

Marshall Islands

UNIFORM APPLICATION

FY 2024/2025 Only Application Behavioral Health Assessment
and Plan

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 12/19/2023 4.10.46 PM)

Center for Mental Health Services

Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State Unique Entity Identification

Unique Entity ID SD96AMWETGC8

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

Agency Name Ministry of Health & Human Services

Organizational Unit Bureau of Human Services

Mailing Address P.O. Box 16, Ministry of Health & Human Services

City Majuro

Zip Code 96960

II. Contact Person for the Grantee of the Block Grant

First Name Francyne W

Last Name Jacklick

Agency Name Ministry of Health & Human Services

Mailing Address P.O. Box 16 Delap Amata Road

City Majuro

Zip Code 96960

Telephone

Fax

Email Address

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? Yes No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date 9/1/2023 11:55:29 PM

Revision Date 12/14/2023 1:26:08 PM

VI. Contact Person Responsible for Application Submission

First Name Stacy

Last Name Anmontha

Telephone 692-456-8456

Fax

Email Address sanmontha@rmihealth.org

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

Footnotes:

State Information

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

Fiscal Year 2024

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 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 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 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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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the 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).

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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: _____

Signature of CEO or Designee¹: _____

Title: _____

Date Signed: _____

mm/dd/yyyy

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

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

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

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 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: Francine Wase-Jackide

Signature of CEO or Designee¹: [Signature]

Title: Acting Secretary

Date Signed: 7-11-23
mm/dd/yyyy

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

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

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

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

Footnotes:



President

REPUBLIC OF THE MARSHALL ISLANDS

February 21, 2022

Tom Coderre
Assistant Secretary
Substance Abuse and Mental Health Services Administration
US Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857


Dear Assistant Secretary Coderre:

This letter authorizes the Secretary of the Ministry of Health and Human Services (MOHHS), to serve as the Governor's Designee and Authorized Signature on Federally Mandated Certificates, Assurances, and Funding Agreements for SAMHSA Federal block and discretionary grant applications for the Marshall Islands, as well as for all existing Federal programs related to the RMI MOHHS.

I entrust members of my Cabinet with the responsibility for program and policy development, performance management, fiscal accountability and compliance with Federal rules and regulations governing Federal funds received to support the delivery of programs and services.

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

Respectfully,


David Kabua
President



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Marshall Islands BSCA Funding Plan 2024

The Republic of the Marshall Islands Behavioral Health team is proposing that the BSCA supplemental fund of \$11,346 is used to enhance the current crisis services for the RMI.

The current RMI situation is that Behavioral Health team is very limited in staff with a total of four nurses rotating shifts 24/7 to assure presence of a staff all the time in our crisis stabilization units as well as our stress ward. The same nurses also do the mobile crisis responses, they do community outreach and follow-up with patients and families, and they run the daily psychiatric out-patient clinics as well.

To provide better support and coverage for our crisis services, the BSCA fund will be used to hire a part-time peer support staff/crisis stabilization unit staff with the wage of \$4.827/hour. Having the extra staff in the team to support our nurses and assist our patients will greatly improve the overall experience of the crisis/in-patient services provided to mental health patients and substance use patients.

The Behavioral health team had a proposed use of the ARPA supplemental fund to hire and train crisis staff to cover all three areas of the crisis team: call center, mobile team, stabilization unit team. It would still be a benefit to have the BSCA bring in at least two support staff to share the work load and at times take the on-call shifts to look after the in-patients and crisis care patients.

Name		Hourly Rate	Annual
#1 Support Staff	Wage	\$4.8275048077	\$10,041.21
	Payroll Taxes	\$0.6273028846	\$1,304.79

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Name		Hourly Rate	Annual
#1 Support Staff	Wage	\$4.34475432692307	
		7	
	Payroll Taxes		\$1,304.79

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To comply with the BSCA acceptable services guidelines, the peer support staff will not be assigned to do in-patient work. The peer support staff will be a member of the crisis mobile team that responds to crisis situations in the community and work with individuals to de-escalate their situation and stabilize them.

For the 10% set-aside for ESMI/FEP, the remaining available fund from the BSCA will be \$1,154.00 and that will be available for the Behavioral health team to use for our EBP Coordinated Specialty Care model to support the Supported Employment program. Individuals with ESMI/FEP who are enrolled in the Supported Employment program are assisted to seek out and do specific types of work that they are good at, or they like to do on a part-time basis as part of the transition/recovery period and they are being compensated at \$100/biweekly or \$200/month basis. How many individuals enrolled in the program and how long they are on Supported Employment depends on the severity of their symptoms, their recovery state, and a work entities willingness to accept them as full-time employees and take over their salaries.

Activity	Hourly Rate	Annual
Peer Support/Crisis Stabilization Unit Staff	\$4.90	\$10,192.00 (tax & health included)
10% Set-aside for ESMI/FEP	10% of \$11,326.60	\$1,154.00
	Total	\$11,346.00

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Activity	Hourly Rate	Annual
Peer Support/Crisis Stabilization Unit Staff	\$4.90	\$10,211.40 (tax & health included)
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A 5% set-aside for ESMI/FEP will be for overtime payment should the need for a nurse be there for emergency cases. Another 5% set-aside for Administration will also be needed should the need arise for an administrator to be involved in emergency situations.

The total proposed and to encumber from this fund for a year will be at \$11,326.60.

Activity	Hourly Rate	Annual
Peer Support/Crisis Stabilization Unit Staff	\$4.90	\$10,192.00 (tax & health included)
5% Crisis Services	5% of \$11,326.60	\$567.30
Administration 5%	5% of \$11,326.60	\$567.30
	Total	\$11,326.60

Marshall Islands BSCA Funding Plan 2024

The Republic of the Marshall Islands Behavioral Health team is proposing that the BSCA supplemental fund of \$11,346 is used to enhance the current crisis services for the RMI.

The current RMI situation is that Behavioral Health team is very limited in staff with a total of four nurses rotating shifts 24/7 to assure presence of a staff all the time in our crisis stabilization units as well as our stress ward. The same nurses also do the mobile crisis responses, they do community outreach and follow-up with patients and families, and they run the daily psychiatric out-patient clinics as well.

To provide better support and coverage for our crisis services, the BSCA fund will be used to hire a part-time peer support staff/crisis stabilization unit staff with the wage of \$4.90/hour with health and tax benefits included. Having the extra staff in the team to support our nurses and assist our patients will greatly improve the overall experience of crisis services provided to mental health patients and substance use patients.

The Behavioral health team had a proposed use of the ARPA supplemental fund to hire and train crisis staff to cover all three areas of the crisis team: call center, mobile team, stabilization unit team. It would still be a benefit to have the BSCA bring in at least two support staff to share the workload and at times take the on-call shifts for crisis care patients.

A 5% set-aside for ESMI/FEP will be for overtime payment should the need for a nurse be there for emergency cases. Another 5% set-aside for Administration will also be needed should the need arise for an administrator to be involved in emergency situations.

The total proposed and to encumber from this fund for a year will be at \$11,326.60.

Activity	Hourly Rate	Annual
Peer Support/Crisis Stabilization Unit Staff	\$4.90	\$10,192.00 (tax & health included)
5% Crisis Services	5% of \$11,326.60	\$567.30
Administration 5%	5% of \$11,326.60	\$567.30
	Total	\$11,326.60

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

Stacy Anmontha

Title

Director

Organization

Human Services Mental Health

Signature:

Date:

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

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

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

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

Footnotes:

Step 1 – Assess the strengths and organizational capacity to address specific populations

The Republic of the Marshall Islands (RMI) is an independent nation which has entered a Compact of Free Association with the United States (US). The US provides funding and access to certain governmental agencies such as the Post Office. Residents of RMI do not have access to Medicaid. The government has a Parliament and a President with Cabinet Members.

The geography of RMI is unique when compared to the continental US. The population of roughly 59,000 people live on 5 islands and 29 atolls covering roughly 70 square miles of land mass and 750,000 square miles of ocean. The largest islands are Majuro and Ebeye which contain approximately 73% of the population. When the third largest atoll Jaliut is added, approximately 85% of the population is covered.

Transportation between Majuro and Ebeye is by plane. The outer atolls connect to Majuro via radio. Assessment is made and interventions recommended. If the person is not better within 72 hours, arrangements are made to transport the person to the hospital in Majuro. There are 58 community health clinics in the 5 atolls. These centers provide a place to connect to the larger islands.

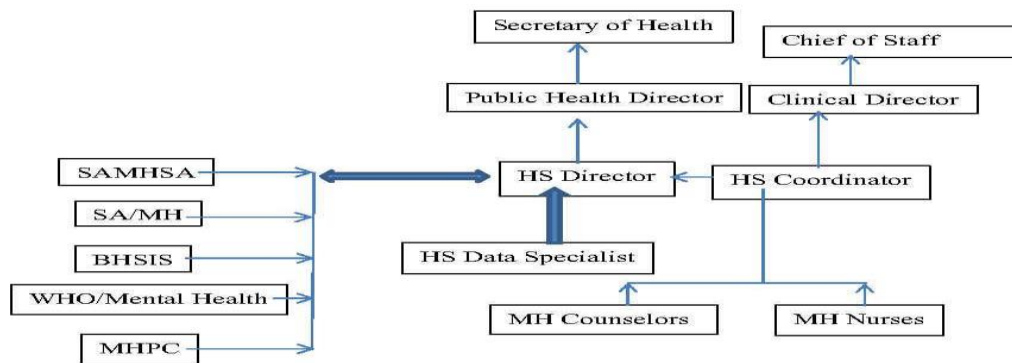
Issues were raised about the expenditure of the Substance Abuse Block Grant (SABG) such that both Mental Health Block Grant (MHBG) and SABG funds have not been accessible since July, 2021. The lack of these federal funds has had a significant negative impact on service delivery.

In the past, the mental health and the substance use programs of the Marshall Islands were under separate management. The Single State Agency (SSA) was under the Ministry of Finance while the mental health program was under the Ministry of Health. Although both programs shared goals and objectives, activities were mostly carried out separately due to minimum coordination and conflict of schedules.

When the block grant funds were frozen, the existing substance use service system was dismantled. The Substance Abuse Office has not existed since December, 2021. The Mental Health Office has provided minimal substance use assessment, intervention, and prevention services within the constraints of limited staff.

The SSA has been transferred to the Ministry of Health. Now the Human Services Office will administer both mental health and substance use services. The Ministry of Health staff do not have access to the previous substance use service records or data. The substance use prevention, treatment, and recovery services system must be completely re-developed with no guidance from prior staff.

2. Organization Structure Chart



The mental health team represents the Human Services Office of the Ministry of Health. The team consists of two physicians (one psychiatrist and one general practitioner), 4 nurses, 1 counselor (currently vacant), 1 data technician, and one managers- in Majuro. The staff on Ebeye consists of one manager and one outreach worker. The counselor position leads the prevention services doing school visits around the two urban atolls and the bigger outer islands especially those with schools or bigger populations. In the past two years, the prevention team joined in on the Ministry's COVID trips to communities and atolls for awareness as well as all atoll trips for vaccinations. It has been a great opportunity to boost mental health education and awareness in most communities and atolls during this pandemic. The mental health prevention team have bee doing most of their public awareness activities on the following topics: mental health and mental illness, major depression and anxiety, suicide prevention, and substance misuse with physical, mental, and social complications.

Number of MH Cases in 2017		
Female	Male	Total
22	45	67

Number of MH Cases by Diagnoses yr 2017	
SCHIZOPHRENIA	30
OTHER PSYCHOTIC DISORDERS	10
Bipolar and Mood Disorders	8
All other Diagnoses	19
No Diagnoses	0
Total	67

Number of Cases in 2022		
Female	Male	Total
80	90	170

Number of MH Cases by Diagnoses yr 2022	
SCHIZOPHRENIA	44
OTHER PSYCHOTIC DISORDERS	5
Bipolar and Mood Disorders	39
All other Diagnoses	34
No Diagnoses	48
Total	170

The mental health team continues to rely on school screenings and school reports/referrals for early detection of psychosis, major depression, and substance misuse. Another means of early detection is the partnership with the well-baby clinic and Pediatrics department for any developmental, behavioral, or emotional disorders. Since November of 2020, major depression and substance use screening have also been incorporated into antenatal and reproductive health clinics. With the mental health team's limited personnel, they trained the Outpatient Department of the hospital (OPD) and the Non-Communicable Disease (NCD) nurses to incorporate depression screening and substance use screening in their respective clinics and refer accordingly. Treatment of mental health conditions as well as substance use related conditions are all under the mental health team. Most mental health cases are treated on an out-patient or community basis with medical therapy of various oral and injectable psychotropics. Some mental health patients take both medical therapy as well as weekly psychotherapy at the mental health clinic provided by the physicians. Severely depressed and suicidal patients, along with substance withdrawal sometimes are treated in the general hospital as in-patients but under the care of the mental health team. Acute treatment of Bipolar patients commonly takes place in the home/community setting. When the symptoms are severe and risks of harm to self or others are imminent, we go through the legal system for temporary detention at the national prison, but with specific rooms separated for mental health patients.

The recovery support system is still almost non-existent for substance recovery support. The mental health counselor provides motivational interviewing and other forms of support therapy. All patients recovering from substance use conditions are also recommended to continue their progress through the AA sessions taking place twice a week at the college of the Marshall Islands. In the recent past, most mental health readmission cases occur when they are returned to their atolls or to communities far from the clinic with little or no support.

The Mental Health Office uses peers to provide support to those receiving services or experiencing symptoms. There are three individuals providing this service. RMI is going to work with SAMHSA to get these individuals training to become Certified Peer Support Specialists.

In the past the substance use service system supported various NGOs, churches, and local governments to do depression screening and substance use screening as well as various prevention services. They also had a number of secondary school counselors and college counselors that did various screenings and sometimes referred to hospital or human services for further care. This system will have to be rebuilt with an emphasis on monitoring the provision of services and data collection. Not all past providers will be considered for substance use services going forward. Prevention services will be organized and contracted according to the six categories and three target groups required by the SUTPRSBG.

When block grant funds are released, it is a big challenge for the Human Services Office with both mental health and substance use finally operational under one administrative unit. A Program Director has been hired to manage administrative activities and to work on the combined block grant application. This position will permit the direct service staff to devote more time to providing services. There are 8 staff working on Majuro in the mental health clinic, and 2 staff in the Ebeye mental health office. Although both offices are open for clinics 8-5 and 5-days a week, most of RMI mental health and substance use treatment and follow-up are done in the community setting. Prevention activities are also primarily done in the communities, schools, and churches. The 58 outer island health centers provide support for the mental health and substance use office through radio communications. Visits are made to the outer atoll on a quarterly basis.

When patients are identified and presented from the outer islands through radio, initial assessments are made, and initial treatments started. When symptoms do not improve in 48-72 hours, the patients are then referred to either Majuro or Ebeye. The two central offices also supply the outer island health clinics psychotropics on a 6-monthly basis based on number of cases registered from each atoll. When patients are identified in the health centers within the two major atolls but far from the hospitals, the health centers call in for case presentation, discussion, assessment, and a management plan but the team routinely travels out all to all cases within Majuro and Ebeye on a weekly basis.

One of the most troubling and ongoing issues with the service system is the response to behavioral health, suicidal, and mental health crisis situations. Too frequently mental health crisis situations are taken into the ER which adds to the load of the department. Other times, these individuals in mental health crisis are taken to the national or local prisons and are kept without proper medical evaluations or care. The mental health team partners with the International Organization for Migration (IOM) as trainers of Psychological First Aid which has been the most consistent tool for community psychosocial support especially during this pandemic period. The mental health team partners with the NGOs Marshall Islands Epidemiology and Prevention Initiative (MIEPI) and Waan Ailong in Majuro (WAM) as the certified Mental Health First Aid trainers around the country. The aim is to train and certify as many people as possible in workplaces, schools, churches, and communities to understand mental health better, to be able to recognize mental health symptoms, to provide evidence-based support, and to refer those that need specialized care to our clinics. In the past three years, this is probably the most effective means of referring patients to the mental health and substance use clinics. The mental health team partners up with the College of Marshall Islands and University of South Pacific providing a direct

referral pathway for staff and students to the mental health clinic. Furthermore, this partnership provides opportunities for our office to do mental health and substance use related workshops, trainings, and presentations with students. This partnership has provided a strong support system for the office during public awareness activities especially world suicide prevention day and world mental health day. The mental health office also collaborates with the National Police, the Micronesian Legal Services, and the NGO Women United Together Marshall Islands (WUTMI) out to create a national Gender Based Violence (GBV) operational procedures for clinical care and referral pathway. As the uniform response shows sensitivity to the survivors' situations and respect for their autonomy, more survivors are expected to speak out and collectively more perpetrators rightfully placed where they belong. The mental health program recently established a partnership with the Majuro Local Government for collaboration and cooperation to hire community members as community mental health workers and for them to provide the program full support for community mental health activities in the near future. It is important to note here that mental health and substance use activities and approach to adults and teens are the same in RMI. For developmental disorders, behavioral disorders, and severe emotional disorders in children, the mental health teamwork with the Pediatrics team to complete a comprehensive medical and mental evaluation, make assessment, and refer to the Public School System (PSS) for their child and family support. There are over 120 teachers trained to work with children with special needs and they are assigned to schools based on the reports and referrals made by the mental health team.

In February, 2023, RMI was able to open a four bed crisis stabilization unit with the hospital for non-hospital stabilization. This unit is staffed by the same mental health staff in the Majoro office, creating even more demands on them. The four nurses rotate 12 hour shifts while also providing outpatient services when not on duty in the new unit. The new unit is in a separate building from the hospital. There are two beds for crisis stabilization and two beds for a Stress Ward. Under the Mental Health Act, only the Clinical Director can approve admissions. Admissions follow the Center for Disease Control guidelines of any one, any where, any time. Individuals who present must be evaluated in person with 24 hours of entry. Individuals with less severe symptoms may stay less than 24 hours. Those who are more seriously ill may have a length of stay up to three months.

In terms of the mental health team and vulnerable groups in the society, it is surprising that nearly half of the people using the mental health services are ethnic and racial minorities like Americans, Chinese, Fijians, Philippines, Indians, and other Asian races. The mental health program and its activities have been especially beneficial for women and for young people that culturally cannot share their feelings, their pains, or their experiences. The program improves their understanding of human rights, mental health and risk factors, and support programs and staff for safety and protection.

The focus is on individuals who are seriously mentally ill or severely emotionally disturbed in both the crisis unit and in outpatient services. There is no specialized service for individuals who are sexual/gender minorities. Language barriers are not an issue in general since most everyone speaks Marshallese or English. The school system is used when interpreters are needed for individuals who are deaf or hard of hearing.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System (URS)**, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

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

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

Footnotes:

Planning Steps

Step 2. Identify the current services needs and critical gaps within the current system.

The Republic of Marshall Islands has a significant challenge to improve its system of mental health and substance use services. The inability to access SAMHSA block grant funds since July 2021, rendered the service delivery system non-functional for substance use services and severely limited for mental health services. Despite the loss of federal funds, routine mental health services have been maintained at a minimal level. RMI was able to start a crisis stabilization unit and hire a Program Director which were both critical needs. Once block grant funds are released, RMI will be better positioned to quickly build upon the existing base while also assuring that funds are expended in a manner that will not result in further audit exceptions.

Improving the administrative infrastructure to support service delivery and monitoring is the first step in moving forward. Additional administrative staff and data management staff are needed to provide the needed service support, assessment, and monitoring. Data reporting continues to be a weakness that will require a data manager and additional equipment and staff training. An assessment of federal reporting requirements as well as what management needs to know is the first step to improving data collection and reporting. Once the needed data elements are identified, the process of collecting them can be established.

Additional direct service and prevention staff are needed to better meet the needs of the target population. Additional nurses need to be added at the Crisis Stabilization Unit to insure 24/7 coverage without staff having to work double shifts. To better meet the needs of those in crisis, a mobile crisis team is needed. It is estimated that a coordinator and 8 staff will be needed to meet the needs on the two major islands. Additional equipment may be needed to facilitate communication with the outer islands/atolls.

Master's level staff are needed to provide direct treatment services for both mental health and substance use. It has been challenging to keep credentialed staff on the islands because the pay is not competitive with what can be earned elsewhere. The salary scale may need to be adjusted to attract and retain credentialed staff to stay in RMI.

The substance use service system needs to be rebuilt. Prevention staff and recovery staff need to be hired and trained. Individuals who have advanced degrees as well as technicians are needed to provide treatment services. Training will be needed for all staff. Medication Assisted Treatment needs to be initiated which will require staff and purchase of medication.

Service delivery in the outlying areas of RMI remains an area of need. More follow-up and on-site service delivery needs to be developed. Since airplane travel is the

most efficient way to get between the islands and atolls, more funding is needed for that. In addition, more peers and outreach workers located in the smaller population areas are needed to provide referrals to service as well as to monitor people returning from more intensive levels of services. Additionally, internet services in the outlying areas can be used for telehealth services making more frequent direct contact with patients in the outer areas possible. Additional iPads or computers will be needed to support this effort.

The public messaging for mental health and substance use awareness and substance use prevention should be updated with more reliance on social media.

The top priorities are to add additional administrative staff to support hiring staff and developing both direct and prevention services. Additional staff are needed for the Crisis Stabilization Unit, for crisis services, and for substance use services of all types. Once staff are hired, they must be trained and supervised appropriately. More managers and supervisors will be needed to assure that services are delivered and documented in an acceptable manner.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Community Mental Health Services
Priority Type: SUP, SUR, MHS, ESMI, BHCS
Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, TB

Goal of the priority area:

Have 50% of community population to visit center and hear about mental health and substance use information within the first year

Strategies to attain the goal:

1. Increase number of community members attending to trainings and workshops
2. Hiring of community members as mental health community workers
3. Number of children and adults visiting the community centers
4. Partnership with other agencies, NGOs, and community leaders in community activities
5. Visits to schools and faith based groups

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Patients served by the mental health department
Baseline Measurement: 50
First-year target/outcome measurement: 25
Second-year target/outcome measurement: 25

Data Source:

Referrals, walk-in,

Description of Data:

Number of patients referred to the clinic from the outer-islands, relatives, hospital, or walk-in patients.

Data issues/caveats that affect outcome measures:

Transportation from the neighboring islands, denial, or refusal

Indicator #: 2
Indicator: Patients served by the mental health department
Baseline Measurement: 50
First-year target/outcome measurement: 25
Second-year target/outcome measurement: 25

Data Source:

walk in patient log sheet
 community outreach
 counseling therapy

Description of Data:

Patient family history
 Diagnose

Data issues/caveats that affect outcome measures:

lack of history report

Priority #: 2
Priority Area: Mental Health Crisis Response Services
Priority Type: SUT, MHS, ESMI, BHCS
Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Provide adequate crisis response and care for individuals with serious mental health and/or substance use crisis or any community member struggling with an acute behavioral health crisis including suicidal and homicidal ideations.

Strategies to attain the goal:

1. Partnership with Police
2. Collaboration with ER and Police on crisis responses
3. Mass education and awareness on crisis services for any behavioral health crisis situations
4. Hire community mental health workers as (CHW)
5. Hire Crisis staff to be first responders to all behavioral health crisis in communities

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Clinical response
Baseline Measurement: 30
First-year target/outcome measurement: 15
Second-year target/outcome measurement: 15

Data Source:

Referrals, admittance, or reported.

Description of Data:

Patients admitted in the holding unit either referred by doctors, relatives, or the public safety department.

Data issues/caveats that affect outcome measures:

Transportation to and from neighboring islands. Lack of holding facility in the neighboring islands.

Priority #: 3
Priority Area: Increase mental health and substance use partnerships
Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS
Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP

Goal of the priority area:

Train and certify 100 community members in psychological first aid and 100 community members in mental health first aid by the end of the calendar year.

Strategies to attain the goal:

- a. Continue quarterly and annual increase number of people certified with psychological first-aid
- b. Continue quarterly and annual increase number of people certified with mental health first-aid
- c. Increase number of patients using the services of GBV/Child Rights between internal affairs, communities, and MOHHS

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Community-Base Collaboration
Baseline Measurement: 6
First-year target/outcome measurement: 3
Second-year target/outcome measurement: 3

Data Source:

MOUs, community and schools' attendance and participation, contributions/donations from private and public sectors, and families/friends.

Description of Data:

Memorandum of understanding with entities, program events by community and schools' attendance and participation, contributions or donations received from the businesses, NGOs, or government sectors, and families/friends

Data issues/caveats that affect outcome measures:

Lack of support for engaging activities from administration, some community members, or others

Priority #: 4
Priority Area: Empower youth for mental awareness and mental wellness
Priority Type: SUP, MHS, ESMI, BHCS
Population(s): SMI, SED, ESMI, BHCS, PP

Goal of the priority area:

Better self-care, mental health literacy, substance use awareness and positive decision making of the youth and teens.

Strategies to attain the goal:

- a. Get MOU with 3-4 private schools to pilot SMHART Club
- b. Work with MIEPI and IOM for training opportunities for Youth MHFA trainers certification program
- c. Plan and integrate mental health annual summer camps
- d. Create National Youth mental health council/congress

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Outreach Activities
Baseline Measurement: 150
First-year target/outcome measurement: 75
Second-year target/outcome measurement: 75

Data Source:

Student attendees

Description of Data:

Students attendance in outreach programs or department events

Data issues/caveats that affect outcome measures:

Weather, communications, scheduling, consents, and conflicts/interferences

Indicator #: 2

Indicator: Youth reached by the mental health department

Baseline Measurement: 150

First-year target/outcome measurement: 75

Second-year target/outcome measurement: 75

Data Source:

Presentation log sheets, community and schools attendance sign in

Description of Data:

Log sheets for participants in campaign

Data issues/caveats that affect outcome measures:

Scheduling, power outages, weather and etc

Priority #: 5

Priority Area: Early identification and treatment for serious mental illnesses

Priority Type: SUT, MHS, ESMI, BHCS

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

Goal of the priority area:

Every newly registered patient with serious mental illness will be reported, referred, presented to the mental health team within 6 months of onset of symptoms.

Strategies to attain the goal:

1. At least 2 trainings/workshops for PFA and MHFA in one year at community level
2. School visits with education on signs and symptoms of ESMI
3. Community cooperation plans of referral in confidential manner
4. House to house community mental health workers survey on mental health and substance use in each house hold

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Assessment, identification, and treatment of serious mental illnesses

Baseline Measurement: 30

First-year target/outcome measurement: 15

Second-year target/outcome measurement: 15

Data Source:

Walk in patients and referred patient

Description of Data:

reports and records of patents disaggregated by gender, age , and illness

Data issues/caveats that affect outcome measures:

Refusals, Denials, Unreported, Stigma, Culture Shyness and etc

Indicator #: 2

Indicator: Assessment, identification, and treatment of serious mental illnesses

Baseline Measurement: 50

First-year target/outcome measurement: 25

Second-year target/outcome measurement: 25

Data Source:

walk-ins, referred, admitted, or reported cases.

Description of Data:

The identification and treatment of patients with serious mental illnesses done after assessment. Cases account for walk-ins, referrals, or admittance.

Data issues/caveats that affect outcome measures:

Challenges occur due to unreported cases or patients, denial by patient or relatives.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

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

Planning Period Start Date: 9/30/2023 Planning Period End Date: 9/29/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG) ^a	I. COVID-19 Relief Funds (SUPTRS BG)	J. ARP Funds (MHBG) ^b	K. BSCA Funds (MHBG) ^c
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention ^d										\$0.00	
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG) ^e		\$150,000.00		\$35,000.00	\$10,500.00		\$24,182.30		\$80,462.30	\$1,154.00	
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital					\$15,000.00						
8. Other 24-Hour Care		\$151,104.00								\$55,000.00	
9. Ambulatory/Community Non-24 Hour Care		\$110,000.00		\$152,050.00			\$205,549.55		\$50,000.00		
10. Crisis Services (5 percent set-aside) ^f		\$150,000.00		\$17,500.00			\$12,091.15		\$211,347.00	\$10,192.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately ^g		\$29,532.00		\$145,450.00					\$20,884.70		
12. Total	\$0.00	\$590,636.00	\$0.00	\$350,000.00	\$25,500.00	\$0.00	\$0.00	\$241,823.00	\$0.00	\$417,694.00	\$11,346.00

^aThe 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

^bThe expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

^dWhile the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

^eColumn 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

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

^gPer statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:

For the ARPA, there is a \$11,347 set aside for prevention. Not a general/public type of prevention but essential training for crisis first responders and a planned national launching of the Crisis services with key national leaders and partners as the program need better advocacy and promotion of the program and its services. In terms of the training, the program is planning to have two major trainings carried out. One training for all new employed crisis staff, and a second training for crisis response/de-escalation and referral coordination amongst emergency medical team (medical crisis team), national and local police (legal crisis team), and the behavioral health crisis team (behavioral crisis team).

Planning Tables

Table 6 Non-Direct Services/System Development

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

MHBG Planning Period Start Date: 09/30/2023 MHBG Planning Period End Date: 09/29/2025

Activity	FY 2024 Block Grant	FY 2024 ¹ COVID Funds	FY 2024 ² ARP Funds	FY 2024 ³ BSCA Funds	FY 2025 Block Grant	FY 2025 ¹ COVID Funds	FY 2025 ² ARP Funds	FY 2025 ³ BSCA Funds
1. Information Systems	\$5,000.00				\$5,000.00			
2. Infrastructure Support	\$20,000.00				\$20,000.00			
3. Partnerships, community outreach, and needs assessment	\$40,000.00				\$40,000.00			
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	\$30,000.00				\$30,000.00			
5. Quality Assurance and Improvement	\$20,000.00				\$20,000.00			
6. Research and Evaluation	\$10,000.00				\$10,000.00			
7. Training and Education	\$10,000.00			\$11,346.00	\$10,000.00			\$11,346.00
8. Total	\$135,000.00	\$0.00	\$0.00	\$11,346.00	\$135,000.00	\$0.00	\$0.00	\$11,346.00

¹ The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

² The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

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

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

¹Druss, 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. Available at: https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:
 - a) Adults with serious mental illness
 - b) Pregnant women with substance use disorders
 - c) Women with substance use disorders who have dependent children
 - d) Persons who inject drugs
 - e) Persons with substance use disorders who have, or are at risk for, HIV or TB
 - f) Persons with substance use disorders in the justice system
 - g) Persons using substances who are at risk for overdose or suicide
 - h) Other adults with substance use disorders
 - i) Children and youth with serious emotional disturbances or substance use disorders
 - j) Individuals with co-occurring mental and substance use disorders

a) Everyone, including adults with serious mental illness have easy access to mental health services. Adults with serious mental illnesses are commonly brought to the clinic by friends and families. Aside from the psychiatric clinic used for assessing patients, the ward serves as a care and treatment unit for patients with substance use disorders. The availability of transportation or access to also improves services when patients are reached through outreach visits.

Provide transportation and outreach increase to access services

b) Women with substances use disorders are admitted for counseling and rehabilitation. Pregnant women are screened at the antenatal clinic for substance use disorders and referral to the mental health and substance use is made accordingly. Even pregnant women who are not booked are being followed up in the communities by the community workers to be screened for both mental health and substance use symptoms and referred to the clinic.

c) The program works closely with the WUTMI, a women organization supporting wellness of women and their families. The counselors of the WUTMI do the substance use and mental health screenings with their women and bring them for professional care when needed.

d) Persons using substance who are at risk for overdose or suicide are counselled, monitored, and provided a rehabilitation plan. Outpatient medication management and psychotherapy are also presented. Currently, the RMI has no record of any injectable drugs and so this is not a practice locally, but education to students and substance users include the various complications associated with injectable drugs.

e) For all persons with a mental health or substance use disorder diagnosed, there is a systematic work-up that includes ruling out NCD, HIV and other STI, TB, Leprosy. In a similar manner, the HIV and TB programs do regularly do substance use and depression screening on their patients and refer them for mental health care, the Behavioral health program also send all mental and substance use patients for screening of infections as well as non-communicable diseases.

f) The Behavioral health program have an agreement with the legal system whereby the court authorizes the mental health team to visit, screen, and treat any individuals within the correction system that needs it. Currently, the team rely on lawyers and police officers to request for Behavioral health evaluations when they notice behaviors in their work place with the inmates.

g) Information sharing on the new facility has been circulated through social media, newspaper, radio announcements that it is a quiet and safe place for people that needs help to recover from substance use related disorders.

h) Patients using substances and are at risk for overdose or suicide are guided, screened, provided intervention, and monitored regularly.

i) Children and youth with serious emotional disturbances or substance use disorders are brought in for counseling and psychotherapy. Mitigation plan is then set to assist in recovery.

j) People with co-occurring mental and substances use disorders are often treated with talking therapies, or cognitive behavioral therapy. Here, the doctors and nurses help patients cope with and treat their own problems.

The execution of outreach plans to educate and screen in the schools and communities is ongoing. Currently the number of staff is lacking and the load is overwhelming for the mental health department to do both prevention and treatment services.

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

The mental health program still provides all treatment to patients free of charge. Initially it was psychotropic treatments that were free of charge, but currently all medical conditions with co-morbid mental health or substance use conditions are provided treatments for free.

In addition, the mental health program provides the supported employment to individuals with severe mental health conditions to mitigate the financial difficulties.

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

- a) Access to behavioral health care facilitated through primary care providers
- b) Efforts to improve behavioral health care provided by primary care providers
- c) Efforts to integrate primary care into behavioral health settings

At the state level, interdepartmental referrals are common for people with co-morbidity. Mental health and substance use cases are frequently referred to Noncommunicable diseases and reproductive health for routine checks and for co-morbid conditions.

At the community level, our health centers staff are combining screening and treatment of various NCD, mental and substance use disorders, and reproductive and sexual health screenings/testing/treatment. Diabetic wound care and mental health staff still travel throughout the communities for their specialized services on a regular basis.

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

- a) Adults with serious mental illness
- b) Adults with substance use disorders
- c) Children and youth with serious emotional disturbances or substance use disorders

.a) adults with serious mental health – The mental health department continues to provide treatment to patient without charge. Services ranging from psychotropic treatment, counseling, outreach programs, to rehabilitation services are all free of charge. The care coordination in adults with serious mental health also goes through other medical areas when needed. Adults with serious

mental health issues are cared for in all areas and with all caretakers whose goal is to achieve effective and improved care for patients.

b) Adults with substance use disorders – whether walk-in or referred, patients with substance use disorders are observed, counseled, and treated based on assessment results. With team effort, mental health staff are able to coordinate, care for, and treat patients. All roles are deliberately carried out to effectively care for patients. As the center of care, the mental health unit coordinates and collaborates with all stakeholders responsible for the patient. Family, community, and management care all contribute to a patient’s access to health-care.

c) The prevention of serious emotional disturbances or substance use disorders in children or youth is utmost important. Outreach programs in the schools and communities not only mitigate financial difficulties due to high cost of treatment but also prevents disturbances and disorders to begin with. Through care coordination, professionals in other medical areas also participate in the patient’s care. Doctors, parents, school teachers, to principals, and even community members, we are all health care providers. Care is coordinated through many entities for the person of providing patients with safer and more effective care and the most important of all is what we should have begin with, and that is through education.

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

The mental health program provides psychotherapy treatment through means of counseling and interactions with patients with co-occurring mental and substances use disorders. Psychotropic medication is also presented to such patients to help stabilize moods. Patients with co-occurring disorders have a high chance in recovery. For the integration of services for both mental health and substance use, the RMI transferred the SSA office and all its duties and responsibilities under our Behavioral health office. The clinical doctor makes sure all nurses and staff do both mental health and substance use screening for all individuals that seek assistance. When treatment plans are developed, they have components for both mental health as well as substance use needs. For preventive services, public education and awareness activities are done with both topics presented as equal importance. The high prevalence of suicide and domestic violence in RMI are strong indicators of the association between mental health symptoms and substance use related problems.

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

The technical assistance needed in this area range from personnel to skills. From time to time the department finds itself understaffed, especially when all services are booked with staff spreading thin over outreach visits and handling and caring of patients. Sometimes the staff finds itself overwhelmed with different aspects of the work. Volunteers that step forward to assist in overwhelming situations and although it is a blessing, the department often find itself shorthanded due to the lack of skills and training required from volunteers.

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Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)¹, [Healthy People, 2030](#)², [National Stakeholder Strategy for Achieving Health Equity](#)³, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the [Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care](#) (CLAS)⁴.

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁵. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁶. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

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

² <https://health.gov/healthypeople>

³ <https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf>

⁴ <https://thinkculturalhealth.hhs.gov/>

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

⁶ <https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf>

Please respond to the following items:

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

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

- 2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? Yes No
- 3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? Yes No
- 4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? Yes No
- 5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? Yes No
- 6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? Yes No

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

Access to mental health services is most difficult for the Marshallese in distant villages or atolls. When the program travels to these distant communities, the attention and interest are only noticed when the native speakers communicate. Informative materials need to be all translated into Marshallese and Chinese as these two specific populations are big and they have a common low level of english literacy.

Please indicate areas of technical assistance needed related to this section

Visual and auditory informative materials in mental health and substance use should be available in at least three languages: english, marshallese, and chinese. Need to search locally for current translation services and fees for the services.

The mental health program will review monthly and annual reports to include the various identified factors in our reporting to better understand the differences/disparity in access by different vulnerable groups.

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Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The [National Center of Excellence for Integrated Health Solutions](#)¹ offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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

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

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General², The New Freedom Commission on Mental Health³, the IOM, NQF, and the [Interdepartmental Serious Mental Illness Coordinating Committee](#) (ISMICC)⁴.

One activity of the EBPRC⁵ was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶ SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series ([TIPS](#))⁷ are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation ([KIT](#))⁸ was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

¹ <https://www.thenationalcouncil.org/program/center-of-excellence/>

² United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

³ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

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

⁵ <https://www.samhsa.gov/ebp-resource-center/about>

⁶ <http://psychiatryonline.org/>

⁷ <http://store.samhsa.gov>

⁸ <https://store.samhsa.gov/?f%5B0%5D=series%3A5558>

Please respond to the following items:

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

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

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

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

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

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

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Psychotherapy	1
Family Support & Family Education	2
Medical Management	3
Supported Employment	2
Case Managers	1

Supported Education	1
---------------------	---

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

FY2024	FY2025
29532	29532

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

-Although there is no Medicaid program in the RMI, the current services for ESMI/FEP clients is free of charge. All employees in both the public and private sector contribute health tax fees that pays for a medical checkup, thus enabling all other patients to pay a minimum \$5 charge for each visit. All services for mental health patients are free

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

1. Medication management: We do have both typical and atypical antipsychotics, we have SSRI for depression and anxiety, and we provide sodium valporate or Lithium for mood stabilizers.
2. Individual and family Psychoeducation, as part of our recovery and patient oriented services, we teach patients and families of symptoms and signs to be aware of and steps to be taken when noticed.
3. Supported Employment, where individuals with ESMI are provided the opportunity to do some work that they feel they can do to help them build that independence and self-confidence as contributors to the family and society.
4. Individual and group cognitive-behavioral therapy has been a big emphasis of the program involving different staff members in the plan and recovery of the patients with ESMI.

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

Yes No

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

Yes No

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

1. Medication management: We do have both typical and atypical antipsychotics, we have SSRI for depression and anxiety, and we provide sodium valporate or Lithium for mood stabilizers.
2. Individual and family Psychoeducation, as part of our recovery and patient oriented services, we teach patients and families of symptoms and signs to be aware of and steps to be taken when noticed.
3. Supported Employment, where individuals with ESMI are provided the opportunity to do some work that they feel they can do to help them build that independence and self-confidence as contributors to the family and society.
4. Individual and group cognitive-behavioral therapy has been a big emphasis of the program involving different staff members in the plan and recovery of the patients with ESMI.

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

The Human Services is gearing up for a social movement of the mental health program where we establish community centers with hired community mental health workers. The community centers will have psychoeducation on ESMI, workshops on mental health community support, and community mapping for support services.

The program also intends to start our Crisis Intervention services which is a first responders appropriate response to people with ESMI and support to avoid ESMI patients being taken to jail and to ER.

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

1. Acute Psychotic Disorder
2. Acute Bipolar Affective Disorder Type I and II
3. Major Depressive Disorder with Psychosis
4. Schizophreniform
5. Schizophrenia

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

The RMI has a new flow of patient encounters since the covid-pandemic. The program was previously having 5-8 newly registered mental health patients in a month. However, since 2020, the program receives 20-30 new registered cases a month. In this number, roughly a quarter or 25% of them are seen as ESMI or FEP, although most of the time it is much less than that 25%. With that said, the Marshall islands roughly has an incidence of 30-45 ESMI/FEP per year.

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

For outreach activities and planning in the RMI which will engage with those with FEP, a number of action plans are in place.

1. The program hired and trained community mental health workers who will do home visits to support the individuals and families with FEP/ESMI. The community workers are encouraged to build that friendship with those clients and to partner with them and their families when carrying out any community workshops/trainings/seminar. The community workers are also trained to do screening for any of the serious mental illnesses and to properly provide information and refer patients.
2. The program started the planning process with student government leaders in all the high schools involving 50-60 junior and senior class officers of all the high schools to plan out a SMART (Student Mental health Awareness and Resiliency Teens) program. In each school, the SMART club will have regular weekly after school information sharing, mental health research, and awareness/promotion activities for the entire school. The plan is to hire mental health staff as school mental health leads who work with the clubs and coordinate with the program on resources and information.
3. The program also looks to enhance the partnership with NGOs especially the mental health coalition to continue their MHFA trainings in the communities. We feel that the more people become certified and able to recognize and identify FEP/ESMI, the earlier we can intervene, connect with them, and provide other EBP support.
4. The program is looking forward to hiring and training crisis staff to man three areas: crisis call center, crisis mobile team, and crisis stabilization center. The plan is to have those who have experienced FEP/ESMI as peer support staff assisting mainly at the stabilization unit as well as the mobile team.
5. The program's nurses continue to do outreach to patients and families and stepping up by taking part in other program outreach activities. For instance, when TB or Covid teams travel to various atolls or villages, the mental health nurses join their teams to add the mental health support/information sharing/screening and education for the patients of the other programs.

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

The RMI Human Services team will continue to need guidance and updates on EBP for care of ESMI and potential new interventions. Secondly, we may benefit from assistance on data collection lessons.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

The Person Centered Planning initiative was introduced and discussed in one of the mental health department's meetings. This concept, although has never been developed in writing, like in an acronym, has always been practice. A well written plan will be produced by the department toward a PCP to better help empower patients to help them help themselves.

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

1. Consumers with serious and severe mental health conditions are required to have someone of their trust to join them with the mental health team or health teams when making health plans/decisions. Especially to improve how the team respond to a relapse of serious symptoms/disorder, the PCP is useful and also guides our counselor and nurses on the support provided during recovery.

2. It is mandatory for individuals under 18 and for persons of severe mental health conditions, but everybody else is also informed of the PCP and its purposes and uses.

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

With the current understanding and concept of "recovery", the mental health program has introduced the PCP to all our clients and all known cases of Schizophrenia and Bipolar have been invited to come in with a friend, a trusted relative, a partner, or more of people they trust. When a plan is created using the information of consumers and the support team, the PCP remains in the file which assists the nurses and counselors and hopefully our future social workers on how to successfully support the consumers in their recovery process.

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

The methods in use to encourage people who use the public mental health system to develop Psychiatric Advance Directives include passport, hospitalization, counseling, community support and self help plan

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

Family support, community support and collaboration, staff development training on mental health or psychological issues or crisis management, skills expert trainers in areas such as gardening, coaching, housing program, awareness, campaigns, medical and dental services and etc.

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6. Program Integrity - Required

Narrative Question

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

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

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

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

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? Yes No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? Yes No

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

There have been times whereby the program proposed activities and expenses but the financial director within the ministry or the public health deputy secretary called the team is to clarify the restrictions of the block grants.

We have also requested SAMHSA to include our ministry finance director in people accessing our grants so that she can periodically review and monitor our funds.

Please indicate areas of technical assistance needed related to this section

he ministry is willing to provide us two separate directors, for mental health and for substance use disorders. The two directors have a management team of about 4 coordinators. The two directors get their reports/plans through the program medical advisor/director. When these positions are filled and they are oriented to their duties, we need the management team to go through a training of SAMHSA grants reports, planning, and financial and managerial skills and protocols.

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7. Tribes - Requested

Narrative Question

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

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

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

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

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

Please respond to the following items:

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

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

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Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

RMI has a traditional system where the family is responsible for their loved ones with mental health/substance use conditions. That has been the primary traditional system that assist our mental health work. The mental health team relies on: 1) weekly community outreach services where they follow-up all patients in their communities and talk with them along with families 2) The team gives information and recommendations to health centers for nurse practitioners and community nurses to routinely follow-up and monitor 3) The team also partners with local police officers who report or refer cases when first noticed symptoms or behaviors in the community.

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

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

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

The mental health services provides the mental, substance misuse and employment services for consumers. Physical, medical, and dental services have twice a year referrals or as needed to the main hospital except for NCD co-morbid consumers go for monthly follow-ups.

The primary concern with chronic and severe mental health patients is the fact that a number of them do not have a home to go to. They have poor hygiene and not adequate and not nutritious diets and no monitoring of their substance use.

3. Describe your state's case management services

The RMI has no functional social services and no case managers. However, the function is closely similar to the range of duties that the mental health nurses provide the consumers. The nurses work with our serious mental health patients to get state ID cards, registration at the GED or college, application forms at worksites that they prefer, and legal documents required for other purposes.

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

The mental health team do regular outreach follow-up visits for mental status examinations and monitoring of medications and

compliance. When early symptoms of relapse are noted, adjusted treatment plans are implemented to prevent/mitigate full-blown relapse.

In hospital settings, the family and trusted friends are included in the management team to assure support and to assist with medication monitoring and supervision.

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

we need TA for social media

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

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

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	89%	0.00085
2.Children with SED	11%	0.0001

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.

Our state calculates the prevalence rate by simply taking the total number of Adults with SMI and dividing it with the total sample size, as we do with the prevalence rate for the Children with SED. For the Incidence rate we calculate these rates by taking the total number of cases with SMI and SED and dividing them with the total population of the state which is 40,000. For now, we don't use the prevalence and the incidence rate for planning purposes. However, we are building capacity to have better use of these rates. We are hoping that in the future we will be utilizing these rates to make plans and decisions to improve our services and to continue to provide quality care.

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

Need TA on how to use these data to paint a picture or to show how we can use these raw data to make plans and decisions that will be beneficial to our work and to the state.

Criterion 3: Children's Services

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

Criterion 3

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

- a) Social Services Yes No
- b) Educational services, including services provided under IDEA Yes No
- c) Juvenile justice services Yes No
- d) Substance misuse 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

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

Staff development training on social work

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

https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

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

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

Criterion 4

- a. Describe your state's targeted services to rural population. [See SAMHSA's Rural Behavioral Health page for program resources](#)

The RMI's targeted services for the rural population mainly emphasizes on education and healthcare services, that are either free or less costly. Other targeted services include safety and well-being and housing programs.

- b. Describe your state's targeted services to people experiencing homelessness. [See SAMHSA's Homeless Programs and Resources for program resources](#)

There is no such service in existence since the culture tends to play an important part of people's lives where everyone takes care of others as extended families play an important role in taking care of each other.

- c. Describe your state's targeted services to the older adult population. [See SAMHSA's Resources for Older Adults webpage for resources.](#)

With respect to our elders, the state passed a resolution for senior discounts in the retails. Housing programs also allow elders ages 62+ eligibility for a \$10k fund for home improvement.

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

Criterion 5: Management Systems

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

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

Criterion 5**a.** Describe your state's management systems.

The RMI has several ministries that operate differently. The Ministry of Finance, for instance, is charged for budget oversight. All other ministries requesting funds will need to go through this entity. Although the Ministry of Health and Human Services has a human resource office, the Public Service Commission is responsible for hiring staff. Training and staff development is solely up to each department or ministry responsible. In any mental health service trainings, the MOHHS is the most qualified to assist in providing or training such service providers. In the current management, the program director reports to the Deputy Secretary of public health, as the Human Services is a department under public health. The clinical director reports to the chief of staff, director of clinical services. The coordinator and nurses report to the director and a clinical doctor stationed there.

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

Communications via the phone, VHF radios, and internet are all sort of telehealth tools used to communicate with and assist mental health responders throughout the RMI, most especially in the neighboring atolls/islands. Since the 1980s, telehealth has been a vital aspect of the RMI. With the geographical set-up of over 100 islands separated by oceans, the people and the government used radio to communicate with each other especially with urgent health issues. Currently, the behavioral health team aims at acquiring laptops and tablets as means of telehealth to better connect with people with mental health crisis and substance use needs.

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

The use of technology can be a challenge. The department will indeed need technical assistance on the use of advanced tools or applications that will ensure better services. Advice and support will also be a need especially in an ever-changing environment like the mental health where you work with different but special entities.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023?

Yes No

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

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12. Trauma - Requested

Narrative Question

Trauma¹ is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services. It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma² paper.

¹ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

² *Ibid*

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

1. Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues? Yes No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? Yes No
3. Does the state provide training on trauma-specific treatment and interventions for M/SUD providers? Yes No
4. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? Yes No
5. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? Yes No
6. Does the state use an evidence-based intervention to treat trauma? Yes No
7. Does the state have any activities related to this section that you would like to highlight.

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

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

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

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

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

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

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

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

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

Please respond to the following items

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

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

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? Yes No
If so, please describe.

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? Yes No

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

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

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.

CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:

- *Crisis call centers*
- *24/7 mobile crisis services*
- *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*

STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed [Crisis Services: Meeting Needs, Saving Lives](#), which includes "[National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit](#)" as well as an [Advisory: Peer Support Services in Crisis Care](#) and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "[National Guidelines for Child and Youth Behavioral Health Crisis Care](#)" which offers best 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 this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

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

The RMI has a Behavioral Health Crisis care as part of the Behavioral health program's policy. The two doctors and 4 nurses are all part of the crisis mobile team. In the past, the crisis response and services were all through the legal system whereby people call police, police respond to the scene, take patients into the prison, then call Behavioral health staff to assess before they visit to court for justifications of patients being put in the prison cells.

Since February of 2023, the Behavioral health program in the ministry of health opens up its crisis holding units and submitted amendments to the public health and safety act to ensure that patients/individuals in crisis are properly taken care of and supported with their rights and dignity in place. The amendment also provided for the program when involuntary assessment and involuntary admission and involuntary treatment is essential for safety of patients and the public. People in the state can dial 988 for any behavioral health crisis and the on-call nurse and on-call doctor will be the crisis call center staff receiving the information and communicating with individuals or families. They are also responsible to coordinate with Police or EMT if the crisis needs the other parties. Behavioral health staff then travel to visit as the crisis mobile team. If there is safety concern, the Police are informed to be partners in the response. When the patient is assessed and brought to the facility, they can be admitted voluntarily or involuntarily. Up to a maximum of three months in the facility, once discharged, the behavioral health team connects with

them on subsequent community follow-up and the discharge individuals are added to the community follow-up list of patients.

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

- a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
- b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.
- c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.
- d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.
- e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.

Other program implementation data that characterizes crisis services system development.

- 1. Someone to talk to: Crisis Call Capacity
 - a. Number of locally based crisis call Centers in state
 - i. In the 988 Suicide and Crisis lifeline network
 - ii. Not in the suicide lifeline network
 - b. Number of Crisis Call Centers with follow up protocols in place
 - c. Percent of 911 calls that are coded as BH related
- 2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the total number of communities)
 - a. Independent of first responder structures (police, paramedic, fire)
 - b. Integrated with first responder structures (police, paramedic, fire)
 - c. Number that employs peers
- 3. Safe place to go or to be:
 - a. Number of Emergency Departments
 - b. Number of Emergency Departments that operate a specialized behavioral health component
 - c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

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

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Someone to respond	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safe place to go or to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

b. Briefly explain your stages of implementation selections here.

For the "someone to talk to" we are currently in installation. We have secured the 988 line which connects directly to the office line specified for crisis and if after hour, the line connects to two cell phones of the nurse and doctor on call. However, it is still installation because the big plan needs to have full time staff that are part of the crisis team who are trained to respond to phone calls, emails, messenger, and other social media. The doctor on-call and nurse on-call may have other schedules in place during the day and not timely respond to crisis calls. For that, we are still very much early in the installation zone.

For "someone to respond", the RMI has been relying heavily on Police but gradually the Behavioral health team is taking over the respond responsibility and doing most of crisis responses lately. Police are stepping aside unless there is physical danger or aggressiveness, then they are involved in the response. It is still in early implementation as we are still talking about the on-call nurse and on-call doctor responding to crisis in the communities and this is unnecessary and unacceptable. The objective is to have staff who are full-time crisis officers who respond and do the initial assessment and talks with the patient and families. Only those that require the stabilization services will be brought to the doctor and the nurse, but in the long run, most of it will be deescalated and stabilized by crisis staff in the community.

For "safe place to go to", The RMI has completed and opened the crisis stabilization facility earlier this year and since February, it has been full that patients are released on "leave of absence" when they are still partially recovered because the rooms are needed for more acute patients that need the support more. And although the facility is operational and manned for the past 10 months, we are at 75% because once admitted, it is still the only doctor and the nurse on-call that are available to provided that support to the patients in crisis. The RMI need to hire peer support staff, counselors, and crisis staff to provide that presence and support for every individual admitted in crisis for our care.

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

To make the crisis system fully operational, RMI has a few steps to prepare:

- 1. A budget must be in place to hire at least 8 and up to 20 individuals that are willing to go through crisis training and to do work on one of the

three different areas of crisis call center/ crisis mobile response team/ and crisis stabilization units.

2. Once the budget is secured, the already approved job descriptions will be advertised. Following the interview and hiring process, we will have training for all crisis new staff to become familiar with mental health, crisis and crisis first responders, de-escalation techniques, coordination with EMT and Police, as well as continued education on a monthly basis locally or through other crisis training opportunities.

3. RMI will invite colleagues from CNMI and Guam to share their experience with the 988 hotline and the crisis response. This is more so on their crisis call centers and their crisis response teams.

4. Further coordination training will be carried out with Police and EMT to have a common protocol of responding and referring to medical crisis, legal crisis and behavioral crisis. The crisis services will be shared to communities, faith based organizations, radio programs with round the table talks, newspaper ads, banners and flyers will be posted around, and social media will be used for enhancement of the information sharing. All these advertisement will be done with the intention of getting feedbacks ahead of a scheduled national launching day to honor the services as an essential work for human rights.

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

The five percent set aside for crisis services is hopefully a budget to have annual trainings involving all behavioral crisis staff and invitations to EMT as well as Police. Along with the annual big training, the set aside is also the program's means of making radio and social media awareness materials, banners and flyers about the crisis services. One of the main challenges for the program is short staff and we are hoping that the set-aside can be increased to 15-20 % to also budget for some peer support staff and community crisis staff.

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

SAMHSA and NASMHPD provided us with crisis services guides and CDC has also been helpful with crisis guidelines and essential services. At this stage, the program would benefit very much from any help with established or models of crisis call center steps in response to crisis calls or specific trainings for crisis call center staff, also, we need to continue to search for de-escalation techniques that are well studied and experienced out there to assist us in the early stage that we are in.

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16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

- 1. Does the state support recovery through any of the following:
 - a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? Yes No
 - b) Required peer accreditation or certification? Yes No
 - c) Use Block grant funding of recovery support services? Yes No
 - d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? Yes No
- 2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
In RMI, adult and child consumers and families are followed up and monitored closely in acute stages at the hospital and clinic. When individuals are stable, they are released back to their communities and families. The only current support services the mental health and SUD have are nurses outreach follow-up with schedules adjusted based on level of improvement of patients and the reports of families.
The primary support services we have for recovery are the families, sometimes friends, and occasionally the church leaders or the Police officers.

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
Acute recovery support and care for SUD patients is usually initiated in hospital for detoxification and rehabilitation. When SUD patients are physically and psychologically stable, they are discharged and unfortunately the existing support service available in RMI is only AA and the location has been reported to be a challenge for a lot of SUD patients who are very far from the town. Mental Health and SUD may need to partner up with AA and communities to have similar support services available in places that are far from town.

5. Does the state have any activities that it would like to highlight?
It is one of our areas of minimal development. The program need to set a work plan to hire community recovery staff that will undergo formal recovery/peer support certification. It will be better to make sub-contracts with community groups to take the role of community support services for SUD recovery.
Please indicate areas of technical assistance needed related to this section.
Online courses on recovery support training and certification. At the same time, we need online training courses/certification in peer support and peer support specialists.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

- Does the state's Olmstead plan include:
 - Housing services provided Yes No
 - Home and community-based services Yes No
 - Peer support services Yes No
 - Employment services. Yes No
- Does the state have a plan to transition individuals from hospital to community settings? Yes No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.¹ Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.² For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.³

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁴

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.⁵

According to data from the 2017 Report to Congress⁶ on systems of care, services:

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

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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

²Kessler, 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.

³Centers 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.

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

⁵Department 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>

⁶http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
 - a) The recovery of children and youth with SED? Yes No
 - b) The resilience of children and youth with SED? Yes No
 - c) The recovery of children and youth with SUD? Yes No
 - d) The resilience of children and youth with SUD? Yes No
2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
 - a) Child welfare? Yes No
 - b) Health care? Yes No
 - c) Juvenile justice? Yes No
 - d) Education? Yes No
3. Does the state monitor its progress and effectiveness, around:
 - a) Service utilization? Yes No
 - b) Costs? Yes No
 - c) Outcomes for children and youth services? Yes No
4. Does the state provide training in evidence-based:
 - a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - b) Mental health treatment and recovery services for children/adolescents and their families? Yes No
5. Does the state have plans for transitioning children and youth receiving services:
 - a) to the adult M/SUD system? Yes No
 - b) for youth in foster care? Yes No
 - c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? Yes No
 - d) Does the state have an established FEP program? Yes No
Does the state have an established CHRP program? Yes No
 - e) Is the state providing trauma informed care? Yes No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The system of care in RMI include various important services as recommended by SAMHSA but not so integrated. The mental health team becomes aware and involve in children and youth mental health substance misuse or legal encounters after direct referrals from the courts or the families. There is minimal social services in the community and this year, the objective is a social movement where all ages and groups in communities can access the services and referrals are further made accordingly. Educational services are ongoing with partnerships between the program and the public school system as well as our NGO partners in "Youth to Youth" and "WAM"

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

We have started planning with 4 private high schools to pilot a school "SMHART CLUB". Student Mental Health Advocacy and Resiliency Teens Club". Instead of the mental health and substance misuse program school visits once or twice in a school year with one or two presentations and screening tests at schools, we are handing over the lead and ownership to schools and the children and youth. Each of the 4 schools get a volunteer teacher as the SMHART club moderator, students volunteer to become members, and the mental health and substance office share facts, data, and information along with annual calendar of mental health events. The clubs have weekly club meetings and activity/project plans.

It is still early in our plans but late in 2021, the two first high schools that got involved in this plan actually planned out and carried out the mental health day events and activities for the October 10 World Mental Health Day. They invited parents, other schools, government and church leaders, designed posters and campaign t-shirts, the program, and the mental health office provided the financial and technical support with the Ministry of Health.

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

Child Welfare and Juvenile justice are areas we have not had experience with. We have recently started our partnership with the courts for adults in the legal system for psychosocial support and workshops/ education for parolees.

In RMI, underage pregnancy is another big problem that we currently are tackling and hope to get informative and educational tools to the community level this year to improve public/community understanding and knowledge and improve the community response to the matters.

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19. Suicide Prevention - Required for MHBG

Narrative Question

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

Please respond to the following:

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

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

In previous plans, the activity is community, school and church based educational sessions. The RMI has since adapted and utilized the ASQ Screening Test for all children in health centers, out patients and pediatric wards up to age 17 of age. However, the two hospitals use it on youth up to age 24 as it covers a bigger target risk group. In hospital protocols, any self-harm or attempted suicide is not discharged by ER until fully assessed and referred to Psychiatric team. Risk assessment tests are done by Psychiatric nurses, safety net plans are made with assistance of nurses and counselors, and the patients are followed up in the community by our lead suicide counselor. The plan for the current year is for the counselor to create a support group/peer support group made up of survivors and families of those that died by suicide.

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

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

If yes, please describe how barriers are eliminated.

the mental health team has been primarily focusing school visits to address suicide and recognition of suicide. Activities and support for those with suicide ideation have been presented in schools.

The RMI Mental Health First Aid (MHFA) training certified over 200 individuals to help with educations, identification, and support to people struggling with suicidal ideation and assistance with information and referral to the program.

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

If so, please describe the population of focus?

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

Suicide is a major problem in this country. It is complex and happens with different backgrounds and age groups but with the fact that 90% of people committing suicide having either mental health or substance misuse history, we are hoping to have guidance and support on evidence based programs for communities and school age children and youth to help fight the suicide national public health problem.

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20. Support of State Partners - Required for MHBG

Narrative Question

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

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

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? Yes No
2. Has your state identified the need to develop new partnerships that you did not have in place? Yes No

If yes, with whom?

A formal partnership with the justice system to create a MOU or policy to assist in diverting juveniles and first time offenders from the current system of hearing and incarceration.

Ministry of Internal Affairs on housing and social support for children experiencing neglect/abuse and adults that are homeless. We need a partnership with Marshall Islands Social Security to review existing benefits for RMI and how to incorporate mental health disability in the benefits.

Lastly, a recommended partnership that never materialized is with private sector/business leaders for employment inclusion of people with mental health and substance use conditions.

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 Ministry of Health and Human Services has memorandum of understandings with other government ministry and non-governmental organizations that aim toward coordinating services to maximize efficiency, effectiveness, quality, and cost effectiveness of mental health issues. With binding MOUs, collaboration between said partners extend services to mental health patients. The Ministry of Culture and Internal Affairs Disability program works closely with the mental health department on domestic and disability affairs. The Marshall Islands Police Department, along with the Majuro Atoll Government's Police force assist in retraining and handling of mentally ill patients that are threat to the community.

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

The narrative question is very informative. We would like to see more examples on different successful partnerships around the country between mental health and partners for the benefits of the patients and their families.

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Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

The council was not involved in the development and review of the state plan and report. The government approved the council in February of this year, and the council was called in for in-person meeting on the 9th of May. The agenda had the MH and SUD integration, the role of the council, and the current mental health and Substance Use block grants plans but the meeting never really got through its agenda. The members were starting out with questions and suggestions on two items: the composition of the council is too big and we should prioritize finding solutions to the freeze of the grants rather than going over plans on the grants uses.

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

In the Marshall Islands, the mechanisms commonly used to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services is:

1. The mental health program director/planner develops draft plan, shares with council members, present it to Public health management who then endorse or get feedback from the ministry of health senior leadership team, then the finalized plan is submitted to SAMHSA and the ministry authorizes the mental health program to execute its plan for all its activities for the calendar or fiscal year.

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

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

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

The newly approved council is named Behavioral Health Board to clearly display the role of serving both mental health and substance misuse disorders. The council now has good representation of various agencies and organizations and also allows us the flexibility and requirement to add more individuals in recovery and families of adults with SMI and parents of children with SED to be added to the council. In the cabinet paper that requested the review and approval of the council, the 9 core duties and responsibilities stated for the council members to facilitate the Behavioral health block grants are: 1) Determine the mission and strategy of the program 2) Select, support and evaluate the program Director and Clinical Director 3) Ensure effective planning 4) Provide oversight of programs and services 5) Oversee financial management and protection of assets 6) Ensure adequate financial resources 7) Develop and maintain a competent board/council 8) Ensure legal and ethical integrity 9) Enhance the organization's reputation

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

1. With the new council and non-existent bi-laws, we would like to request for samples/links to existing council bi-laws that may be reviewed for adaptation by our council.

2. If some states have already practiced the open invitation for council membership application, can we see some samples of the application? Or can we simply invite individuals, families, and parents that are known to be very active and supportive in the care and services for mental health and substance use disorders.

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Advisory Council Members

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

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

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Claret Chonggum	Others (Advocates who are not State employees or providers)		Majuro Hospital Majuro MH, 96960	clareтчonggum@gmail.com
Adri Hicking	State Employees		Majuro Hospital Majuro MH, 96960	ahicking@rmihealth.org
Marilynn Jacklick	State Employees		Public School System Majuro MH, 96960	mjacklick@pss.edu.mh
Eric Jorbon	State Employees		Marshall Islands Police Dept Majuro MH, 96960	jorbon2@gmail.com
Joy Kawakami	State Employees		Ministry of Culture and Internal Affairs Majuro MH, 96960	mociacrc@gmail.com
Alson Kelen	State Employees		WAM MH, 96960	alsonjkelen@gmail.com
Daisy Momotaro	State Employees		WUTMI Majuro MH, 96960	alik_momotaro@yahoo.com
Molly Murphy	Family Members of Individuals in Recovery (to include family members of adults with SMI)		MIEPI Majuro MH, 96960	miepi.data@gmail.com
Wallace Peter	State Employees		Behaviorla Health Services Majuro MH, 96960	bjohn@rmihealth.org
Veronica Silk	Parents of children with SED		Majuro Hospital Majuro MH, 96960	
Lino Thompson	Persons in recovery from or providing treatment for or advocating for SUD services		Iakwe Ward Majuro MH, 96960	

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

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Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	1	
Parents of children with SED	1	
Vacancies (individual & family members)	5	
Others (Advocates who are not State employees or providers)	1	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	8	53.33%
State Employees	7	
Providers	0	
Vacancies	0	
Total State Employees & Providers	7	46.67%
Individuals/Family Members from Diverse Racial and Ethnic Populations	5	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	21	

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22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

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

a) Public meetings or hearings? Yes No

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

If yes, provide URL:

No

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

No

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

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

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The Marshall Islands public Behavioral Health office has not shared the plan with the public although plans and proposals are regularly shared with the ministry's senior leadership team.

The ministry of health leadership and the public in general are equally concerned with the program and the government solving the SAMHSA audit and freeze funds situation. The fact that the public commonly ask for updates on the situation of the SAMHSA funds being frozen and inaccessible seems like the most critical issue. Without knowing if we would ever get our funds back, there is little interest of the public in hearing of our plans. As recommended by members of our council and senior leadership, once there is progress on the status of the audit response by the government, the Behavioral health team and its council will hold public hearing on the plan, will post it on the journal (only newspaper in the state), and also post it for comment on the ministry's website.