SED

**Goal of the priority area:**

To increase access to mental health treatment for individuals with SMI and/or SED to treatment by increasing the capacity of mental health and peer support counselors to deliver evidence-based treatment approaches that are culturally relevant and effective in rural communities.

**Strategies to attain the goal:**

Identify evidence-based treatment approaches that are culturally relevant to address mental health needs

Identify a specialized-content trainer or consultant to provide training to SSA behavioral counselors as well as mental health treatment service providers or partner agencies.

Identify behavioral health agencies providing mental health treatment and coordinate partnerships for training of the workforce in evidence based mental health treatment approaches.

Collaborate with community-based peer support service providers to offer training of evidence based mental health treatment approaches to increase access to treatment in the community.

#### Annual Performance Indicators to measure goal success

**Indicator #:** 1

**Indicator:** Number of individuals with SMI/SED accessing mental health treatment through SSA and in the community

**Baseline Measurement:** 50

**First-year target/outcome measurement:** 50

**Second-year target/outcome measurement:** 60

**Data Source:**

SSA mental health treatment client data

Community mental health service providers client data

Court referrals for individuals with a SMI, SED or ESMI

**Description of Data:**

Number of individuals with a SMI, SED or ESMI receiving or referred for mental health treatment

**Data issues/caveats that affect outcome measures:**

**Priority #:** 2

**Priority Area:** Trauma Informed Care

**Priority Type:** MHS, ESMI, BHCS

**Population(s):** SMI, SED, ESMI

**Goal of the priority area:**

To reduce trauma experiences affecting the mental health and wellness of individuals with a SMI and/or SED, or early signs/episodes of a SMI or SED by implementing Trauma Informed Care across the behavioral health delivery system as well as the community.

**Strategies to attain the goal:**

Identify a trainer/consultant who can provide training in Trauma Informed Care for territorial behavioral health workforce and community service providers.

Develop public messaging fand information materials on Trauma Informed Care to be both advertised and disseminated across the general public in the territory

Coordinate and collaborate with community NGOs to delivery community outreach focused on Trauma Informed Care

### Annual Performance Indicators to measure goal success

**Indicator #:** 1

**Indicator:** Number of behavioral health workforce and services implementing Trauma Informed Care

**Baseline Measurement:** 25

**First-year target/outcome measurement:** 25

**Second-year target/outcome measurement:** 30

**Data Source:**

SSA
Behavioral Health NGO Service Providers
Media Outlets

**Description of Data:**

Number of behavioral health staff trained in Trauma Informed Care
Number of governmental and NGO service providers trained in Trauma Informed Care
Number of media outlets advertising Trauma Informed Care messages
Number of individuals accessing media outlets or considered the "audience" of the media outlets advertising Trauma Informed Care messages

**Data issues/caveats that affect outcome measures:**

**Priority #:** 3

**Priority Area:** Suicide Prevention

**Priority Type:** SUP, MHS, ESMI, BHCS

**Population(s):** SMI, SED, ESMI, BHCS

**Goal of the priority area:**

To reduce suicidal ideation and triggers for suicide by increasing awareness and education around suicide risk and protective factors and resources to access for suicide prevention and crisis response.

**Strategies to attain the goal:**

Identify and select evidence-based community outreach and public messaging activities focused on suicide prevention

Collaborate with crisis response service providers in the territory to coordinate community-based suicide prevention outreach presentations and resources to access crisis response and support services

Develop effective public messaging about suicide prevention that is culturally appropriate and relevant

### Annual Performance Indicators to measure goal success

| | |
|---|---|
| **Indicator #:** | 1 |
| **Indicator:** | Number of Individuals attending Suicide Prevention Outreach Presentations |
| **Baseline Measurement:** | 200 |
| **First-year target/outcome measurement:** | 200 |
| **Second-year target/outcome measurement:** | 250 |

**Data Source:**

Sign-in sheets from community outreach presentations
Attendance count of individuals who attend community outreach presentations

**Description of Data:**

Sign-sheets collect basic demographic information and no personal identifying information (such as name)
Attendance count is a literal count of individuals in attendance at community outreach presentations

**Data issues/caveats that affect outcome measures:**

OMB No. 0930-0168 Approved: 06/15/2023 Expires: 06/30/2026

**Footnotes:**

## Planning Tables

### Table 2 State Agency Planned Expenditures

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2025

| 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) | J. ARP Funds (MHBG)[b] | K. BSCA Funds (MHBG)[c] |
| 1. Substance Use Prevention and Treatment | | | | | | | | | | | |
| a. Pregnant Women and Women with Dependent Children | | | | | | | | | | | |
| b. Recovery Support Services | | | | | | | | | | | |
| c. All Other | | | | | | | | | | | |
| 2. Primary Prevention | | | | | | | | | | | |
| a. Substance Use Primary Prevention | | | | | | | | | | | |
| b. Mental Health Prevention[d] | | $55,000.00 | | | | | | $10,000.00 | | $10,000.00 | |
| 3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e] | | $35,678.00 | | | | | | | | $28,505.00 | $1,135.00 |
| 4. Other Psychiatric Inpatient Care | | | | | | | | | | | |
| 5. Tuberculosis Services | | | | | | | | | | | |
| 6. Early Intervention Services for HIV | | | | | | | | | | | |
| 7. State Hospital | | | | | | | | | | | |
| 8. Other 24-Hour Care | | $30,000.00 | | | | | | | | | |
| 9. Ambulatory/Community Non-24 Hour Care | | $200,422.00 | | | | | | $144,278.00 | | $213,950.00 | $9,644.00 |
| 10. Crisis Services (5 percent set-aside)[f] | | $17,840.00 | | | | | | | | $14,025.00 | |
| 11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g] | | $17,840.00 | | | | | | $8,120.00 | | $14,025.00 | $567.00 |
| **12. Total** | **$0.00** | **$356,780.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$162,398.00** | **$0.00** | **$280,505.00** | **$11,346.00** |

[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. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, 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. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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**Footnotes:**

## Planning Tables

### Table 6 Non-Direct Services/System Development

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: 10/01/2023 MHBG Planning Period End Date: 09/30/2025

| Activity | FY 2024 Block Grant | FY 2024[1] COVID Funds | FY 2024[2] ARP Funds | FY 2024[3] BSCA Funds | FY 2025 Block Grant | FY 2025[1] COVID Funds | FY 2025[2] ARP Funds | FY 2025[3] BSCA Funds |
|---|---|---|---|---|---|---|---|---|
| 1. Information Systems | | | | | | | | |
| 2. Infrastructure Support | | | $10,000.00 | | | | | |
| 3. Partnerships, community outreach, and needs assessment | $5,000.00 | | $10,000.00 | $2,500.00 | $5,000.00 | | $10,000.00 | $2,500.00 |
| 4. Planning Council Activities (MHBG required, SUPTRS BG optional) | $2,500.00 | | | | $2,500.00 | | | |
| 5. Quality Assurance and Improvement | | | | | | | | |
| 6. Research and Evaluation | | | | | | | | |
| 7. Training and Education | $8,000.00 | | $20,000.00 | $2,500.00 | $8,000.00 | | $20,000.00 | $2,500.00 |
| **8. Total** | **$15,500.00** | **$0.00** | **$40,000.00** | **$5,000.00** | **$15,500.00** | **$0.00** | **$30,000.00** | **$5,000.00** |

[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. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. Note: If your state has an approved no cost extension, 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 "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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**Footnotes:**

There are no updates for Table 6

## 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

To improve access to care for mental disorders, substance use disorders, and co-occurring disorders, the SSA established two community-based behavioral health sites on each end of the island available to the general public. In each of these community-based behavioral health sites, the SSA offers behavioral health screening, assessment and treatment, and recovery support for individuals experiencing symptoms of a mental disorder, substance use disorder, and/or a co-occurring disorder. One site in particular has a dedicated space for day treatment for individuals with a Severe Mental Illness where a variety of activities and education are conducted to improve symptoms and daily functioning. The community sites were made possible through the MHBG COVID funding to increase the availability and accessibility of treatment sites and to also provide a community-based setting to reduce stigma, fear, and apprehension to attend treatment.

In addition to establishing the community-based behavioral health sites, the SSA continues its partnership with NGO behavioral health providers based in the community to develop peer-support services in the community to encourage individuals experiencing mental disorder/SUD symptoms or crisis to connect with a peer support counselor to help them access services.

**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.

At this time the SSA and the Medicaid office in American Samoa have not had discussions regarding parity enforcement. As reported in past MHBG plans, there is no Medicaid funding coming into state mental health treatment and prevention services because behavioral health is not a specified area of focus or need in the American Samoa Medicaid State Plan. Efforts through a collaboration of the SSA, other state behavioral health partners and NGOs to submit a proposal to the Medicaid local office with recommendations of revisions to the state plan to include behavioral health treatment and prevention services.

**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

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

As of late January 2023, the SSA designation was transferred to the American Samoa Department of Health (ASDOH) and all SAMHSA grant programs and services were relocated to ASDOH. Since this consolidation of behavioral health services under ASDOH, the SSA has placed emphasis emphasized the integration of behavioral health care through primary care providers. ASDOH oversees the community health centers (CHCs) for the territory. Space has been designated at the main CHC (with the most traffic of patients) for behavioral health staff to conduct assessment and treatment for individuals referred from the primary care clinic for behavioral health needs. Currently, there is a mental health physician and behavioral health nurses located in this office space to receive referrals from the primary care clinic.

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

As the SSA, the ASDOH Behavioral Health Services Division has provided training on screening tools for mental disorders and substance use disorders for CHC physicians and nurses. Of the seven CHCs in the territory, to date, one CHC has begun to implement behavioral health screening in their primary care clinic. Additional and continued training is needed for medical personnel and support staff at the primary care clinics in screening, We plan to eventually incorporate the SBIRT model at the primary care clinics to strengthen the integration and collaboration between behavioral health care and primary care providers. This effort will require training in SBIRT and additional behavioral health staff who can be bi-located across behavioral health and primary care.

c) Efforts to integrate primary care into behavioral health settings
This is an area that the SSA will need technical assistance and resources to help guide and support the integration of primary care into behavioral health settings. Due to the challenge of limited medical personnel presently on the island, it is difficult to implement this integration at this time. However, the SSA is exploring recruiting physicians with a background in mental health or behavioral health, or nurses with behavioral health training who can conduct a rotation through behavioral health settings to integrate physical health screens and examinations for individuals receiving treatment services at behavioral health settings across the community.

**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

Presently the SSA and a few other stakeholders such as: PAMI, American Samoa Medical Center Authority, and office of Legal Affairs, meet once/month to discuss civil commitment cases and the adult individuals with a SMI who are civilly committed and

housed at a transitional residential facility. This is a high-level of care coordination that although is driven by the legal status of each individual's court case, there is care coordination that takes place between the medical care providers from the hospital and the behavioral health clinical team from the SSA or ASDOH.

Care coordination at all levels and for individuals with SUD and children/youth with SED happens at all a smaller scale and is not consistent with the collaboration found with the civil commitment cases. Care coordination and clinical case management is needed for adults with a SUD and children/youth with a SED. The SSA will make a recommendation to the AS Behavioral Health Advisory Council to assist in the development of a care coordination model that consists of providing adequate care planning and coordination for all individuals at all levels.

**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.

This is an area that the SSA will need technical assistance and resources to help guide and support the integration of primary care into behavioral health settings. Due to the challenge of limited medical personnel presently on the island, it is difficult to implement this integration at this time. However, the SSA is exploring recruiting physicians with a background in mental health or behavioral health, or nurses with behavioral health training who can conduct a rotation through behavioral health settings to integrate physical health screens and examinations for individuals receiving treatment services at behavioral health settings across the community.

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

TA that supports: (1) SBIRT or integrated screening process that will collect data we need but also ensure patient or client receives brief education/treatment and referral to treatment after they have been screened at the primary care settings or CHCs; (2) TA to support the BHPAC on effective ways to leverage resources and how to build and sustain a COC in the current service delivery system, (3) Strategic planning or curriculum building for integrated services/COC.

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**Footnotes:**

## 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?

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 SSA has a lot of work to do in developing data driven plans and workforce training plans targeting and addressing health disparities in the territory. Despite not have these plans in place, the SSA regularly reviews and monitors client level data collected to identify health disparities and discuss how treatment service providers can better reduce these disparities. For example, for individuals enrolled in M/SUD treatment who are challenges with accessing services due to geographic and economic disparities, the SSA provides transportation support either through use of program vehicles to pick up clients or coordinating client pick up with available public and private transport that are also ADA approved. For clients who live in remote areas of the main island or live on the outerlaying island areas, the SSA will conduct home visits and take medication to the client's home where a nurse is present to administer medication when needed or required.

Please indicate areas of technical assistance needed related to this section

Technical assistance is needed to:

- develop data-driven plans to address and reduce health disparities
- develop and implement workforce training plan to build capacity of M/SUD providers to identify disparities in access, services received and outcomes , and, ensure culturally and linguistic competency is incorporated

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**Footnotes:**

## 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**

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**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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**Footnotes:**

## Environmental Factors and Plan

### 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

**Please respond to the following items:**

**1.** Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

| Model(s)/EBP(s) for ESMI/FEP | Number of programs |
|---|---|
| Family Psychoeducation | 1 |
| Social Skills Training | 1 |
| CBT and Motivational Interviewing | 1 |
| | |
| | |
| | |

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

| FY2024 | FY2025 |
|---|---|
| 18003 | 18003 |

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

   Presently, ESMI/FEP services are being billed to Medicaid. As reported in past MHBG plans, there is no Medicaid funding coming into state mental health treatment and prevention services because behavioral health is not a specified area of focus or need in the American Samoa Medicaid State Plan. Efforts through a collaboration of the SSA, other state behavioral health partners and NGOs to submit a proposal to the Medicaid local office with recommendations of revisions to the state plan to include behavioral health treatment and prevention services.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

   SSA funds the following EBPs to address FEP or address early serious mental illness symptoms: Cognitive Behavioral Therapy and Motivational Interviewing Program, Family Psychoeducation, Case Management and Social Skills Training (Weekly Check In Group).

5. Does the state monitor fidelity of the chosen EBP(s)?

   ○ Yes ● No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

   ● Yes ○ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

   Treatment and education programs are now available at three sites with 2 of the 3 sites community-based and located at opposite ends of the island to accommodate individuals from more remote villages or areas on the island. Ongoing case management with other behavioral healthcare partners and advocates helps to improve client outcomes through a coordinated effort to assess treatment plan to ensure it is appropriate for the individual and meets their needs as well as identifying resources to make referrals of an individual with ESMI/FEP to ensure that different levels of care are available and provided accordingly.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

   For FY 2024-2025, the SSA will be collaborating with primary healthcare providers to develop and implement the integration of behavioral health in primary care clinics across the seven community health centers in the territory to both increase access to behavioral health care services as well as improve identification of ESMI/FEP and make appropriate referrals and treatment planning to improve outcomes for individuals with a ESMI/FEP.

   SSA also plans to collaborate with NGOs to develop community-based peer support services as well as telehealth treatment options to expand available treatment options for individuals with an ESMI/FEP and ensures appropriate referrals for key services are made.

   In addition, to these program plans, the SSA intends to coordinate training in CBT. MI and Trauma Informed Care for behavioral health care providers especially in the schools and community, to increase the capacity for conducting interventions that will increase the individual's awareness of ESMI/FEP symptoms and motivation to seek treatment and support services.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

   (1) Schizophrenia; (2) Bipolar I and II Disorder; (3) Major Depressive Disorder; (4) PTSD; (5) Schizoaffective Disorder

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

    This data for the territory as a whole is not available at this time; however, based on SSA treatment and referrals data as well as anecdotal reports and observations, the incidence of individuals with a FEP in the territory is increasing from past years from less than 2% to now 5% of the SSA's total count of individuals referred for mental health treatment. This number however could possibly be higher in the community.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

    The state will continue to provide outreach through media campaigns (e.g. TV and Radio Programming) and outreach programs to high schools and church youth groups.

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

    TA on the ACT evidence based program/model to assist individuals with a ESMI/FEP.

**Footnotes:**

# Environmental Factors and Plan

## 5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

**1.** Does your state have policies related to person centered planning? ○ Yes ◉ No

**2.** If no, describe any action steps planned by the state in developing PCP initiatives in the future.

Although there are no state policies related to person-centered planning in place at this time, the SSA provides programs and services that promote person-centered planning in treatment services. Regular clinical supervision and staff in-service monitors and ensures the engagement of clients in their treatment planning. Furthermore, counselors are trained in various treatment approaches that recognize the client's strengths and motivation to change.

To develop PCP initiatives, the SSA plans to work with key behavioral healthcare stakeholders and the American Samoa Behavioral Health Advisory Council to draft policies related to person-centered planning. The advisory council consists of consumers and peer support specialists who can also speak to and advocate for person-centered planning and be the voice for consumers.

The SSA will also utilize existing and planned partnerships with peer support service providers to develop peer support workforce development including certification of peer support workers to further strengthen, enforce, and ensure the implementation of person-centered policies across the service delivery system.

**3.** Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The SSA engages its consumers mainly through its regular home visits to consumers and their caregivers to follow up on the status of their treatment plan, which includes medication management and plans for ongoing care of the individual. Healthcare decisions can be challenging and complex for some families with an individual who has or is at risk of a SMI or SED. It is essential for SSA treatment providers to engage and collaborate with consumers and their caregivers to determine critical healthcare needs of the client and make necessary referrals while assisting the consumer and their family members in making decisions that will improve the client's overall health. During weekly psychoeducation and counseling groups, clients are provided information and resources to assist with their behavioral and physical healthcare needs and decisions.

Individuals with a SMI or SED are visited weekly by a RN or LPN to assess healthcare needs and administer medication if needed. During these visits, the nursing staff also provides education on managing and reducing symptoms and assists the consumers and their caregivers on developing a response plan to emergency healthcare needs should they arise.

**4.** Describe the person-centered planning process in your state.

As of this submission, PCP is not a formalized process. Informal processes however include the use of memorandums of understanding (MOUs) between the SSA and key behavioral health stakeholders and healthcare personnel. These MOUs will detail what services each agency is responsible for in support of the consumer and his/her care plan. The MOUs also detail the process by which contact is made with the consumer, how visits or sessions/encounters are conducted for the consumer, and lastly, how the data or reporting of the outcome of these encounters is shared. Other processes that are occurring and in need of formal documentation are: those described previously (see question 2), such as: the involvement of consumers and their families in discharge planning meetings when discharged from the state hospital as well as during the community case management team meetings. Advocates are also invited to be a part of these meetings in order to ensure that service providers are being held

accountable. The involvement of consumers and their families in discharge planning meetings when discharged from the state hospital as well as during the community case management team meetings. Advocates are also invited to be a part of these meetings in order to ensure that service providers are being held accountable.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

   The SSA is requesting technical assistance regarding developing the Psychiatric Advance Directives as it is not known publicly and SSA treatment providers and healthcare personnel will need to receive training.

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

   The SSA is requesting technical assistance regarding developing the Psychiatric Advance Directives as it is not known publicly and SSA treatment providers and healthcare personnel will need to receive training.

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**Footnotes:**

# 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?

The SSA is the sole service provider. Aside from Medicaid and Medicare, there are no other insurance providers. Therefore, there has been no need for specific policies regarding these resources.

Please indicate areas of technical assistance needed related to this section

TA is requested in order to explore how to introduce and implement specific policies and procedures regarding program requirement conveyance.

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**Footnotes:**

# Environmental Factors and Plan

## 7. Tribes - Requested

Narrative Question

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

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

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

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

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

### Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

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

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

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**Footnotes:**

## Environmental Factors and Plan

### 9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

**Please respond to the following items**

### Criterion 1

**1.** Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

There are several available services and resources in the territory to support individuals with a mental illness, including those with co-occurring mental and substance use disorders.

Treatment services available include: the SSA's Community Mental Health program which offers mental health screening, assessment, treatment, prevention/education and recovery support services; the Veterans Affairs Outpatient Community Center offers treatment for mental disorders, substance use disorders, and co-occurring disorders for the military veteran population; the community-based NGO, Foeoletini Foundation offers peer support services and telehealth treatment services for individuals experiencing a mental health crisis and/or substance use disorder; and the NGO EPIC offers counseling services for at-risk youth and adolescents experiencing trauma and/or crisis.

Other available resources are coordinated through collaboration and partnership with recovery and peer support services based in the community. Partnering with these services has allowed for increased training opportunities and capacity building in mental health and substance abuse screening and referrals. Partnering agencies share resources openly through coordinated training and public messaging on general media outlets as well as social media platforms to ensure that individuals with a mental illness can access this information easily. Peer support and advocacy services based in the community are made available through NGOs and they offer services such as crisis counseling and warm lines.

Community outreach activities help to educate the general public, consumers and caregivers of resources to help manage mental illness and substance use disorder. Ongoing education and training services coordinated through the SSA and key stakeholders increase the capacity of treatment service providers and peer support services to effectively engage individuals with a mental illness to offer treatment as well as recovery support.

**2.** Does your state coordinate the following services under comprehensive community-based mental health service systems?

| | | Yes | No |
|---|---|---|---|
| **a)** | Physical Health | ◉ | ○ |
| **b)** | Mental Health | ◉ | ○ |
| **c)** | Rehabilitation services | ○ | ◉ |
| **d)** | Employment services | ◉ | ○ |
| **e)** | Housing services | ◉ | ○ |
| **f)** | Educational Services | ◉ | ○ |
| **g)** | Substance misuse prevention and SUD treatment services | ◉ | ○ |
| **h)** | Medical and dental services | ◉ | ○ |
| **i)** | Support services | ◉ | ○ |
| **j)** | Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA) | ◉ | ○ |
| **k)** | Services for persons with co-occuring M/SUDs | ◉ | ○ |

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

MH/SUD screening and assessment, referrals, evidence-based treatment, community outreach, service needs, concerns

**3.** Describe your state's case management services

Case management is a collaborative effort between three primary behavioral health service providers (i.e., SSA, SMHA, and the local hospital). Discharge planning meetings occur in the acute care facility and are followed-up through the community mental health team, which includes the SMHA, SSA, peer advocate, Office of Protection and Advocacy, and the identified individual. While still in its infancy, there is a greater effort to collaborate and communicate more consistently through interdisciplinary team meetings. local hospital).

**4.** Describe activities intended to reduce hospitalizations and hospital stays.

Case Management, SMI case review committee, Regular mental health/SUD screening and assessment, FEP screening and referrals to treatment, consistent follow up

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

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

## Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

| Target Population (A) | Statewide prevalence (B) | Statewide incidence (C) |
| --- | --- | --- |
| 1.Adults with SMI | n/a | n/a |
| 2.Children with SED | n/a | n/a |

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Currently, the state does not calculate/utilize incidence and prevalence rates for planning purposes. When assessing and planning state activities, the state looks at the number of individuals who present as critical cases through their contact with the criminal system (i.e., those who are brought to the attention of the Case Review Committee). Although there is an epidemiological profile for American Samoa, data related to prevalence rates for the mental health population are not adequately captured. The enhanced collaboration between agencies will lead to more cohesive and robust data that can be shared between programs in order to better inform services in the future. Data collection is still a developing area in AS.

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

TA on how to utilize SSA client data and other service providers' data to calculate statewide prevalence and incidence.

## Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

| | | Yes | No |
|---|---|---|---|
| **a)** | Social Services | ◉ | ○ |
| **b)** | Educational services, including services provided under IDEA | ○ | ◉ |
| **c)** | Juvenile justice services | ○ | ◉ |
| **d)** | Substance misuse preventiion and SUD treatment services | ◉ | ○ |
| **e)** | Health and mental health services | ◉ | ○ |
| **f)** | Establishes defined geographic area for the provision of services of such systems | ◉ | ○ |

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

TA on effective and evidence-based comprehensive programs for addressing needs of children experiencing SED or multiple needs related to their behavioral health.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
***https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf***

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

## Criterion 4

**a.** Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

The state conducts weekly street outreach services and home visits to individuals identified as having a serious mental illness (SMI) or co-occurring substance use disorder. Individuals who reside in these remote areas continue to face barriers to service due to lack of transportation. Transportation services are being provided for these individuals to access other services that are conducted at office (e.g. psycho-educational classes, check-in groups, anger management, etc.) and to their appointments at the state hospital.

**b.** Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

The state provides homeless and outreach services to individuals who are literally homeless or are in an imminent risk of becoming homeless. These services are funded by the Projects for Assistance in Transition from Homelessness (PATH) Program. Other targeted services for this population include medication and case management, assessments, referrals and other support services.

**c.** Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

Currently, the state has no specific treatment programs for this population. The services provided are typically the same for all adult population with serious mental illness or co-occurring substance use disorder.

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

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

## Criterion 5

**a.** Describe your state's management systems.

1. SSA is 100% federally funded and the MHBG and SUBG focus primarily on the direct services to individuals with a SMI/SED, SUD or co-occurring disorders. The SSA's other federal funding to support mental health programs and services include: PATH, 988 Crisis Response Grant and funding from NASHMPD (via SAMHSA) for the Transformation Transfer Initiative to support plans to improve the mental health workforce and access to crisis response and mental health treatment services. Presently, the state government does not allocate any monies from local revenue to mental health services. The SSA is also not a sub-grantee for potential other mental health funding received by other departments or agencies in American Samoa. Other agencies that receive mental health funding operate their own mental health services and funding is not streamlined into one pool of mental health funding for the state. All program funding disbursements or payments are monitored and authorized only by the American Samoa Department of Treasury and programs are not allowed to have direct access to program funds. However, programs operate based on approved program budgets and requests for payments or expenditures from the program funds are initiated by the programs and processed through the financial management system of the SSA department and final approval is made by the Treasury Department.

The SSA workforce is supported through the federal funding received and often are cost-shared across funding streams because the limited workforce who is responsible for implementing multiple behavioral health treatment and recovery support services. The recruitment of behavioral health staff is the responsibility of the

2. Training for mental health service providers is made possible through the MHBG funding as well as PATH and occasionally in partnership with the SUBG funding when it applies to co-occurring or other treatment skill(s) that can be used in both substance abuse and mental health services. MHBG paid providers receive regular training in-house (through the SSA), attend training off the island and attend training related to mental health services provided by another local service provider.

3. SSA in collaboration with the advisory council members, coordinates training that includes emergency health services so to ensure that they are aware and familiar with SMI and SED.

4. SSA intends to expend this grant for the next two years to meet its priority areas (children's mental health, trauma-informed care, FEP and service connection). Specifically for this current fiscal period, the SSA is focusing time and effort to accomplishing objectives toward improving children's mental health in schools on island.

**b.** Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Currently, the territory does not have a territory-wide telehealth policy or plan for how telehealth is delivered across government service provider agencies or departments. However, in terms of capabilities, the SSA has telehealth capability and capacity and has established an internal telehealth services policy and procedures. Although staff has not been formally trained in the delivery of telehealth treatment using video conferencing applications or virtual meeting platforms. Nevertheless, the SSA treatment providers implemented telehealth treatment during the pandemic and were able to successfully carry out virtual counseling/treatment sessions by way of telephone and video conferencing using virtual meeting platforms such as Zoom or Google Meet. Both treatment providers and clients were given instructions and guidelines for virtual counseling sessions to ensure client confidentiality and privacy was maintained at all times.

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

TA on telehealth treatment and recovery support services.

**Footnotes:**

## Environmental Factors and Plan

### 11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

**Please respond to the following items:**

**1.** Has your state modified its CQI plan from FFY 2022-FFY 2023? ◯ Yes ◯ No

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

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**Footnotes:**

## Environmental Factors and Plan

### 12. Trauma - Requested

Narrative Question

**Trauma**[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.

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

**Footnotes:**

# 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.

[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:

- ☐ Coordination across mental health, substance use disorder, criminal justice and other systems
- ☐ 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, including those related to medications for opioid use disorder
- ☐ 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, 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
- ☐ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- ☐ 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

**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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**Footnotes:**

# 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 American Samoa 988 crisis center is operated under the leadership and oversight of the American Samoa Department of Health (ASDOH) with advisory guidance provided by the American Samoa 988 Coalition. The American Samoa 988 crisis center is the only onboarding Lifeline crisis center in American Samoa and is accredited by the International Council of Helplines (ICH). The crisis center is in its final stage of review by Lifeline Vibrant to approve the transition from onboarding to an official Lifeline crisis center. At this time and until the 988 calls are returned to American Samoa, the ASDOH 988 Crisis Response Program continues to offer and provide 24/7 mental health and suicide crisis response and support through a local three-digit number (220) which is answered by trained crisis counselors and is also free and accessible from anywhere on the island and is available for all individuals. There are established policies and procedures for this crisis line for any caller experiencing a crisis or at imminent risk for suicide, to be referred accordingly to emergency first responders for rescue or life-saving measures. Referrals are also made to mental health treatment services and any other support service accordingly.

The territorial crisis response system also includes emergency crisis first responding agencies such as the Department of Public Safety (police), 911 Dispatch and the Emergency Medical Services (EMS). The Department of Human and Social Services operates a 24/7 crisis line dedicated to calls

regarding child abuse/neglect and domestic violence.

Presently, American Samoa does not have a formal mobile crisis response service; however, mobile crisis response is available through the SSA or ASDOH's community mental health services or mental health clinical staff who provide mobile crisis response when requested by police or EMS. The procedure for crisis stabilization at this time is for the individual to be transported to the hospital's Emergency Room. The hospital's psychiatry services personnel (Psychiatrist) conducts a suicide assessment for these cases and makes the determination for admission or referral to outpatient mental health treatment.

**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.

Someone to talk to - Program Sustainment
- The SSA oversees and manages the American Samoa 988 Crisis Response Program which includes a 24/7 crisis call center staffed by trained crisis counselors (trained in Lifeline training modules and criteria) and is funded by SAMHSA's 988 Crisis Response grant program.

Someone to respond - Partial Implementation
- While there is no formal mobile crisis service in place at this time for the territory, there is partial implementation in regards to a designated agency or individual to respond to a person in crisis. The procedure for any call received by the American Samoa 988 Crisis Call Center that warrants mobile crisis response or someone to respond to the caller in person, the call is immediately referred to emergency first response such as the police or EMS to conduct their assessment and evaluation. Should the emergency first response need additional crisis response support from behavioral health services, the SSA's community mental health services staff and the ASDOH Psychiatrist and behavioral health clinical leadership is on stand-by to respond in person.

Safe place to go or to be - Majority Implementation

The American Samoa Medical Center Authority or local hospital does have an Emergency Room which currently serves as a "safe place to go" for an individual at imminent risk for suicide. There are hospital procedures in place to ensure that a Psychiatrist or mental health professional conducts a suicide risk assessment of the individual and will determine admission to the hospital's acute inpatient psychiatric unit or behavioral health facility to further secure the safety of the individual.

Having additional safe places for the individual to go or increasing the capacity of the hospital for these admissions would meet program sustainment.

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

To develop the territorial crisis system, the SSA plans to collaborate with key crisis response service providers to develop a uniformed territorial strategic plan for crisis response that is followed by all service providers. Unfortunately, each crisis response service provider is currently operating on individual crisis response procedures which can lead to duplication of services, confusion of services, and gaps in ensuring proper referral to crisis response services and mental health treatment services. The territorial strategic plan will incorporate SAMHSA's National Guidelines for Behavioral Health Crisis Care as well as the Lifeline protocols for crisis center's response to ensure that the territory's crisis system meets the expected standards for crisis care and crisis response.

As such, the SSA will work collaboratively with crisis response service agencies to enhance the territory’s capacity to ensure referral connection post-988 contact. Planning meetings and discussions have begun between the AS 988 crisis center and crisis emergency first responders such as DPS and EMS regarding referrals for individuals or callers into crisis stabilization services or follow-up care. However, there is no formal agreement and understanding of the procedures. Finalizing the referral process must be done in coordination with other crisis response service providers in the territory, especially crisis services available in the community or through NGOs. Referral connections made post-988 contact must be effectively coordinated utilizing best practices and skills that engages the individual experiencing crisis to ensure mental health support is available and can be accessed.

• A Sustainability Plan will be submitted by the end of March 2026 or six months prior to the end of the project period. In this sustainability plan, the American Samoa 988 Crisis Response project will provide the plan for sustaining the crisis center’s workforce capacity beyond the grant funding. Some of the financial resources to be explored to assist with sustaining the 988 workforce include Medicaid, local or state/territory funding, and leveraging of federal grant opportunities. The sustainability plan will also provide the plan for maintaining the Lifeline Key Performance Indicators (KPI) metrics for full implementation of calls, chats, and texts after the end of the project period. The American Samoa 988 Crisis Response project’s sustainability will depend extensively on active coordination and collaboration across the territory’s crisis response system.
• A Comprehensive Quality Assurance Plan will be submitted one year after the project award or by September 30, 2024. The quality assurance plan will explain how the American Samoa 988 Crisis Response project will implement required activities, goals, and objectives utilizing evidence-based best practices and in compliance with what is allowable and expected by the grant project. In addition to assuring quality implementation, the comprehensive quality assurance plan will include the territory’s protocols for identifying and reviewing critical incidents where the last contact was provided by the American Samoa 988 crisis center, if identified within 7 days after contact or as defined by the territory. To date, the American Samoa 988 crisis center has collaborated with local crisis emergency first responder services to develop procedures for identifying and reviewing critical incidents (i.e.,
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deaths by suicide) where the last contact was provided by the American Samoa 988 crisis center. These discussions and collaborations will be instrumental in developing the grant project’s comprehensive quality assurance plan.

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

The proposed/planned activity utilizing the 5% set aside for crisis response is to support the development of the territorial crisis system and crisis response strategic plan. The set aside will be used to contract technical assistance or consultation for the development of this system and document (strategic plan) and costs for planning meeting supplies, venue, and training materials.

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

TA on crisis system development and territorial strategic plan.

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**Footnotes:**

## 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.

**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.

    Recovery is promoted and encouraged through treatment services of the SSA where counselors work closely with clients who have reached recovery to develop a plan to sustain their recovery. Recovery planning is available to both adults with a SMI and/or child with SED. There are also recovery programs through a few non-profit organizations for adults with SMI and/or children with SED such as recovery support planning, relapse prevention and independent living skills education.

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

    As stated in the response for #3, recovery support services for individuals with substance use disorders include recovery planning with a counselor, relapse prevention (teaching skills), and support from Alcoholics Anonymous or Celebrate Recovery - both groups are available through non-profit organizations on island.

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

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

TA on resources to support community organizations delivering programs supporting recovery; training and funding opportunities to develop a recovery support specialist certification for service providers.

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**Footnotes:**

## Environmental Factors and Plan

### 17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

**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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**Footnotes:**

# 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**

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**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

**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.)

At this time, integrated services through the system of care targeting children needs to be better established, delivered and sustained for children with SED. (This is the main reason that American Samoa has selected screening for children with SED as our focus for the 10% early psychosis requirement and have made children's mental health as a priority). In regards to children with SED, the SSA is currently collaboration with the Department of Education to roll out training on SEDs and trauma-informed care when working with children. These training are intended to build the capacity of school counselors, administrators and staff to recognize signs and symptoms of SED (depression, anxiety, suicidal ideation, trauma-related issues) so that they may adequately screen and refer to SSA for treatment. Children with SUD receive integrated services from the SSA and juvenile detention centers in our partnership to begin screening youth/children who are detained for SUD related services, or referrals from SUD treatment at the SSA for mental health counseling through the Department of Health or another service provider. Department of Health is also currently screening for SUD at the community health centers where they may also make a referral for SUD treatment to the SSA.

**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.

TA on effective ways to integrate services to support children with SED and/or children with SUD, treatment approaches to be used across services for children/youth with SED and/or SUD, and co-occurring.

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**Footnotes:**

# Environmental Factors and Plan

### 19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

### Please respond to the following:

**1.** Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

**2.** Describe activities intended to reduce incidents of suicide in your state.

(1) Outreach through media campaigns (e.g., TV programming, radio programming) and outreach programs at high schools and church youths and organizations to help decrease stigma associated with discussing suicide; (2) Staff development (TA providers conducted ASIST training for staff; (3) Training of individuals manning crisis lines; (4) Case Review Committee/Discharge Planning meetings with stakeholders to ensure continuity of care. Routine discharge planning meeting whereby relevant service providers were invited to participate in routine discharge planning meetings for individuals, which includes those who were hospitalized due to suicidal/parasuicide actions.

**3.** Have you incorporated any strategies supportive of Zero Suicide? ○ Yes ◉ No

**4.** Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

If yes, please describe how barriers are eliminated.

**5.** Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? ◉ Yes ○ No

If so, please describe the population of focus?

The population targeted for the suicide prevention is youth/adolescents and young adults. In the 2015 YRBS, 24.1% of 1693 students reported having attempted suicide within that year, while 26.1% made a plan to commit suicide and 24.2 seriously considered suicide. Depression screening at the schools and community health centers for children (ages 12-18) will help to identify individuals with potential for suicidal ideations. Suicide prevention will also be useful for adults, specifically adults with a pre-existing condition or diagnosis such as a SMI or ESMI.

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

1. Effective and efficient integration of Zero Suicide initiatives in the community
2. Suicide Assessment and Risk aversion.

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**Footnotes:**

## Environmental Factors and Plan

### 20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

**Please respond to the following items:**

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

   If yes, with whom?

   Foeoletini Foundation - The Christopher James Foeoletini Ledoux Foundation (The Foeoletini Foundation) is a 501(c)(3) nonprofit organization founded to provide recovery and response assistance for individuals and families experiencing mental health crises, suicidal ideation and SUD. The Foeoletini Foundation seeks to provide essential services to target at-risk individuals and communities. Other initiatives include:
   ? Telehealth services.
   ? Temporary recovery houses
   ? Referrals for incarcerated individuals with a history or known SUD
   ? Outreach
   ? Educational resources for families and communities.
   ? Peer-to-peer support groups for individuals experiencing mental health challenges and their families.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality

and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The SSA's existing partnerships with key behavioral health stakeholders and NGOs is instrumental in our ability to effectively coordinate treatment and recovery services for individuals with a SMI/SED, SUD or co-occurring disorders. There are many avenues in which information and resources are shared across the territorial behavioral healthcare system which improves collaboration in turn maximizes efficiency. Training and skill-building opportunities are shared widely across service providers to ensure that even with a limited behavioral health workforce we recognize the need to enhance the overall capacity of providers to engage clients effectively for the best possible outcomes. Partnering with NGOs who provide peer support services for both mental health and substance abuse has been extremely instrumental in reducing stigma and refusal to seek treatment and as a result improving access to care and services. Increasing the community's awareness and knowledge of resources and risk/protective factors for SMI, ESMI, SED and SUD is a more coordinated effort now between the SSA/government service agencies and community-based programs or NGOs.

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

TA on development and implementation of peer support services.

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**Footnotes:**

# Environmental Factors and Plan

## 21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]

### Please consider the following items as a guide when preparing the description of the state's system:

**1.** How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The plan has not been reviewed by the council in its entirety. One of the challenges the state agency is faced with is consistent attendance from the current council. A major obstacle to consistent attendance is that there is another council created by the former Governor several years ago called the American Samoa Behavioral Health Advisory Council which does not recognize the state's Behavioral Health Council and therefore does not attend regularly when meetings are called. The state is preparing a request to the current Governor to include oversight of the CMHBG to the BHA council so that there is more involvement, engagement and attendance from service providers, consumers and community members.

**2.** What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

The state uses several evidence-based practices to implement substance misuse prevention, SUD treatment and recovery services. The state works collaboratively with other service providers to ensure that there is open communication with regards to referrals and the implementation of EBPs across the service delivery system.

**3.** Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ○ No

**4.** Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ● Yes ○ No

**5.** Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The primary duties and responsibilities of the Council include:
(1) Meeting on a quarterly basis to review progress;
(2) Review of CMHSBG and provide feedback;
(3) Form subcommittees to help provide more coverage of issues that pertain to the interest of consumers and family members.
The Council is comprised of 50% percent of consumers and their family members, who are also actively involved in other aspects of the work.

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

PSATTC and MHTTC were contacted to provide TA to council members on Mental Health, SUD treatment, prevention and recovery.

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**Footnotes:**

## Environmental Factors and Plan

### Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

| Name | Type of Membership* | Agency or Organization Represented | Address,Phone, and Fax | Email(if available) |
|---|---|---|---|---|
| Dr. Peni Biukoto | Providers | | Pago Pago AS, 96799<br>PH: 684-699-6380 | peni.biukoto@doh.as |
| Talalupelele Fiso | State Employees | | Department of Health Pago Pago AS, 96799<br>PH: 684-699-6380 | talalupelele.fiso@doh.as |
| Dr. Julia Foifua | State Employees | | Department of Health Pago Pago AS, 96799 | julia.foifua@doh.as |
| Pete Galea'i | Providers | | Pago Pago AS,<br>PH: 684-699-1372 | |
| Elizabeth Ma'ilo | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | Nu'uuli Pago Pago AS, 96799 | mailo02324@gmail.com |
| Mark Mulipola | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | Malaeimi Pago Pago AS, 96799 | |
| Pa'ulia Pelenato | State Employees | | Department of Human and Social Services Pago Pago AS, 96799<br>PH: 684-633-2696 | ppelenato@dhss.as |
| Faiilagi Poufa | State Employees | | Medicaid Office Pago Pago AS, 96799 | faiilagi.faiai@medicaid.as.gov |
| Gwendolyn Pu'u | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | Pago Pago AS, 96799 | |
| Adney Reid | Providers | | P.O. Box 1270 Pago Pago AS, 96799<br>PH: 684-272-6218 | adneyreid@gmail.com |
| Andra Samoa | Persons in recovery from or providing treatment for or advocating for SUD services | | Pago Pago AS,<br>PH: 684-733-3191 | andra.samoa@gmail.com |
| Ricky Siatunu'u | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | Pago Pago AS, 96799 | |

| | | | | |
|---|---|---|---|---|
| Peka Tofi | Family Members of Individuals in Recovery (to include family members of adults with SMI) | | Pago Pago AS, 96799 | |
| Mona Uli | Others (Advocates who are not State employees or providers) | | Pago Pago AS, 96799 | monauli57@gmail.com |
| Sarona Vaimauga | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | Pago Pago AS, 96799 | |

*Council members should be listed only once by type of membership and Agency/organization represented.

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**Footnotes:**

The state is currently recruiting members from the Education and Criminal Justice agencies.

## Environmental Factors and Plan

### Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

| Type of Membership | Number | Percentage of Total Membership |
|---|---|---|
| Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | 5 | |
| Family Members of Individuals in Recovery (to include family members of adults with SMI) | 1 | |
| Parents of children with SED | 0 | |
| Vacancies (individual & family members) | 0 | |
| Others (Advocates who are not State employees or providers) | 1 | |
| **Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others** | **7** | **50.00%** |
| State Employees | 4 | |
| Providers | 3 | |
| Vacancies | 0 | |
| **Total State Employees & Providers** | **7** | **50.00%** |
| Individuals/Family Members from Diverse Racial and Ethnic Populations | 0 | |
| Individuals/Family Members from LGBTQI+ Populations | 0 | |
| Persons in recovery from or providing treatment for or advocating for SUD services | 1 | |
| Representatives from Federally Recognized Tribes | 0 | |
| Youth/adolescent representative (or member from an organization serving young people) | 0 | |
| **Total Membership (Should count all members of the council)** | **15** | |

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**Footnotes:**

There are no parents of children with a SED/SUD on the council which has been very challenging primarily because there are currently no children with an official SED or SUD diagnosis in treatment. There are children and/or clients under the age of 18 in treatment for substance abuse or mental health; however, they may not meet all of the criteria needed for a SED or SUD diagnosis.

The CMHS Branch Manager and counselors will continue to assess current and future referrals for mental health to identify a child with a SED or SUD and talk to the parent(s) to determine any interest in being a part of the advisory council.

## Environmental Factors and Plan

### 22. Public Comment on the State Plan - Required

Narrative Question

**Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51)** requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

### Please respond to the following items:

**1.** Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

- **a)** Public meetings or hearings? ○ Yes ● No
- **b)** Posting of the plan on the web for public comment? ○ Yes ● No

  If yes, provide URL:

  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

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**Footnotes:**

Unfortunately, the SSA was not able to hold a public hearing or post/advertise the plan publicly this year. There were many challenges with convening a public meeting or hearing due to time conflicts with scheduling such a gathering. We were also not able to advertise for public comment due to issues with processing payment for this advertisement. Since the SSA has relocated under new leadership earlier this year, we no longer have a dedicated URL or website by which to post the plan for public comment. We will make sure this does not happen next year as we intend to be better situated with the support mechanisms in place to ensure public comment on the state plan.

Is it possible to post on social media to request public comment?