American Samoa

UNIFORM APPLICATION
FY 2026/2027 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 03/09/2026 5.32.51 PM)

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

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

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	Saipale
Last Name	Fuimaono
Agency Name	DEPARTMENT OF HEALTH
Mailing Address	PO BOX 5666
City	PAGO PAGO
Zip Code	96799
Telephone	684-633-4606
Fax	
Email Address	sfuimaono@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	9/1/2025 11:03:49 PM
Revision Date	3/6/2026 1:22:05 PM

VI. Contact Person Responsible for Application Submission

First Name	Talalupelele
Last Name	Fiso

Telephone 684-699-0315
Fax
Email Address talalupelele.fiso@doh.as

Footnotes:

State Information

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

Fiscal Year 2026

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**
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Section 1913	Certain Agreements	**42 USC § 300x-2**
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Section 1920	Crisis Services	**42 USC § 300x-9**

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

management program developed under the 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: Dr. Saipale Fuimaono

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.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

PULAALI'I NIKOLAO PULA
GOVERNOR

PULUMATAALA AE AE JR.
LT. GOVERNOR

OFFICE OF THE GOVERNOR
AMERICAN SAMOA GOVERNMENT
PAGO PAGO, AMERICAN SAMOA 96799
Telephone: (684) 633-4116 | (684) 633-4121

Serial No.: 797 – 25

June 20, 2025

Christopher D. Caroll, MSc
Principal Deputy Assistant Secretary
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD. 20857

Subject: Designation of Single State Authority for Substance and Mental Health

Dear Principal Deputy Assistant Secretary Caroll:

The Territory of American Samoa receives funding from the U.S. Department of Health and Human Services through the Substance Abuse and Mental Health Services Administration (SAMHSA) to support substance abuse and mental health programs. The American Samoa Department of Health (DOH) is the designated Single State Authority (SSA) for these services.

I hereby designate Dr. Saipale Fuimaono, Director of the Department of Health, as the Governor's Designee and Authorized Signatory for all SAMHSA – related matter. This includes federally mandated certificates, assurances, and funding agreements for both SAMHSA block and discretionary grant applications, as well as all existing federal programs administered by the DOH.

As Governor, I have entrusted members of my cabinet with responsibility for program and policy development, performance management, fiscal oversight, and full compliance with all federal regulations governing the use of federal funds in the Territory.

Thank you for your continued partnership and support of the people of American Samoa.

Sincerely,

Pulaali'i Nikolao Pula
Governor

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

Dr. Saipale Fuimaono

Title

Director

Organization

Department of Health

Signature:

Date: July 24, 24

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

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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.
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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: Dr. Saipale Fuimaono

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: July 24, 25

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

American Samoa Government Department of Health

Behavioral Health Services Division

2026 BIPARTISAN SAFER COMMUNITIES ACT (BSCA) PLAN

The American Samoa Department of Health (ASDOH) Behavioral Health Services Division (BHSD) proposes utilizing the fourth Bipartisan Safer Communities Act (BSCA) allotment to continue its partnership with the Foeoletini Foundation. This funding will support the continuation of services outlined in the 2024 BSCA plan.

Additionally, the funding will be utilized to develop educational brochures, fact sheets, and resources for distribution to the selected schools. These intervention materials will provide young individuals with information and guidance on identifying early signs and symptoms of FEP/ESMI and offer strategies to safely manage mental health crises, bullying and violence within the school environment.

Budget OR UTILIZATION OF FUNDS

Total BSCA funding for American Samoa $11,553

COSTS:

Contract	a. Peer Support Outreach b. Peer Support Counseling c. FEP Screening d. Referral for Mental Health Treatment	$9,820
FEP/ESMI	a. FEP/ESMI brochures • Identification of signs and symptoms of FEP/ESMI • Coping Strategies	$1,155
Crisis Services	a. Crisis Service brochures • Tips on how to manage crisis within the schools • What to do when in crisis	$578

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

Dr. Saipale Fuimaono

Title

Director

Organization

Department of Health

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

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 prevention system (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 behavioral health 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 mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. 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."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

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 service system is the same for both youth and adults.

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.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

ASDOH, as stated above, is the state's SSA and SMHA and also the primary mental health and substance use treatment service provider in the territory. Treatment services offered and provided by ASDOH, through its Behavioral Health Services Division, include evidence-based 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.

The American Samoa Medical Center Authority (ASMCA) is a semi-autonomous facility that serves as the territory's only hospital. In addition to the medical care services they provide, they also operate an acute psychiatric inpatient care facility (the only inpatient psychiatric facility in the territory). Services offered by ASMCA in this facility include diagnostic assessments, medication-assisted

treatment, care management, individual and family therapy and referral.

The services offered by the Veterans Affairs Clinic and Outpatient Community Center are limited only to veterans and service members with support services available for family members. ASDOH maintains continued communication and collaboration with the two state agencies 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 contributes to territorial planning for mental health and substance use disorder treatment and prevention programs.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

The American Samoa MH/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 utilizes evidence-based substance use disorder and Mental Health treatment program such as: Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Psychoeducation, SBIRT and a combination of MET-CBT 12 and MATRIX. Our prevention efforts include community education, outreach programs, media campaigns, and evidence-based programs such as SSF, RBST, and Life Skills Training.

The SSA utilizes the 10 percent set-aside from its block grant to sustain programs such as psychoeducation and the development of outreach materials tailored for individuals with ESMI and SED, as well as their families.

Individuals with SMI/SED experiencing homelessness are supported through the Projects for Assistance in Transition from Homelessness (PATH) program. This program provides:
- Street outreach
- Assistance in accessing mental health services and nutritional assistance
- Referrals to the Department of Human and Social Services and Vocational Rehabilitation for housing and employment needs

The SSA has implemented the ACT program that offers community-based services to SED/SMI children, adults and older adults which include those living in remote areas. These services include the administering of medication and injections.

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 meet the broader needs of the community, the SSA (ASDOH BHSD) relies on these partnerships to coordinate community-based outreach activities that raise awareness about behavioral health and how residents can access available 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.

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Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of 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 should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, 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, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Currently, the SSA does not conduct statewide needs assessments for mental health and substance use disorders. However, we recognize the need for a comprehensive needs assessment to identify unmet needs, service gaps, and challenges in the delivery of quality care and prevention services. The SSA has identified the development of a statewide needs assessment as a priority for the current year and it's an item on the agenda for the council to discuss when the first meeting takes place later this month.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Access to Services
Despite the successful integration of behavioral health and physical care at the Territorial CHCs and the availability of two community sites, access to care remains a constant concern due to low motivation, cultural stigma, and a pervasive fear of being labeled or marginalized within the community. In addition, SMI/SED individuals living in remote areas or other islands of American Samoa such as Aunu'u rely on small boats to travel to the main island of Tutuila to access the services.
Housing
The Department of Human and Social Services operate a 24-hour homeless shelter. The shelter's limited capacity to house more than 3 families often result in others needing shelter to be on the waiting list which includes individuals with SMI. Additionally, there seems to be a reluctance in the shelter staff to accept SMI individuals due to the lack of training on how to safely manage

and support individuals during SMI-related episode. DHSS also offers Rapid-Rehousing program which is currently experiencing a shortage of available units.

Limited Employment Opportunities
URS data indicates a significant decrease in stable employment among individuals with a diagnosable Serious Mental Illness (SMI), with only 14.8% currently maintaining stable positions when compared with the national average which is approximately 50%. Furthermore, many individuals referred to the American Samoa Department of Vocational Rehabilitation for supported employment have remained on waiting lists for several years. This challenge is primarily due to a lack of available employment opportunities and a limited number of employers willing to hire individuals with mental health or substance use conditions.

Inadequate Facilities
Presently, mental health treatment facilities are limited to one government agency, the local hospital, and two NGOs. The only inpatient psychiatric resource is a 12-bed acute care facility at the local hospital, which does not provide an option for individuals requiring long-term residential care for mental health or substance use disorders. ASDOH oversees a residential transitional housing facility which is intended to help SMI individuals under civil commitment prepare and re-enter the community and return home. Due to the nature of their symptoms, residents are unlikely to reenter the community within a reasonable timeframe. Consequently, all current residents have remained in the facility for the last four years when the facility was first opened.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

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) Trauma-informed training;
a. Coordinate with SAMHSA or NASMHPD to identify a trauma-informed training that is culturally relevant.
b. Train all behavioral health counselors and clinicians;
c. Coordinate with partners and other mental health service providers to participate in training.
(4) Needs Assessment;
a. Coordinate with council and stakeholders to develop a statewide needs assessment to identify the target populations' unmet needs, determine adequacy of services, challenges and service gaps.

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Footnotes:

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Integrate Peer Support Services into Primary Care

Priority Type: MHS, ESMI, BHCS

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

Goal of the priority area:

To reduce stigma associated with mental health, which often creates significant barriers to treatment, and improve help-seeking behaviors, treatment outcomes, and overall recovery rates.

Strategies to attain the goal:

Identify peer support TA to train both the mental health counselors and the peer specialists.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of SMI/SED individuals receiving mental health services through SSA and in the community showing reduced stress levels related to social stigma and those with increased intentions to seek professional help following peer interaction.

Baseline measurement (Initial data collected prior to and during 2026): 30

First-year target/outcome measurement (Progress to the end of 2026): 30

Second-year target/outcome measurement (Final to the end of 2027):

Data Source:

SSA
Self-Reports

Description of Data:

- SSA mental health treatment data
- Community mental health service providers client data
- Pre and Post Surveys
- Face-to-Face Interviews

Data issues/caveats that affect outcome measures:

Priority #: 2

Priority Area: Trauma Informed Treatment

Priority Type: SUT, MHS

Population(s): SMI, SED

Goal of the priority area:

To reduce trauma related mental health symptoms and challenges in at least 25% of clients referred to treatment.

Strategies to attain the goal:

- Identify a EBP trauma-informed treatment program/model that is culturally appropriate and fitting for Samoan population.
- Train MH/SUD treatment providers or counselors in the selected trauma-informed treatment EBP.
- Train community providers and partners in trauma-informed practices or skills.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline measurement (Initial data collected prior to and during 2026): 25

First-year target/outcome measurement (Progress to the end of 2026): 25

Second-year target/outcome measurement (Final to the end of 2027): 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: Increase Access to Mental Health Treatment

Priority Type: MHS, ESMI, BHCS

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

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 evidenced-based treatment approaches that are culturally relevant to address mental health needs and identified a specialized 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 inidivudals with SMI/SED accessing mental health treatment through SSA and in the community

Baseline measurement (Initial data collected prior to and during 2026): 50

First-year target/outcome measurement (Progress to the end of 2026): 50

Second-year target/outcome measurement (Final to the end of 2027):

Data Source:

SSA 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:

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Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application *Funding Agreement/Certifications and Assurances.*

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2027

Activity	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), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis Services								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$35,590.00						$1,155.00
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								$9,820.00
10. Ambulatory/Community Non-24 Hour Care		$284,716.00			$60,000.00			
11. Crisis Services (5 percent Set-Aside)[c]		$17,795.00						$578.00
12. Other Capacity Building/Systems Development								
13. Administration[d]		$17,795.00						
14. Total		**$355,896.00**	**$0.00**	**$0.00**	**$60,000.00**	**$0.00**	**$0.00**	**$11,553.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	
1b. Crisis Services for Adults	17795.00
1c. CSC/ESMI program for Adults	35590.00
1d. Other outpatient/ambulatory services for Adults	179345.00
1e. *Other Direct Services for Adults	
2. Subtotal of Services for Adults	232730.00
3. Services for Children	
3a. EBPs for Children	
3b. Crisis Services for Children	17795.00
3c. CSC/ESMI program for Children	35590.00
3d. Other outpatient/ambulatory services for Children	49825.00
3e. *Other Direct Services for Children	
4. Subtotal of Services for Children	103210.00
5. Other Capacity Building/Systems Development[a]	7500.00
6. Administrative Costs[b]	12456.00
7. *Any Other Cost	
8. Total MHBG Allocation[c]	**355896.00**

Please provide brief explanation for services with an asterisk* below:

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 10/01/2025 MHBG Planning Period End Date: 09/30/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems		
2. Infrastructure Support		
3. Partnerships, Community Outreach, and Needs Assessment	$5,000.00	
4. Planning Council Activities	$2,500.00	
5. Quality Assurance and Improvement		
6. Research and Evaluation		
7. Training and Education		
8. Total	**$7,500.00**	**$0.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

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The state does not plan to use the 4th BSCA funding on other capacity building/systems development activities.

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **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 health 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: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

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 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 details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

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

g) Persons with substance use disorders in the justice system

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

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

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

To improve access to care for both children with SED, co-occurring SED and IDD and adults with SMI and co-occurring SMI and SUD, 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. Furthermore, the SSA is utilizing its 4th BSCA funding to continue this partnership with Foeoletini Foundation to conduct FEP screening within the schools, provide peer support services, and provide referral to the SSA for individuals needing mental health services.

Furthermore, the state has initiated discussions with the Director of the Department of Public Safety to coordinate a comprehensive training for first responders and law enforcement that focuses on identifying and recognizing signs and symptoms of ESMI, SMI and SED, as well as learning crisis deescalation techniques; and how to administer naloxone. This training is tentatively scheduled for March 2026.

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 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.

The DOH-BHSD utilizes a holistic approach to reduce the impact of co-occurring conditions through a single point of care. Currently, the SSA has successfully integrated behavioral health screenings into the primary clinic triage process. This process also applies to direct referrals to Behavioral Health Services. For youth and adult individuals identified as having co-occurring disorders, the psychiatrist will work together with the BH nurse and treatment counselor from the community-based outpatient programs to coordinate treatment services.

a. Please describe how this system differs for youth and adults.

The system is the same for both youth and adults.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

IT-COD has not been implemented.

c. How many IT-COD teams do you have? Please explain.

N/A - IT-COD has not been implemented.

d. Do you monitor fidelity for IT-COD? Please explain.

N/A

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. 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

d) How the state provides integrated treatment for individuals with co-occurring disorders

Access to Behavioral Health Care
Behavioral health screening has been successfully integrated into the triage process at our primary clinics. Individuals identified as requiring behavioral health services are referred to the Behavioral Health Clinic located within the Tafuna Community Health Center. Conversely, patients at the behavioral health clinic requiring primary care are referred back through the same established process.

Clinical Training and Referrals
Due to the specialized focus of our primary care clinicians, all individuals identified during screening as needing behavioral health services are referred directly to the Behavioral Health Clinic to ensure they receive appropriate care.

Integrated Triage and Outreach
Triage is currently integrated into the intake process at the Behavioral Health Clinic. Furthermore, triage is conducted during community prevention outreach programs at schools, government agencies, and religious organizations that have requested mental health and substance use prevention outreach.
Integrated Treatment for COD
The psychiatrist works closely with the treatment counselors to ensure the individual with a COD receives both services simultaneously.

5. 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 (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

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 which will include adults with SMI and I/DD, children/youth with SED or SUD, and children/youth with SED and I/DD.

6. 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.

The DOH-BHSD utilizes a holistic approach to reduce the impact of co-occurring conditions through a single point of care. Currently, the SSA has successfully integrated behavioral health screenings into the primary clinic triage process. This process also applies to direct referrals to Behavioral Health Services. For youth and adult individuals identified as having co-occurring disorders, the psychiatrist will work together with the BH nurse and treatment counselor from the community-based outpatient programs to coordinate treatment services. This system is the same for both youth and adults.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD 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 services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD).

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

TA on the implementation of IT-COD.

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Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for 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 individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The 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-5TR (APA, 2022). 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 the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The 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.

States 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 experiencing 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.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Family Psychoeducation	1.00
Social Skills Training	1.00
CBT and Motivational Interviewing	1.00
	0.00

	0.00
	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
36,553.00	36,553.00

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

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. The SSA will continue collaboration with other 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.

SSA continues to fund the following EBPs to address ESMI 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 or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? ◉ Yes ○ No

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

Treatment and education programs continues to be 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 in FY2026 and FY2027 for your state's ESMI programs.

The state will continue to use the 10% percent set-aside from its block grant to sustain the following ESMI programs: Cognitive Behavioral Therapy and Motivational Interviewing Program, Family Psychoeducation, Case Management and Social Skills Training (Weekly Check In Group).

9. Please list the diagnostic categories identified for each of your state's ESMI 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 experiencing first episode psychosis in the state?

Due to the lack of a statewide needs assessment, the state is unable to provide actual prevalence and incidence data.

11. What is the state's plan to outreach and engage those experiencing ESMI 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.

12. Please indicate area of technical assistance needs related to this section.

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

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process 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. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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 people with SMI and their caregivers in making health care decisions, and enhances 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.

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 **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.

6. Please indicate areas of technical assistance needs 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

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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 behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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)**, there are periodic 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. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. 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 private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based 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 behavioral health 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 mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

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

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

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

4. Please indicate areas of technical assistance needs 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

6. 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-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The SMHA or DOH-BHSD offers 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.

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

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

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

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.

3. Describe your state's case management services

The SSA maintains ongoing case management with LBJ and OPAD regarding treatment and discharge plans, particularly for patients under civil commitment. We are also coordinating with LBJ to facilitate a warm handoff of clients to DOH-BHSD for follow-up care and linkage to support services.

Furthermore, the SSA continues its case management collaboration with the Department of Human and Social Services concerning treatment plans and follow-up for children and youth experiencing trauma which are done twice a month and on an as-needed basis.

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

The SSA operates a 24/7 suicide helpline that offers immediate crisis services and provides 100% coverage across the territory. While the SSA does not have an official Mobile Crisis Team, a team that comprises of mental health clinicians and treatment counselors are available to respond to crisis calls received by the helpline from the community or the police.

The American Samoa Medical Authority (LBJ hospital) operates an acute psychiatric inpatient care facility that provides stabilization services.

5. Please indicate areas of technical assistance needs related to this section.

N/A

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

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health 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		
2.Children with SED		

2. 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.

The state does not calculate prevalence and incidence rates. Instead, the state utilizes the URS data on service utilization and penetration rates to monitor the number of individuals receiving care, assess the reach of public health systems and identify areas of service demand.

3. Please indicate areas of technical assistance needs related to this section.

TA on how to develop a statewide needs assessment

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

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

2. Please indicate areas of technical assistance needs related to this section.

SSA does. not require TA

[1] *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.*

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 tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

The SSA has implemented a partial Assertive Community Treatment program. This initiative involves a multidisciplinary team—comprised of a psychiatrist, Licensed Practical Nurses, and PATH program staff—to provide treatment to SMI/SED individuals living in remote areas of the island.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

The SSA receives PATH funding from SAMHSA to support one outreach worker dedicated to providing street outreach services for eligible SED/SMI individuals. These services include mental health treatment referrals and assistance with accessing food stamps, housing, and employment. Outreach is conducted weekly on Wednesdays, with additional responsive visits based on community referrals. Since the consolidation of DHSS behavioral health programs under DOH, the PATH staff have teamed up with the behavioral health nurses to conduct outreach and home visits.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

Same service as stated in question A.

d. Please indicate areas of technical assistance needs related to this section.

N/A

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

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.

Criterion 5

1. 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.

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.

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 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 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 federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. 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.

3. Please indicate areas of technical assistance needs related to this section.

TA on telehealth treatment and recovery support services.

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

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

The SSA currently collects BCI data, which are reported annually in the URS. We are currently working with the BHSIS data submission team at Hendall to build the SSA's capacity to report MH-CLD.

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

The current data collection and reporting system is specific to mental health and substance use services.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

   The American Samoa Medical Authority (LBJ Hospital) and the Department of Health (SSA) utilizes a shared electronic health record (EHR) system which is fully interoperable between the hospital and the medical clinics managed by the SSA. The EHR system is currently not linked to any other external databases.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

   The SMHA currently does not report outcome data at the client level.

5. Briefly describe the limitations of the SMHA 's existing data system.

   The SMHA staff who worked at the Community-based outpatient programs do not have access to the EHR system. Data collected by these programs are saved on Excel spreadsheets.

6. What strategies are being employed by the SMHA to enhance data quality?

   The SMHA are currently working with Rainbow Health to develop a database system for DOH-BHSD.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

   Personnel shortage and HIPPA laws that might prevent data-sharing for federal reports.

8. Please indicate areas of technical assistance needs related to this section.

   TA on how to report outcome data.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

There is a mandatory 5 percent set-aside within 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 evidence-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 fund 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 expending 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 has 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, 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 services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, 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 the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis 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 published 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 published 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.*

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 contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☑	☐	☐
Safe place to be	☐	☐	☐	☐	☑	☐

3. 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.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth 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.,

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.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 0

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 public safety first responder structures (police, paramedic, fire): 0
b. Integrated with public safety first responder structures (police, paramedic, fire): 1
c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 1
b. Number of Emergency Departments that operate a specialized behavioral health component: 0
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 1

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

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.

7. Please indicate areas of technical assistance needs related to this section.

TA on crisis system development and territorial strategic plan.

Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical 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 a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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, there are 10 identified 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 **Working Definition of Recovery.**

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 several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

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 funds for recovery support services? ○ Yes ◉ No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health 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?

6. Please indicate areas of technical assistance needs 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

11. 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 disorder 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 using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 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 use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. 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 on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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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 use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: 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**

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 use 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 Early Serious Mental Illness (ESMI) services?	● Yes	○ No
d) Is the state providing trauma informed care?	● Yes	○ No

6. Describe how the state provides 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?

8. Please indicate areas of technical assistance needs 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.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to 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 items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? ○ 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 new staff 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 the Zero Suicide Initiative? ○ Yes ◉ No

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

If yes, please describe how barriers are eliminated.

ASDOH maintains regular communication and case management meetings with ASMCA to discuss the patients' discharge plans and any known potential barriers to outpatient care.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 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.

6. Please indicate areas of technical assistance needs related to this section.

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, 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 justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- 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.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. 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?

The state did not add new partners since the last planning period.

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.

4. Please indicate areas of technical assistance needs related to this section.

TA on development and implementation of peer support services.

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Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

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 assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

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, letter from the Council Chair etc.)

The American Samoa Behavioral Health Planning and Advisory Council was not involved in the development and review of the state plan. The draft of the executive order to reconstitute the ASBHPAC was submitted to the governor's office, through the Executive Advisor for Health and Human Services. The executive order was signed by the governor on December 23, 2025 and posted on the American Samoa Facebook page. The official copy was received by the SSA on December 29, 2025. DOH Director is aware and will be calling the first meeting later this month. We plan to provide training for new council members on their roles and responsibilities before presenting them with the MHBG plan for their review and feedback.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ◉ No

b. State Report ○ Yes ◉ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

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

The state uses several evidence-based practices to implement substance misuse prevention, SUD and community mental health 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.

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

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ◉ Yes ○ No

6. 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 duties and responsibilities of the Council are as follows:

1. Meet at least quarterly to review annual MHBG applications and implementation reports from the previous year before submission; provide written recommendations to the Director of Health and forward to SAMHSA.
2. Advocate for adults with SMI, children with SED, and individuals with mental illness by:
a. Advising the Governor, Fono, and High Court on behavioral health needs;
b. Promoting service delivery improvements;
c. Identifying and advocating for policy changes enhancing mental health care access;
d. Coordinating and exchanging behavioral health services information.
3. Monitor, review, and evaluate mental health services allocation and adequacy at least annually, including:

a. Identifying service gaps and recommending enhancements;
b. Reviewing service quality, consumer satisfaction, and outcomes;
c. Assessing wait times, workforce capacity, and geographic distribution;
d. Evaluating adequacy of housing, employment, and peer supports;
e. Providing annual progress reports on comprehensive behavioral health care system development with performance and outcome
data.

Additional duties:

1. Establish policies and procedures for patient care and facility staffing;
2. Develop operational plans and annual budgets and recommend long-term operations for future planning;
3. Have ultimate authority for planning, implementing, and managing all behavioral health funding from government and non-government sources;
4. Establish sub-committees as necessary.

7. Please indicate areas of technical assistance needs related to this section.

Technical assistance is needed to train the anticipated newly revised council membership about its roles, responsibilities and duties, as well as its functions in planning and advising state initiatives and efforts related to SMI/SED/SUD treatment, prevention and recovery.

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Footnotes:

PULAALI'I NIKOLAO PULA
GOVERNOR

PULUMATAALA AE AE, JR.
LT. GOVERNOR

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AMERICAN SAMOA GOVERNMENT
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EXECUTIVE ORDER NO. 010 – 25

AN ORDER TO ESTABLISH THE AMERICAN SAMOA BEHAVIORAL HEALTH PLANNING AND ADVISORY COUNCIL, PROVIDING FOR ITS PURPOSE, DUTIES, RESPONSIBILITIES AND MEMBERSHIP IN COMPLIANCE WITH FEDERAL LAW

Section 1: Authority

This Executive Order is issued under the authority granted to the Governor in Article IV, Sections 6 and 7 of the Revised Constitution of American Samoa and the American Samoa Code Annotated § 4.0111(b), and 42 U.S.C. § 300x-3, which mandates a State Mental Health Planning Council for receiving federal Community Mental Health Services Block Grant (MHBG) funding.

Section 2: Preamble

WHEREAS, a state-of-the-art behavioral health facility integrating inpatient, transitional, and outpatient services will be completed by end of 2026, providing:

- Secure accommodations for treatment of 24 individuals;
- Inpatient substance abuse and mental illness rehabilitation;
- Transitional residential housing for recovery and community reentry; and
- Outpatient behavioral health treatment, crisis response, and prevention services.

WHEREAS, A.S.C.A. § 13.0206 (3)(c) requires the Department of Health (DOH) to improve and maintain public health through planning and implementing programs that promote healthy behaviors and prevent disease and injury;

WHEREAS, A.S.C.A. § 13.1501 designates the Director of Health to determine the manner and place for diagnosis, treatment, and care of persons with mental illness or deficiency, and to ensure ongoing psychiatric treatment for committed individuals;

WHEREAS, DOH is designated the Single State Authority (SSA) for substance abuse and mental health services under the Substance Abuse and Mental Health Services Administration (SAMHSA), receiving MHBG and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) funding;

WHEREAS, 42 U.S.C. § 300x-3(b) and (c) require, as a condition of MHBG funding, establishment of a planning council with specific composition and duties, ensuring state employees and providers do not exceed 50% of membership;

WHEREAS, 42 U.S.C. § 300x-3(c)(1) requires council representatives from mental health, education, vocational rehabilitation, criminal justice, housing, social services, and Medicaid agencies;

WHEREAS, 42 U.S.C. § 300x-3(c)(2) requires inclusion of adults with serious mental illness (SMI) and parents/family members of children with severe emotional disturbance (SED);

WHEREAS, 42 U.S.C. § 300x-3(b) mandates the council:

- Review annual MHBG applications and implementation reports with recommendation to SSA before submission;
- Advocate for adults with SMI, children with SED, and individuals with mental illness;
- Monitor, review, and evaluate mental health services allocation and adequacy annually;

WHEREAS, the Council shall promote cooperation among territorial behavioral health agencies, coordinate use of behavioral health grants, and collaborate with DOH, Lyndon B. Johnson Tropical Medical Center (LBJTMC), Department of Human and Social Services (DHSS), and other agencies, to foster best practices.

NOW, THEREFORE, I, PULAALI'I NIKOLAO PULA, Governor of American Samoa, by virtue of the authority vested in me by the Revised Constitution of American Samoa and the American Samoa Code Annotated, hereby execute this order.

Section 3: Creation of the American Samoa Behavioral Health Planning and Advisory Council

(a) Establishment

The American Samoa Behavioral Health Planning and Advisory Council (Council) is hereby created in compliance with 42. U.S.C. § 300x-3.

(b) Pursuant to 42 U.S.C. § 300x-3(b), the Council shall:

(1) Review annual MHBG applications and previous years implementation reports before submission; provide written recommendations to the Director of Health and forward to SAMHSA.
(2) Advocate for adults with SMI, children with SED, and individuals with mental illnesses by:
    (i) Advising the Governor, Fono, and High Court on behavioral health needs;
    (ii) Promoting service delivery improvements;
    (iii) Identifying and advocating for policy changes enhancing mental health care access;
    (iv) Coordinating and exchanging behavioral health services information.
(3) Monitor, review, and evaluate mental health services allocation and adequacy at least annually, including:
    (i) Identifying service gaps and recommending enhancements;
    (ii) Reviewing service quality, consumer satisfaction, and outcomes;
    (iii) Assessing wait times, workforce capacity, and geographic distribution;
    (iv) Evaluating adequacy of housing, employment, and peer supports;
    (v) Providing annual progress reports on comprehensive behavioral health care system development with performance and outcome data.

(c) Additional Duties: The Council shall:
(1) Establish policies and procedures for patient care and facility staffing;
(2) Develop operational plans and annual budgets and recommend long-term operations for future planning;
(3) Have ultimate authority for planning, implementing, and managing all behavioral health funding from governmental and non-governmental sources;
(4) Establish subcommittees as necessary.

(d) Administrative Support

DOH, LBJTMC, and DHSS shall provide administrative and professional staff support at the Council's request.

(e) Meetings

The Council shall meet at least quarterly. All meetings shall be open to the public.

(f) Leadership

The Director of Health shall serve as Chairperson. The Council shall elect a Vice Chairperson for a two-year term at the first meeting and successive terms are permitted. Vacancies shall be filled at the next scheduled meeting.

Section 4: Council Membership (Federal Compliance)

(a) Compositional Requirements
- (1) Per 42 U.S.C. § 300x-3(c):
  - (i) State employees and providers shall not exceed 50% of membership;
  - (ii) Representatives required from mental health, education, vocational rehabilitation, criminal justice, housing, social services, and Medicaid agencies;
  - (iii) Adults with SMI who receive or received services must be included; and
  - (iv) Parents/family members of children with SED must be adequately represented.

(b) Council Members (21 voting members)
- (1) Government employees and providers (10 members = 47.6 %)
  - (i) Director of Health (or designated senior deputy);
  - (ii) Department of Education, Special Education Division representative;
  - (iii) Office of Vocational Rehabilitation (Director or designee);
  - (iv) Department of Public Safety (Chief of Police or designee);
  - (v) Department of Human and Social Services (Director or designee);
  - (vi) Medicaid Office (Director or designee);
  - (vii) LBJTMC (Chief Medical Officer or behavioral health designee);
  - (viii) Department of Legal Affairs/Office of the Attorney General (Attorney General or designee);
  - (ix) One licensed mental health provider employed by territorial agency or funded non-profit (Governor appointed); and
  - (x) Governor's designated health representative.
- (2) Non-governmental employee and non-providers (11 members = 52.4%)
  - (i) Community and non-governmental providers (4 members):
    - (A) Tautua Samoa Representative
    - (B) Foeoletini Foundation representative
    - (C) Veteran's Affairs Clinic designee
    - (D) Veteran's Affairs VetCenter designee
  - (ii) Adults with SMI (3 members)
    - (A) Three adults with SMI receiving or having received services (Governor-appointed with consumer advocacy organization consultation).
  - (iii) Parents/Family Members of Children with SED (3 members)
    - (A) Three parents/family members of children with SED (Governor-appointed with family advocacy organization consultation).
  - (iv) Ex Officio Legislative Member (1 non-voting advisory member):
    - (A) Chairman, House Committee on Health (or designee).

(c) Appointments and Terms

(1) Agency representatives serve at the pleasure of the appointing authority;
(2) Other members are appointed by the Governor for up to three-year terms and may be reappointed;
(3) Initial appointments shall be staggered: one-third shall serve for one year, one-third for two years, and one-third for three years.
(4) Members serve without compensation or emoluments, and may receive reimbursements for reasonable travel and meeting expenses subject to appropriations.

(d) Vacancies

(1) The Governor shall fill appointed position vacancies within 60 days; replacements serve the remainder of unexpired terms. Agency heads shall replace their representatives.

Section 5: Federal Reporting and Compliance

(a) Annual letter to SAMHSA

The Chairperson shall submit an annual letter to SAMHSA detailing Council activities, MHBG application review, advocacy efforts, and service adequacy evaluation.

(b) Compliance

The Council shall comply with 42 U.S.C. § 300x et. seq. and applicable SAMHSA guidance documents.

(c) Integration with Substance Use Planning

The Council is encouraged to integrate SUPTRS BG planning and review activities and include substance use disorder treatment and recovery community perspectives.

Section 6: Repealer

Executive Order No.: 001-2016 is rescinded and replaced by this Order.

Section 7: Effective Date

This Order shall take effect immediately upon issuance.

Date: 12/23/25

PULAALI'I NIKOLAO PULA
Governor of American Samoa

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 Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Dora Ah Sue	State Employees			
Peni Biukoto	State Employees			
Faiilagi Faiai	State Employees			
Dr. Saipale Fuimaono	State Employees			
Luisa Kuaea	State Employees			
Elizabeth Mailo	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Kathryn McCutchan	Providers			
Mark Mulipola	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Dr. Celestine Nix	State Employees			
Gwendolyn Pu'u	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Adney Reid	Providers			
Henry Roberts	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Andra Samoa	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Herman Scanlan	State Employees			
Ricky Siatunu'u	Individuals in recovery (including adults with SMI who are receiving or have received mental			

	health services)			
Norma Smith	State Employees			
Trude Sunia	Advocates/representatives who are not state employees or providers			
Dr. Mary Taufete'e	State Employees			
Malia Tavai	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Denise Thomsen	Advocates/representatives who are not state employees or providers			
Peka Tofi	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Sarona Vaimauga	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			

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

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Footnotes:

State Mental Health Agency: Dr. Saipale Fuimaono & Dr. Peni Biukoto
State Education Agency: Dr. Mary Taufete'e
State Vocational Rehabilitation Agency: Dora Ah Sue
State Criminal Justice Agency: Dr. Celestine Faumuina-Nix & Faiilagi Faiai
State Social Services and Housing Agency: Norma Smith
State Medicaid Agency: Luisa Kuaea

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	6	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	3	
3. Parents of children with SED	0	
4. Vacancies (individuals and family members)	3	
5. Total individuals in recovery, family members, and parents of children with SED	**12**	**48.00%**
6. State Employees	9	
7. Providers	2	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**11**	**44.00%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	2	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**2**	**8.00%**
16. Total membership (all members of the council)	**25**	

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Footnotes:

The SSA will collaborate with clinicians and mental health treatment providers to identify parents/family members of children with SED. The SSA aims to fill the vacancies before March 1, 2026.

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

Please respond to the following items:

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

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

https://doh.as/

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

https://doh.as/

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

d) Please indicate areas of technical assistance needs related to this section.

The state does not require TA related to this section.

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Footnotes: