WEST VIRGINIA
Department of
Health & Human Resources

Bureau for Behavioral Health and Health Facilities

Announcement of Funding Availability

Prevention works! Treatment is effective! And Recovery happens!

Proposal Guidance and Instructions

AFA Title: Women's Treatment and Recovery Programming Targeting Region 2

AFA Number: AFA-11B-2013-SA

West Virginia Department of Health and Human Resources
Bureau for Behavioral Health and Health Facilities
350 Capital Street, Room 350
Charleston, WV 25301-3702

For Technical Assistance please include the AFA # in the subject line and forward all inquiries in writing to:
DHHRBHHFAnnouncement@wv.gov

Key Dates:	
Date of Release:	September 11, 2013
TECHNICAL ASSISTANCE MEETING:	TBD, details to follow
Letter of Intent Deadline:	Sept. 25, 2013 Close of Business – 5:00PM
Application Deadline:	October 30, 2013 Close of Business – 5:00PM
Funding Announcement To Be Made:	November 15, 2013
Funding Amount Available:	Not to exceed $ 750,000.00

The following is a guide and instructions for submitting a proposal to the Bureau for Behavioral Health and Health Facilities (BBHHF). The document includes general contact information, program information, administrative, and fiscal requirements. Responses must be submitted using the required AFA Application Template available at DHHR.WV.GOV/BHHF/AFA. Responses must be submitted electronically via email to DHHRBHHFAnnouncement@wv.gov with the AFA Title and Number in the subject line. All submissions must be received no later than 5:00 PM on the application deadline date. Notification that the proposal was received will follow. Paper copies of proposals *will not* be accepted. It is the sole responsibility of applicants to insure that all documents are received by deadline dates. Incomplete proposals or proposals submitted after the application deadline will not be reviewed.

LETTER OF INTENT

All organizations planning to submit an application for an Announcement of Funding Availability (AFA) must submit a Letter of Intent (LOI) by **September 25, 2013 close of business (5:00pm)** to the email address: **DHHRBHHFAnnouncement@wv.gov** prior to submission of the AFA.

Please list the AFA Title and Number found on Page 1 of this document in the email subject line.

These letters of intent shall serve to document the applicant's interest in providing each type of service (AFA) and will not be considered binding until documented receipt of the application.

RENEWAL OF AWARD

The BBHHF may renew or continue funding beyond the initial fiscal year award for a period not to exceed one additional fiscal year period beyond the stated AFA period (January 1, 2014 through September 30, 2014). As such, at the discretion of the BBHHF funding may be renewed for a period no later than September 30, 2015. Future funding will be contingent on availability of funds and successful implementation of goals and documented outcomes.

LEGAL REQUIREMENTS

All applicants must be able to provide proof of 501(c) 3 status and possess a valid West Virginia business license. If the applicant is not already registered as a vendor in the State of West Virginia, this must either be completed by the award notification date or the vendor must demonstrate proof of such application. It is also required that the applicants have a System for Award Management (SAM) registration and have a Dun & Bradstreet or DUNS number. For more information visit: https://www.sam.gov

The Grantee is solely responsible for all work performed under the agreement and shall assume all responsibility for services offered and products to be delivered under the terms of the award. The State shall consider the designated Grantee applicant to be the sole point of contact with regard to all contractual matters. The Grantee may, with the prior written consent of the State, enter into written sub agreements for performance of work; however, the grantee shall be responsible for payment of all sub awards.

FUNDING AVAILABLITY

This funding announcement is part of a statewide plan to expand regionally based substance abuse and crisis services that have been identified as a priority for Region 2. This funding recommendation was made possible by Governor Earl Ray Tomblin on August 23, 2012, with the availability of a maximum of $750,000.00 to support the development of women's treatment and recovery facility.

Funding for a **Women's Treatment and Recovery Program** will be awarded based on accepted proposals that meet all of the required criteria contained within this document. Funding availability for this AFA is as follows:

REGION	REGIONAL FUNDING AVAILABILITY Not to exceed:
2	$750,000.00

Start Up Costs

Applicants who wish to request reasonable startup funds for their programs must submit a separate "Startup" target funded budget and budget narrative along with their proposals.

For the purposes of this funding startup costs are defined as non-recurring costs associated with the setting up and opening of a program, such as fees, registrations, training, equipment purchases, renovations and/or capital expenditures.

For the purposes of proposal review, all startup costs requests submitted by the applicant will be considered to be necessary for the development of the service and/or program outlined in the applicant proposal. As such, where/if capital/start-up costs exceed funding availability BBHHF staff will contact the applicant agency and arrange a time to meet and discuss.

BACKGROUND INFORMATION

In June 2010 the needs assessment process to support the development of the strategic plan for Substance Abuse Prevention, Treatment and Recovery services was initiated in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) with a series of meetings of key stakeholders and representatives of the BBHHF. A total of 14 key stake holder, focus groups and community forums engaging more than 400 participants were conducted to assess current public perception about substance misuse, use, and abuse, treatment availability, prevention efforts and what is currently absent from and working effectively in communities across the state. In addition, various topic or agency specific work sessions (youth, law enforcement and others) were convened to support a full understanding of and development of action strategies needed.

On September 6, 2011, Governor Earl Ray Tomblin issued Executive Order 5-11, establishing the Governor's Advisory Council on Substance Abuse (GACSA) and six (6) Regional Task Forces (RTF's). These newly formed entities meet regularly and share a collective charge to provide guidance regarding implementation of the approved *Statewide Substance Abuse Strategic Action Plan*, recommend priorities for the improvement of the statewide substance abuse continuum of care, identify planning opportunities with interrelated systems and provide recommendations to the Governor emphasizing the enhancement of: substance abuse education; collecting, sharing and utilizing data; and supporting policy and legislative action. Significant legislation was passed during the regular 2012 Legislative Session to improve conditions regarding substance abuse, including but not limited to $7.5 Million in additional State revenue supporting the Substance Abuse Continuum of care. After completing a thorough review of the service delivery system and considering community identified need, the Governor is pleased to announce, in coordination with the Bureau for Behavioral Health and Health Facilities, the availability of these funds.

REGIONS IN WEST VIRGINIA

The BBHHF is currently utilizing the six region approach designated by the Governor's Advisory Council on Substance Abuse (GACSA).

Region 1: Hancock, Brooke, Ohio, Marshall, and Wetzel Counties

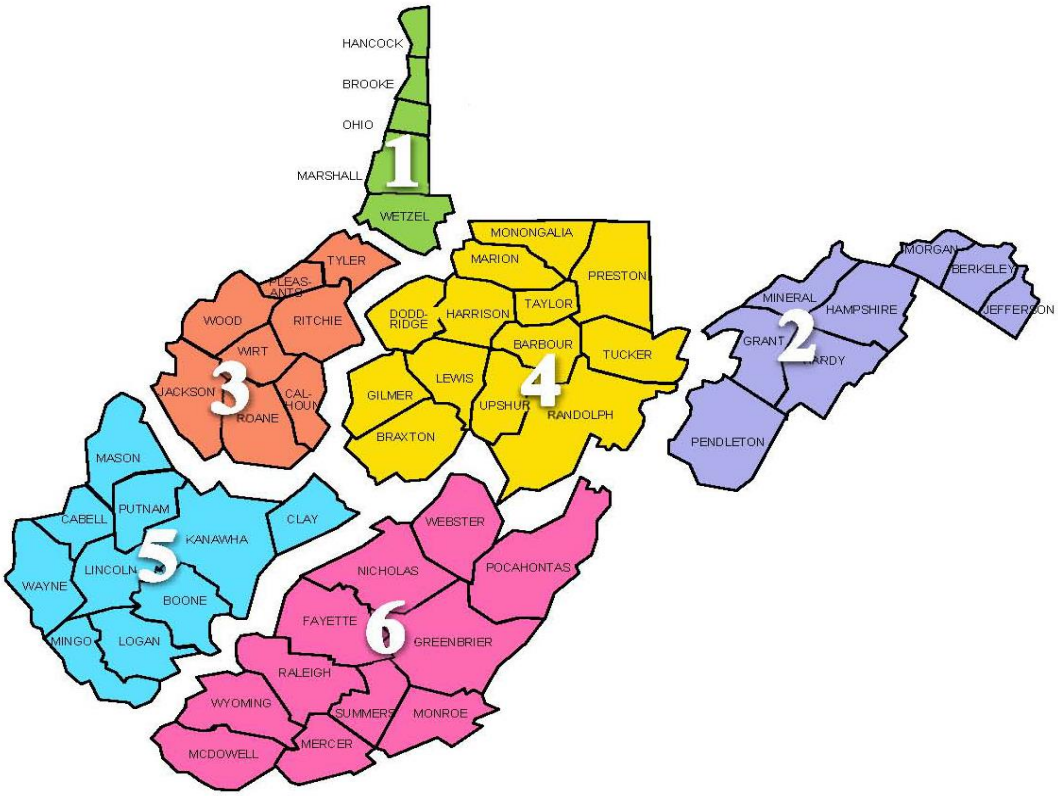
Region 2: Morgan, Berkeley, Jefferson, Mineral, Hampshire, Grant, Hardy, and Pendleton Counties

Region 3: Tyler, Pleasants, Wood, Ritchie, Wirt, Jackson, Roane, and Calhoun Counties

Region 4: Monongalia, Marion, Preston, Doddridge, Harrison, Taylor, Barbour, Tucker, Gilmer, Lewis, Upshur, Randolph, and Braxton Counties

Region 5: Mason, Cabell, Putnam, Kanawha, Clay, Wayne, Lincoln, Boone, Mingo, and Logan Counties

Region 6: Webster, Nicholas, Pocahontas, Fayette, Greenbrier, Raleigh, Summers, Monroe, Wyoming, McDowell, and Mercer Counties



Section One: **INTRODUCTION**

Individuals and families cannot be healthy without positive mental health and freedom from addictions and abuse of substances. Prevention, treatment, and recovery support services for behavioral health are important parts of health service systems and communitywide strategies that work to improve health status and lower costs for individuals, families, businesses, and governments.

Substance abuse, addictions, poor emotional health, and mental illnesses take a toll on individuals, families, and communities. They cost money, and they cost lives, in the same way that physical illnesses that are not prevented, are left untreated, or are poorly managed. Their presence exacerbates the cost of treating co-morbid physical diseases and results in some of the highest disability burdens in the world compared with other causes of disability. The impact on American's children, adults, and communities is enormous:

- *The annual total estimated societal cost of substance abuse in the United States exceeds $600 billion annually and includes:*
  - *193 billion for illicit drugs*[1]
  - *193 billion for tobacco*[2]
  - *235 billion for alcohol*[3]
- *Serious mental illnesses cost society $193.2 billion in lost earnings per year.*[4]
- *By 2020, behavioral health disorders will surpass all physical diseases as a major cause of disability worldwide.*[5] *In 2009, there were an estimated 45.1 million adults aged 18 or older in the United States with any mental illness in the past year. This represents 19.9 percent of all adults in the U.S.*[6]
- *Two million (8.1%) youth aged 12 to 17 had a major depressive episode during the past year with only 34.7 percent of these adolescents suffering from major depressive episodes received treatment during this period.*[7]

- *In 2009, an estimated 23.5 million Americans aged 12 and older needed treatment for substance use but only 11.2 percent of those people receive treatment*[8]
- *Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24.*[9]

West Virginia, in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), is working to improve understanding about mental and substance use disorders, promote emotional health and the prevention of substance abuse and mental illness, increase access to effective treatment, and support recovery.

Leading by Change: A Plan for SAMHSA's Roles and Actions

West Virginia is committed to creating communities wherein collaboration is central to the planning and development of community based services. Collaboration may include individuals, families, schools, faith-based organizations, coalitions, agencies, associations and workplaces supporting our statewide capacity to take action to focus on behavioral health prevention and promotion efforts supporting improved emotional and physical health of WV citizens.

West Virginia Behavioral Health System

The Division on Alcoholism and Drug Abuse and the Divisions of Child, Adolescent and Adult Behavioral Health, operating divisions of the Bureau for Behavioral Health and Health Facilities (BBHHF) within the West Virginia Department of Health and Human Resources (WV DHHR), are charged in code with being the Single State Authority (SSA) primarily responsible for prevention, control, treatment, rehabilitation, education research and planning for substance abuse and mental health related services.

Prevention works! Treatment is effective! And Recovery happens!

The principles that guide the work of the Bureau for Behavioral Health and Health Facilities are aligned with SAMHSA in understanding that the evidence base behind

behavioral health prevention, treatment and recovery services continues to grow and promises better outcomes for people with and at risk for mental and substance use disorders.

Behavioral Health Integration

As health reform efforts are being enacted and SAMHSA is promoting the importance of integrated behavioral health, it is necessary for WV to align its thinking and planning processes within these parameters. In so doing we must continually review, assess and acquaint ourselves with the climate of our state and through the careful collections and review of key indicators and prevalence data. Included below are indicators considered in the development and evolution of the behavioral health system of care in WV:

Substance Abuse in WV

- *Prescription drug overdoses in WV rose 300% from 164 deaths in 2001 to 656 deaths in 2011.*[10]
- *In 2010, Alcohol was a factor in 31% of fatal motor vehicle accidents in WV.*[11]
- *In 2011, WV had the highest annual number of retail prescription drugs filled at pharmacies nationwide at 19.3 per capita.*[12]
- *Opiates are the number one cause of death associated with drug overdoses in WV.*[13]
- *In 2010 the WV Poison Control Center received 4 calls related to bath salt exposures; in 2011 the number increased to 253 exposure calls – a 6200% increase in one year's time.*[14]
- *Hospitalization admissions with an alcohol abuse/dependence related diagnosis at discharge rose 11% from 2005 to 2009.*[15]

Mental Illness in WV

- *Almost 8% of West Virginians at least one major depressive episode within the past year.*[16]
- *In 2010, approximately 25.1% of the people experiencing homelessness staying in shelters in WV reported mental illness and/or substance abuse.*[17]

- *The WV age-adjusted suicide rate in 2010, 14.1 per 100,000 population, was above the national average at 12.1 per 100,000 population* [18]
- *In 2011, over 10% of WV's youth reported making a suicide plan in the past year.* [19]
- *Over 5% of students in grades 9 through 12 reported a suicide attempt within the past 12 months.*[20]
- *In 2010, almost 30% of domestic violence survivors identified that substance abuse was a contributing factor to their abuse.*[21]

Women and Substance Misuse and Abuse

According to the 2010 US Census Bureau Data, West Virginia had a population of 1,852,994 residents, 50.7% of whom are female and with the following racial/ethnic demographics: 93% White/Non-Hispanic, 3.5% Black Non-Hispanic, 1.4% two or more races, less than 1% American Indian or Asian and 1.3% were of Hispanic/Latino ethnicity (most were White/Hispanic); and 97.7% of WV's population speaks English (with the remaining 2.3% as mostly Spanish speaking).[22]

There is a growing body of research regarding the differences related to gender and addiction. Certain risk factors may make the female population vulnerable to substance abuse. A three-year study on women and young girls aged 8–22 revealed that girls and young women use substances for different reasons than boys and young men. The study found that risk factors such as low self-esteem, peer pressure, and depression make girls and young women more vulnerable to substance use as well as addiction, in that females become dependent faster and suffer the consequences sooner, compared to males.[23] Substance use is a growing problem among females. The 2009 National Survey on Drug Use and Health (NSDUH) reported that approximately 6.6% of women aged 12 and older reported use of an illicit drug in the past month.[24] Women in the criminal justice system display an even higher rate of substance use. According to data from the Bureau of Justice Statistics, approximately 59.3% of State and 47.6% of Federal female prisoners surveyed in 2004 indicated that they had used drugs in the month prior to their offense. Additionally, approximately 60.2% of State and 42.8% of

Federal female prisoners surveyed in 2004 met drug dependence or abuse criteria. With the rising prevalence of female substance abuse, more women are in need of treatment. In 2007, 32.3% of the approximately 1.8 million admissions to drug/alcohol treatment in the U.S. were female admissions.[25] Because women are more likely to be victims of physical or sexual abuse, which contributes to drug and alcohol misuse/abuse, depression, and criminal activity, there is a growing need for more gender-specific substance use treatment services for women.[26] Effective substance abuse prevention and treatment for girls and women requires crafting programs to address the specific risks and consequences of substance use that are more frequently associated with females.

As many traditional treatment programs do not allow for the inclusion of children, a woman may be torn between the need to care for her dependent children and the need for treatment. Involvement with the child welfare system also complicates a woman's decision to seek care, because admitting to a substance abuse problem may lead to involvement with the criminal justice system and/or the loss of custody of children. This must change; women should not feel torn between seeking treatment and caring for their families. There are many model family-based treatment programs around the country that prove families do not need to be separated in order for them to achieve success in treatment and recovery.[27]

Pregnant Women and Substance Misuse and Abuse

A national report suggests about 4.5% of pregnant women aged 15-44 use illicit drugs compared to 10.6% for non-pregnant women of the same age. The proportion changes when looking at different age categories in that those ages 18-25 years illicit drug use is 7.1% for pregnant women and 16.8% for non-pregnant women and for those 26.44 years illicit drug use falls to 2.2% for pregnant women compared to 7.6% for non-pregnant women. Among women ages 15-44 years 10% of pregnant women report current alcohol use in the last 30 days compared to 54.4% of non-pregnant women. 4.4% of pregnant women report binge drinking compared to 24.5% of non-pregnant women.[28] A 2009 study on the prevalence of substance use by pregnant women who

delivered in West Virginia (WV) hospitals states that nearly one-fifth of babies born were to mothers who used drugs and/or alcohol while pregnant. In the study, 759 umbilical cord samples from eight regional hospitals in WV were tested to determine the presence of substances. The study found that almost one in five babies (19.2%) born during this period in these 8 diverse West Virginia hospitals had evidence of drug or alcohol exposure.[29] Smoking among pregnant women in WV is higher (27.3%) than in the general population and occurs at a higher rate than any other state in the nation (National average being 10%).[30]

The problem of maternal substance abuse and addiction during pregnancy is that it has dramatic effects on both the unborn children and our local healthcare system. Neonatal Abstinence Syndrome is a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb. Babies of mothers who drink during pregnancy may develop similar conditions known as Fetal Alcohol Spectrum Disorder (FASD), which can include physical problems as well as problems with behavior and learning.[31] These and other substances pass through the placenta to the baby during pregnancy. The placenta is the organ that connects the baby to its mother in the womb. The baby becomes addicted along with the mother. At birth, the baby is still dependent on the substance. Because the baby is no longer getting the substance after birth, symptoms of withdrawal may occur. These symptoms depend on the type, dose and frequency of substance(s) used by the mother during her pregnancy, as well as how the mother's body breaks down the substance(s). Babies can exhibit symptoms as early as 1 - 3 days after birth, while others can take up to 5 - 10 days to appear. [32]

Strategic Direction

The WV Bureau for Behavioral Health and Health Facilities (BBHHF), Division on Alcoholism and Drug Abuse has developed and published a Comprehensive Substance Abuse Strategic Action Plan to guide services and service continuum development over the next 3-5 years. The Plan sets forth four priority areas to guide system oversight and evolution (see below). In addition, the Plan has been acknowledged by Governor

Tomblin with its implementation being overseen by the Governor's Advisory Council on Substance Abuse (GACSA). The Plan is aligned with the WV's 2012 SAMHSA Integrated Block Grant Application and will be updated annually to insure continued consistency. Both documents can be located as follows for reference:

The SAMHSA Integrated Block Grant Application can be found at the following link:
http://www.dhhr.wv.gov/bhhf/resources/Pages/FinancialResources.aspx
The WV Comprehensive Substance Abuse Strategic Action Plan may be found at:
http://governorssubstanceabusetaskforceswv.com/images/Resources/strategicactionplan-info.pdf

Behavioral Health Prevention, Treatment and Recovery System Goals	
Priority 1 Assessment and Planning	Implement an integrated approach for the collection, analysis, interpretation and use of data to inform planning, allocation and monitoring of the WV behavioral health service delivery system.
Priority 2 Capacity	Build the capacity and competency of WV's behavioral health workforce and other stakeholders to effectively plan, implement, and sustain comprehensive, culturally relevant services.
Priority 3 Implementation	Increase access to effective behavioral health prevention, early identification, treatment and recovery management that is high quality and person-centered.
Priority 4 Sustainability	Manage resources effectively by promoting good stewardship and further development of the WV behavioral health service delivery system.

Section Two: **SERVICES DESCRIPTION**

Substance Abuse Women's Treatment and Recovery Programming

Purpose

The purpose of the Women's Treatment and Recovery Program is to expand the availability of comprehensive substance abuse treatment, prevention, and recovery support services for women, pregnant and postpartum women, and their minor children. Programs developed will include components that focus on engagement, utilization of community supports and treatment services for non-residential family members of the women and children. Programming will approach service delivery from a family-centered perspective, meet the multiple individual needs of the population of focus, and consider the health and well-being of the family members within the context of their families, and other important relationships. Programming must be gender-specific and trauma-informed. Programming will provide a safe and drug-free environment for individuals and their families supporting their focus on recovery.

Programming must support evidence-based parenting and treatment models including trauma-specific services in a trauma-informed context that will:

- Decrease the use and/or abuse of prescription drugs, alcohol, tobacco, illicit and other harmful drugs (e.g., inhalants) among pregnant and postpartum women
- Increase safe and healthy pregnancies; improve birth outcomes; and reduce perinatal and environmentally related effects of maternal and/or paternal drug abuse on infants and children
- Improve the mental and physical health of the women and children; prevent mental, emotional, and behavioral disorders among the children
- Improve parenting skills, family functioning, economic stability, and quality of life
- Decrease involvement in and exposure to crime; violence; neglect; and physical, emotional and sexual abuse for all family members

Program Overview

The populations of focus are women, age 18 and over, who are pregnant, postpartum (the period after childbirth up to 12 months), and/or non-pregnant that have limited access to quality behavioral health services. The program will be equipped to accommodate the minor children, age 17 and under, of women accessing the program. The Bureau for Behavioral Health and Health Facilities (BBHHF) aligns with the Substance Abuse and Mental Health Services Administration (SAMHSA) as it recognizes the importance of early childhood as the foundation for healthy social and emotional development. Therefore all applicant proposals must clearly describe programming to be implemented that will appropriately meet the needs of minor children (varying in age under 17) to be served in conjunction with the mother's programming. Applicants are encouraged to carefully consider the design of the program, in addition to the complexities associated with the special population targeted for this announcement.

All proposals must provide for the following three components:

- Detoxification
- Treatment; including treatment for infant withdrawal or exposed newborns
- Recovery Supports/Strategies; including aftercare for all program participants

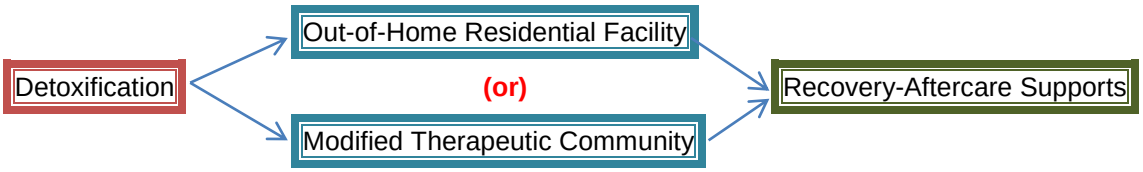
In doing so, applicants will develop a treatment and recovery program using one of two Models of Care options below:

- A stand-alone, Out-of-Home Residential Treatment Program/site with a separate or contiguously configured recovery program

  (OR)
- A Modified Therapeutic Community wherein all required phases of treatment and recovery programming are developed within the confines of an existing or developed community-based housing option. The recovery program requirement may be developed at the same housing location or at an alternate site.

More information regarding the Models of Care is provided in ***Appendix A*** *of this document.*

Diagram of Required Components:



Medication Treatment Services including detoxification or medication assisted treatment for mother and baby are required program components as prescribed. Programs are responsible for partnering with healthcare professionals and/or facilities to insure that babies born during the residential stay are, if needed, brought safely through withdrawal, housing the babies with the mother and coordinating a full range of services for both mom and baby during and post treatment. Engagement, community supports and out-patient services should, ***when appropriate***, be extended to fathers of the children, partners of the women, and other family members of the women and children who do not reside with the woman/mother at the treatment location. The BBHHF requires that all grantees provide a smoke-free workplace and the promotion of abstinence from all tobacco products for program participants.

<u>Out-of-Home Residential Treatment Program Option:</u>

Under this grant announcement, Out-of-Home Residential Treatment Programs are defined as:

> *Programs that provide 24/7 clinically managed care, high intensity and are co-occurring capable providing organized treatment services that feature a planned regimen of care in a safe, structured and stable environment.*

<u>Modified Therapeutic Community Program Option:</u>

Under this grant announcement, Modified Therapeutic Community programming is defined as:

> *A modified therapeutic community is an intensive, long-term residential treatment program designed to meet the special needs/issues of the identified target*

population. The program will provide a range of activities, including specific psychotherapies and social interaction to form the treatment program.

The core goal of therapeutic community models has always been to promote a more holistic lifestyle and to identify areas for change such as negative personal behaviors--social, psychological, and emotional--that can lead to substance use. Residents make these changes by learning from fellow residents, staff members, and others.

Program Expectations

Regardless of the Model of Care chosen to implement all applicants are required to provide for programming as outlined below, taking into consideration that development of these requirements may vary significantly for each model. Not all key considerations are extensively outlined within this document and will be explored further during this project's face-to-face technical assistance meeting (See Page 1 for details). All programs/programming developed is, where applicable, subject to and must abide by all requirements for licensure as set forth by the WVDHHR Office of Health Facility Licensure and Certification (OHFLAC) for the delivery of Behavioral Health Rehabilitation Services.

I. Occupancy

Projects must support women who enter the program accompanied by their unborn, newborn, and/or minor children. Keeping in mind both regulatory requirements and bed capacity needs, projects must provide for minor children to reside with their mother during her program enrollment.

Key considerations:

- When minor children **cannot reside** in the treatment facility with their mother alternative, safe and/or appropriate living accommodations for the children must be arranged in consultation with the mother.
- For those children and other family members who **do not reside** in the treatment facility, they are expected to participate in the required services and interventions

(see **Appendix B**: Additional Proposal Requirements), and encouraged to be actively engaged in the family treatment and recovery process. If any services are provided off-site, they must be well-coordinated and integrated to ensure that specific aspects of the individual and family treatment plan are implemented.

II. Length of Programming

Applicants will propose program length of stay requirements and must detail any/all phases of treatment that may be part of the overall length of stay. Programming must be consistent with the applicant's experience with, and knowledge of, the population of focus and what is reflected in the literature for women who have previously used such services. Applicants should use information about length of stay for this population of focus to more accurately estimate the number of women, children and family members to be served by the project. Ultimately, a woman's length of stay in the residential treatment phase should be guided by her assessment and individual service/treatment plan.

Key considerations:

- While exceptions may arise, it is recommended that that residential treatment not exceed 6 months in duration.

III. Medication Assisted Treatment Services (MAT)

MAT including detoxification for mother and baby are required program components as prescribed or warranted for women accessing the program. Depending on the applicant's Model of Care development applicants may partner with existing providers of these services to meet this requirement.

Key considerations:

- Out-of-Home residential Programs must adhere to the Patient Level of Care Guidelines as set forth by the American Society of Addictions Medicine (ASAM) for the level of services offered by a *Level III.5: Clinically Managed, Medium/High Intensity Residential Treatment* program.

IV. Service/Treatment Planning

Applicants are required to develop comprehensive individualized and family service/treatment plans to meet the needs of each family member and the family unit as a whole. These plans must be developed in consultation with the women, children and family members of both the women and children as appropriate. Plans must include individual, group, and family counseling, as appropriate, as well as follow-up relapse prevention, supplemental treatment, and prevention, engagement, community and recovery support services. In order to sustain recovery in the community, applicants are required to provide for peer/recovery support services to assist in the development of transition planning with all women served.

V. Collaborations and Memorandums of Understanding:

Applicants must demonstrate that a coordinated and integrated service system is in place to meet the complex needs of women and their families. In doing so, Memoranda of Understanding (MOUs) must be completed with key partnering agencies and organizations, which may include but is no restricted to:

- Local Public Housing Authorities
- Behavioral Health (Substance Abuse and Mental Health)
- Primary Health
- Hospitals
- Obstetric/Gynecological
- Pediatric
- Childcare
- MAT Facilities
- Family Assistance Programs
- Early Intervention and Home visiting programs
- Family and/or Drug Courts
- Criminal Justice
- Employment
- Education and/or Vocational programs

Program Requirements

All applicants for funding to operate this Women's Treatment and Recovery Program must provide statements agreeing to meet the following standards and submit comprehensive detail(s) demonstrating their capacity to provide for programming that:

1. Is culturally and linguistically competent;
2. Will be operated at a location that is readily accessible to the population served;
3. Provides for minor children to reside with the mother throughout the duration of care/treatment;
4. Provides for engagement, treatment and community support services incorporating best practice strategies to stabilize, strengthen, preserve and reunite families. Such strategies will be implemented for the women, their minor children, fathers of the children, partners of the women, and the extended family members of the women and children as appropriate;
5. Provide for a minor children's service system that is gender, age, culturally and developmentally appropriate accounting for the following age groups: 1) birth to three; 2) four to six; 3) seven to ten; and 4) eleven to seventeen;
6. Will offer a comprehensive service system that provides evidence-based trauma-informed care including assessments and interventions that consider the individual's adverse life experiences within the context of their culture, history, and exposure to traumatic events;
7. Will provide evidence-based prevention program(s), including parenting interventions, that have positive effects on parenting behavior and the developmental trajectories of the children; and
8. Will screen and assess clients for the presence of co-occurring substance use (disorders, abuse, and dependence), mental disorders, and trauma and use the information obtained from the screening and assessment to develop appropriate treatment approaches for those identified as having such conditions.

Section Three: **PROPOSAL INSTRUCTIONS / REQUIREMENTS**

Eligible applicants must provide proof of 501(c) 3 status and possess a valid West Virginia business license.

All proposals must include a one-page proposal abstract. The abstract should include the project name, description of the population to be served, planned strategies/interventions, and a general overview of project goals and measurable objectives, including the number of people projected to be served annually. Project abstracts may be used for governmental reports and public release. As such, all applicants are encouraged to provide a well-developed abstract document not exceeding 35 lines in length.

All applications will be reviewed by the BBHHF staff for administrative compliance with all required guidelines. All applications passing the administrative review will be subsequently forwarded to an independent grant review team which will score the proposal narrative consisting of five areas:

Proposal Narrative and Supporting Documentation – The Proposal Narrative describes your project. It consists of Sections A through E. Sections A-E together may not be longer than **30** pages; applicants must utilize 12pt. Arial or Times New Roman font and single line spacing. Supporting Documentation provides additional information necessary for the review of your application. It consists of Sections F and G. These documents and/or attachments will not be counted towards the Project Narrative page limit; Section F and G together may not be longer than **20** additional pages.

A. Population of Focus and Statement of Need (20 points)
B. Proposed Evidence-Based Service/Practice (25 points)
C. Proposed Implementation Approach (35 points)
D. Staff and Organizational Experience (10 points)
E. Data Collection and Performance Measurement (10 points)

Section Four: **PROPOSAL OUTLINE**

All proposal submissions must include the following components without exception.

Abstract:

Provide a brief description of the project proposed as earlier set forth in this announcement and as provided for on the proposal template

Project Narrative and Supporting Documentation:

A. <u>Population of Focus and Statement of Need:</u>

- Document the need for the proposed project in West Virginia and more specifically in the identified catchment area of Region 2. Clearly indicate which region and county(ies) that will be served by the proposed project
- Provide as much information as is feasible regarding: the population of focus including demographic and prevalence data; areas targeted to be served; current resource capacity; clarification regarding the insufficiency of existing services; patient referral and placement criteria; assessment and screening options; sub-populations and specifically information relevant to serving the minor children of the women participants
- Describe the alcohol, tobacco and other drug (ATOD) problems and consequences in the region, including each county being proposed to serve by identifying: prevalence of use, risk and protective factors, perception or risk of harm and other supporting data
- Discuss your agencies current level of participation in the Governor's Regional Task Force Meetings in the proposed region and ability to attend future meetings

B. <u>Proposed Evidence-Based Service/Practice:</u>

- Describe the purpose of the proposed project
- Clearly state project goals, objectives and strategies. These must relate to the intent of the AFA and performance measures identified in Section E: Data Collection and Performance Measurement

- Describe evidence-based practice(s) (EBP) that will be used and justify use for your population(s) of focus, your proposed program, and the intent of this AFA
- Describe how the proposed practice(s) will address the following issues in the population(s) of focus, while retaining fidelity to the chosen practice: in demographics (race, ethnicity, religion, gender, age, geography, and socioeconomic status), language and literacy, sexual identity (sexual orientation and gender identity) and disability
- Discuss any screening tools that will be used and basis for selection
- Describe how health disparities will be addressed including information related to sub-populations identified in the proposed region and suggested strategies to decrease the differences in access, service use, and outcomes among those sub-populations. A strategy for addressing health disparities is use of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care which can be found at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15
- Describe how the organization will address cultural competence in proposal implementation. All BBHHF sub-grantees are required to receive cultural competence training and to ensure that no one will be discriminated against due to race, ethnicity, religion, gender, age, geography or socioeconomic status. All project materials associated with awarded funding should be developed at low literacy levels for further understanding and comprehension in WV communities
- Briefly describe how privacy and confidentiality will be ensured, including an explanation of what data will be collected and how it will be used

C. Proposed Implementation Approach:

- Reference **Appendix B** for the Additional Program Requirements Checklist. Reviewers will look for checklist elements within this section of the Project Narrative. A fillable version of the Checklist is required as part of the proposal narrative template to be completed and submit by all applicants as **Attachment 2**
- Reference **Appendix C** for the Non-Treatment Recovery Program Standards.

Reviewers will look for applicants documented awareness/knowledge of and commitment to upholding these standards within this section of the Project Narrative

- Describe briefly how all required program components will be developed, which Model of Care will be implemented and how the required program components (Detoxification, Treatment, and Recovery / Aftercare Supports) will be coordinated with one another to provide for a full continuum of care for women, women who are pregnant and women with minor children
- Describe additional training to be sought and utilized in the development of the project, identifying key training components (by title) and their relevance
- Describe how you will promote the project's availability, as well as the process for increasing access to the target population and subpopulation(s)
- Describe how achievement of the goals will produce meaningful and relevant results for the population(s) served as well as the community and support BBHHF's goals for the program
- Describe the proposed project activities and how they fit within or support the development of the statewide and regional continuum of care, as well as how they relate to your goals and objectives
- Provide a chart or graph depicting a realistic time line for the entire project period showing key activities, milestones of the intervention(s) (EBPs), and staff(s) responsible for action. Be sure to show that the project can be implemented and service delivery can begin as soon as possible and no later than six (6) months after award. [Note: The time line should be part of the Project Narrative. It should not be placed in an attachment.]
- Describe how you will ensure the input of clients (i.e. the women, their minor children and their families/primary supports) in assessing, planning, and implementing your project. Describe the feedback loop between the clients, your organization, project partners/key stakeholders, and the BBHHF in all implementation stages of the project.
- Identify any other organizations that will participate in the proposed project. Describe their roles and responsibilities and demonstrate their commitment to the

project. Include letters of support from community organizations supporting the project in **Attachment 1**

- Clearly state the unduplicated numbers of individuals you expect to serve (annually) with grant funds, including the types and numbers of services to be provided. Include projections for sub-populations (minor children) served separate from projections for the targeted population
- Describe how you will ensure the utilization of other revenue realized from the provision of substance abuse treatment and recovery services to the extent possible and use BBHHF grant funds only for services to individuals for whom coverage has been formally determined to be unaffordable; or for services that are not sufficiently covered by an individual's health insurance plan (co-pay or other cost sharing requirements are an acceptable use of BBHHF grant funds). Also describe how you will facilitate the health insurance application and enrollment process for eligible uninsured clients
- Describe how you will work across systems to ensure that services provided to these target populations are coordinated and considered by multiple levels and systems
- Describe the potential barriers to successful conduct of the proposed project and how you will overcome them
- Describe your plan to continue the project after the funding period ends. Also, describe how program contiguity will be maintained when there is a change in the operational environment (e.g. staff turnover, change in project leadership) to ensure stability over time
- Describe the facility(ies) to be utilized and may describe an existing facility already owned and operated by the applicant agency, or a facility for which the applicant agency has a detailed business plan for acquisition, leasing, or other manner of habitation. The BBHHF is available to discuss what options may exist for securing a building or other location in the event that a location is not readily available. If the applicant agency chooses to speak to the BBHHF regarding what options may exist, the discussions must occur prior to submission of the proposal. Any diagrams that may exist may be included as **Attachment 3**

D. <u>Staff and Organization Experience:</u>

- Discuss the capability and experience of the applicant organization. Demonstrate that the applicant organization has linkages to the population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) of the population(s) of focus
- Provide a complete list of staff positions for the project, including the Project Director and other key personnel, showing the role of each and their level of effort and qualifications
- Discuss how key staff have demonstrated experience and are qualified to serve the population(s) of focus and are familiar with the culture(s)

E. <u>Data Collection and Performance Measurement:</u>

- Document your ability to collect and report on the required performance measures as specified in Section Five: Expected Outcomes / Products of this AFA. Describe your plan for data collection, management, analysis, and reporting. Specify and justify any additional measures or instruments you plan to use for your project
- Describe the data-driven quality improvement process by which population and sub-population disparities in access/use/outcomes will be tracked, assessed, and reduced
- Describe how data will be used to manage the project and assure that the goals and objectives at a systems level will be tracked and achieved.
- Describe how information related to process and outcomes will be routinely communicated to program staff, governing and advisory bodies, and stakeholders

F. <u>Budget Form and Budget Narrative:</u> *All requirements set forth in Section F must be included in* ***Attachment 4*** *and will not count toward the Project Narrative page limit*

- Include a proposed Target Funding Budget (TFB) with details by line item including sources of other funds where indicated on the TFB form
    - Include expenses for attending Quarterly BBHHF Provider Meetings

- Include a Budget Narrative document with specific details on how funds are to be expended
    - The budget narrative clarifies and supports the budget (TFB). The narrative should clearly/specify the intent of and justify each line item in the budget (TFB)
- Describe any potential for other funds or in kind support. Please include a description of such funds as a supplement to the Budget Narrative document.
- Prepare and submit a separate TFB for any capital or start-up expenses and accompany this separate TFB with a coordinating Budget Narrative document
- Additional financial information and requirements are located in **Appendix D**

All forms referenced in Section F: Budget Form and Budget Narrative can be accessed through the BBHHF web-site at:
http://www.wvdhhr.org/bhhf/resources.asp

G. Attachments 1 through 4: *Will not count toward the Project Narrative page limit*

- **Attachment 1:** Letters of Support
- **Attachment 2:** Other Program Requirements Checklist – *fillable form available within Proposal Template, content located in* ***Appendix B***
- **Attachment 3:** Facility/site diagrams (if applicable/available)
- **Attachment 4:** Budget Form(s) and Budget Narrative(s)

Section Five: **EXPECTED OUTCOMES / PRODUCTS**

All grantees must discuss their ability to report the data collected through web-based reporting by the 5th of each month, in accordance with National Outcome Measures (NOMS), state guidelines and timeframes established by US Center for Substance Abuse Treatment (CSAT), The Substance Abuse and Mental Health Services Administration (SAMHSA), and all other regulatory bodies. Specific outcome measures will include the following:

Treatment Performance Measures

Performance Measure	Admission Clients	Discharge Clients
Number of admission by level of care and number of persons served	☑	
Number of persons served (unduplicated count) for alcohol and other drug use by age, sex, race, and ethnicity	☑	
Number of clients employed or students (full-time or part-time) prior 30 days	☑	☑
Number of clients living in a stable living condition prior 30 days	☑	☑
Number of clients without arrests prior 30 days	☑	☑
Number of clients with no alcohol use in the last 30 days	☑	☑
Number of clients with no drug use in the last 30 days	☑	☑
Number of clients participating in self-help groups prior 30 days	☑	☑
Length of stay (in days) of clients completing treatment		☑

Program Specific Performance Measures

Decrease barriers to accessing treatment resulting in early entry into treatment during their pregnancy and a decrease in the barriers to accessing project related services
Improve quality of life as measured by improvement in areas such as housing and employment
Number of direct staff and partners rendering services through formal agreements who participate in cross-training to understand the requirements of the grant and the multi-disciplinary approaches to comprehensive service delivery
Number and type of evidence-based services and practices (i.e. trauma and parenting interventions) the grantee or MOU partner provided; and the number of clients receiving such services (e.g. women, children, fathers or children, partners of the women, and other family members of the women and

children).
Number of women in treatment and the number of children with whom they were reunified in the treatment facility; and the number reunited who reminded in external care.
Number of fathers reunited with their children while they resided in the residential facility with their mothers; and the number of children with whom the father was reunited while they remained in external care.
Number of individualized/family service plans that include child health promotion, prevention and treatment interventions.
Number of individualized/family service plans that include engagement and active involvement of fathers and the children, partners of the women, and other family members of the women and children
Increase the coordination and integration of services systems for members of the population of focus.
Improve child functioning in terms of social, emotional, cognitive, and physical development.
Improve the mother-child relationship/attachment.
Improve the father-child relationship/attachment.
Improve the family functioning and wellbeing.

Peer Review Process

All grantees must discuss their willingness to participate in a peer-review process to assess the quality and appropriateness of substance services that will foster the increased availability and sustainability of evidence based practices, programs and policies.

Section Six: **TECHNICAL ASSISTANCE**

The **Bureau for Behavioral Health and Health Facilities (BBHHF)** will provide technical assistance to all applicants through a scheduled technical assistance meeting and/or conference call as indicated on Page 1 of this document.

Technical assistance needs may also be submitted via email to: **DHHRBHHFAnnouncement@wv.gov.** All emailed technical assistance inquiries will be addressed by the BBHHF and posted to a Frequently Asked Questions (FAQ) document on the BBHHF website available at **DHHR.WV.GOV/BHHF/AFA.**

1. Additional data resources are available at the BBHHF web-site. Explore 'Links' to all Division Teams, including 'Prevention' with a sample of Substance-Specific Presentations.
   http://www.dhhr.wv.gov/bhhf/sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Pages/default.aspx
2. **WV Behavioral Health Profile** (also accessible by clicking 'Resources' on DADA webpage): Contains State-wide data pertaining to Substance Abuse and Mental Health issues, includes substance-specific data, suicide trends, etc.
   http://www.dhhr.wv.gov/bhhf/resources/Documents/WV%202012%20Behavioral%20Health%20Profile.pdf
3. **WV County Profiles:** Contains County-level data pertaining to SA/MH issues, uses convenient 'at a glance' format
   http://www.dhhr.wv.gov/bhhf/sections/programs/ProgramsPartnerships/AlcoholismandDrugAbuse/Research/Pages/CountyProfiles.aspx
4. **SAMHSA Recovery Supports** http://www.samhsa.gov/recovery/
5. **ASAM III.5 Residential Criteria:** A reference for the *Level III.5: Clinically Managed, Medium/High Intensity Residential Treatment* program criteria
   http://www.legis.nd.gov/information/acdata/html/..%5Cpdf%5C75-09.1-03.pdf
6. **Provider Resources:** See ***Appendix A*** for a list of providers with experience developing and sustaining Models of Care similar to those described within this AFA

Appendix A
Program Models

Out-of-Home Residential Model of Care:

- ✓ **FMRS Health Systems, Inc.**
  - Kathy Armentrout, Associate Director, FMRS Health Systems, Inc.
    - To contact, please email: KArmentrout@fmrs.org
    - Model Program – 'Turning Point' and 'Mother's Program"

- ✓ **Prestera Center for Mental Health Services, Inc.**
  - Kim Miller, Director of Development
    - To contact, please email: Kim.Miller@prestera.org
    - Model Program – 'Renaissance Program' and 'Pinecrest Apartments'

Modified Therapeutic Community Model of Care:

- ✓ **Safe Port**
  - Pam Baston, Former Executive Director of Safe Port
    - To contact, please email: pam@solutionsofsubstance.com
    - Model Program – 'Safe Port'

Non-Treatment Recovery Program Model of Care:

- ✓ **Rea of Hope**
  - Marie Beaver, Director, Rea of Hope
    - To contact, please email: marie.beaver@reaofhope.org
    - Model Program – 'Rea of Hope'

Appendix B: Additional Program Requirements Checklist

All proposal submissions must include a completed 'Checklist' as ***Attachment 2***

Required Supplemental Prevention, Treatment, and Recovery Support Services

The following services are required and deemed necessary for comprehensive substance abuse prevention, treatment, and recovery support services system for women, their children, and family members. These services must be provided either by the applicant or through MOUs with partners in the network.

Women:

- Outreach, engagement, pre-treatment, screening, and assessment;
- Detoxification;
- Substance abuse education, treatment, and relapse prevention;
- Medical, dental, and other health care services, including obstetrics, gynecology, diabetes, hypertension, and prenatal care;
- Postpartum health care including attention to depression and anxiety disorders, and medication needs; specialized assessment, monitoring, and referrals for education, peer support, therapeutic interventions and physical safety;
- Mental health care; including a trauma-informed system of assessments and interventions;
- Parenting education and interventions;
- Home management and life skills training;
- Education, testing, counseling, and treatment of hepatitis, HIV/AIDS, other STDs, and related issues;
- Employment readiness, and job training and placement;
- Education and tutoring assistance for obtaining a high school diploma and beyond;
- Childcare during periods in which the woman is engaged in therapy or in other necessary health or rehabilitation/ habilitation activities;
- Peer-to-peer recovery support activities such as groups, mentoring, and coaching; and
- Transportation and other wraparound services.

Children:

- Screenings and developmental diagnostic assessments regarding the social, emotional, cognitive, and physical status of the infants at birth through developmental trajectories of the children;
- Prevention assessments and interventions related to mental, emotional, and behavioral wellness;
- Mental health care; including a trauma-informed system of assessments, interventions, and social-emotional skill building services;
- Developmental services and therapeutic interventions, including child care, counseling, play and art therapy, occupational, speech and physical therapies;

- Primary and pediatric health care services, including immunizations, and treatment for asthma, diabetes, hypertension, and any perinatal and environmental effects of maternal and/or paternal substance abuse, e.g., HIV, abuse and neglect;
- Social services, including financial supports and health care benefits; and
- Education and recreational services.

Family:

- Family-focused programs to support family strengthening and reunification, including parenting education and interventions and social and recreational activities;
- Alcohol and drug education and referral services for substance abuse treatment;
- Mental health promotion and assessment, prevention and treatment services, in a trauma-informed context; and
- Social services, including home visiting, education, vocational, employment, financial, and health care services.

Case Management:

- Coordination and integration of services, and support with navigating systems of care to implement the individualized and family service plans;
- Assess and monitor the extent to which required services are appropriate for women, children, and the family members of the women and children;
- Assistance with community reintegration, before and after discharge, including referrals to appropriate services and resources; and
- Assistance in accessing resources from Federal, State, and local programs that provide a range of treatment services, including substance abuse, health, mental health, housing, employment, education and training.
- Connection to safe, stable, and affordable housing that can be sustained over time.

Appendix C
Required Level IV Recovery Residence Standards

The West Virginia Bureau for Behavioral Health and Health Facilities (BBHHF), in order to better assure that recovering individuals have safe, recovery-oriented, habitual housing requires adherence to the following Substance Abuse Recovery Residence Standards for its grantees. All Recovery Residences must be managed in an ethical, honest, and reasonable fashion.

The process of establishing and monitoring minimum standards is an evolving one, intended to elevate the quality of Recovery Residences. There are six major components of the standards which broadly include (1) Organizational/Administrative, (2) Fiscal Management, (3) Operational, (4) Recovery Support, (5) Property and (6) Good Neighbor Standards.

The following are **Level IV Recovery Residence** standards:

1. Organizational/Administrative Standards
1.1 The Recovery Residence is a legal business entity, as evidence by business license or incorporation documents;
1.2 The Recovery Residence has a written mission statement and vision statement;
1.3 The Recovery Residence has a written code of ethics;
1.4 The Recovery Residence property owners/operators carry general liability insurance;
1.5 The Recovery Residence complies with State and Federal requirements, including licensure or certification
1.6 The Recovery Residence clearly identifies the responsible person(s) in charge of the Recovery Residence to all residents;
1.7 The Recovery Residence clearly states the minimum qualifications, duties, and responsibilities of the responsible person(s) in a written job description and/or contract;
1.8 The Recovery Residence provides a drug and alcohol free environment;
1.9 The Recovery Residence collects and reports accurate process and outcome data for continuous quality improvement
1.10 The Recovery Residence have written permission from the owner of record to operate a Recovery Residence on their property;
2. Fiscal Management Standards
2.1 The Recovery Residence maintains an accounting system that fully documents all resident financial transactions such as fees, payments and deposits;
3. Operation Standards
3.1 The Recovery Residence posts emergency procedures (including evacuation maps, emergency numbers) and staff emergency contact information in conspicuous locations;
4. Recovery Support Standards
4.1 The Recovery Residence maintains a staffing pattern;
4.2 The Recovery Residence use an applicant screening process that helps maintain a safe and supportive environment for a specific group of persons in recovery;

4.3 The Recovery Residence adheres to applicable confidentiality laws;
4.4 The Recovery Residence keeps resident records secure with access limited to authorized staff only;
4.5 The Recovery Residence has a grievance policy and procedure for residents;
4.6 The Recovery Residence creates a safe, structured, and recovery supportive environment through written and enforced residents' rights and requirements;
4.7 The Recovery Residence has an orientation process that clearly communicates residents' rights and requirements prior to them signing any agreements; collects demographic and emergency contact information and provides a new resident with written instructions on emergency procedures and staff contact information;
4.8 The Recovery Residence fosters mutual supportive and recovery-oriented relationships between residents and/or staff through peer-based interactions, events, and/or other social activities;
4.9 The Recovery Residence fosters recovery-supportive, alcohol and drug-free environments through written and enforced policies and procedures that address: residents who return to alcohol and/or drug use; hazardous item searches; drug-screening and/or toxicology protocols; and prescription and non-prescription medication usage and storage;
4.10 The Recovery Residence encourages each resident to develop and participate in their own personalized recovery plan;
4.11 The Recovery Residence informs residents on the wide range of local treatment and recovery support services available to them including: 12-step or other mutual support groups, recovery community centers, recovery ministries, recovery-focused leisure activities and recovery advocacy opportunities;
4.12 The Recovery Residence provides nonclinical, recovery support and related services;
4.13 The Recovery Residence encourages residents to attend mutual supportive, self-help groups and/or outside professional services;
4.14 The Recovery Residence provides access to scheduled and structured peer-based services such as didactic presentations;
4.15 The Recovery Residence provides access to 3rd party clinical services in accordance to State laws;
4.16 The Recovery Residence offers life skills development services;
4.17 The Recovery Residence offers clinical services in accordance to State laws;
5. Property Standards
5.1 The Recovery Residence abides by all local building and fire safety codes;
5.2 The Recovery Residence provides each resident with food and personal item storage;
5.3 The Recovery Residence places functioning fire extinguishers in plain sight and/or in clearly marked locations;
5.4 The Recovery Residence has functioning smoke detectors installed. If the residence has gas appliances, functioning carbon monoxide detectors are installed;
5.5 The Recovery Residence provides a non-smoking living environment;
5.6 The Recovery Residence has a community room large enough to accommodate house meetings and sleeping rooms that adhere to Local and State square footage requirements;
5.7 The Recovery Residence has one sink, toilet, and shower per six residents or adhere to Local and State requirements;
5.8 The Recovery Residence has laundry services that are accessible to all residents;
5.9 The Recovery Residence maintains the interior and exterior or the property in a functional, safe and clean manor that is compatible with the neighborhood;
5.10 The Recovery Residence has a meeting space that accommodates all residents;
5.11 The Recovery Residence has appliances that are in working order and furniture that is in good

condition;
5.12 The Recovery Residence addresses routine and emergency repairs in a timely fashion;
6. Good Neighbor Standards
6.1 The Recovery Residence provides neighbors with the responsible person(s) contact information upon request. The responsible person(s) responds to neighbor's complaints, even if it is not possible to resolve the issue. All neighbor complaints and responsible person(s) response and actions must be documented;
6.2 The Recovery Residence has rules regarding noise, smoking, loitering, and parking that are responsive to neighbor's reasonable complaints;
6.3 The Recovery Residence has and enforces a parking courtesy rule where street parking is scarce.

Appendix D
Other Financial Information

Allowable costs:

Please note that Departmental Policies are predicated on requirements and authoritative guidance related to Federal grants management and administrative rules and regulations, Grantees shall be required to adhere to those same requirements when administering other DHHR grants or assistance programs, the source of which is non-Federal funds (e.g. state-appropriated general revenue and appropriated or non-appropriated special revenue funds) unless specifically provided direction to the contrary.

Cost Principles:

For each kind of grantee organization, there is a set of Federal cost principles for determining allowable costs. Allowable costs are determined in accordance with the cost principles applicable to the organization incurring the costs. The following chart lists the kinds of organizations and the applicable cost principles. The Grantee agrees to comply with the applicable cost principles as set forth below.

If the Grantee is a:	**OMB Circulars Codified at:**
State, local or Indian tribal government use the cost principles in **OMB Circular A-87**.	DHS codified at **45 C.F.R. § 92** and **45 C.F.R. § 95** USDA codified at **7 C.F.R. § 3016**; EDUC codified at **34 C.F.R. § 80**; EPA codified at **40 C.F.R. § 31**.
Private nonprofit organization other than an (1) institution of higher education, (2) hospital, or (3) organization named in **OMB Circular A-122** as not subject to that circular use the cost principles in **OMB**	DHS codified at **45 C.F.R. § 74**; USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**;

Circular A-122.	EPA codified at **40 C.F.R. § 30**.
Educational Institution use the cost principles in **OMB Circular A-21.**	DHS codified at **45 C.F.R. § 74**; USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**; EPA codified at **40 C.F.R. § 30**.
Hospital use the cost principles in **Appendix E of 45 C.F.R. § 74**.	DHS codified at **45 C.F.R. § 74**; USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**; EPA codified at **40 C.F.R. § 30**.
For-profit organization other than a hospital and an organization named in **OMB Circular A-122** as not subject to that circular use the cost principles in **48 C.F.R. pt. 31** Contract Cost Principles and Procedures.	DHS codified at **45 C.F.R. § 74**; USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**; EPA codified at **40 C.F.R. § 30**.

Grantee Uniform Administrative Regulations:

For each kind of grantee organization, there is a set of Federal uniform administrative regulations. The following chart lists the kinds of organizations and the applicable uniform administrative regulations for each listed type of grantee.

If the Grantee is a:	**OMB Circulars Codified at:**
State, local or Indian tribal government use the uniform administrative requirements in **OMB Circular A-102.**	Department of Health and Human Services (DHS) codified at **45 C.F.R. § 92** and **45 C.F.R. § 95**; Department of Agriculture (USDA) codified at **7 C.F.R. § 3016**; Department of Education (EDUC) codified at **34 C.F.R. § 80**;

	Environmental Protection Agency (EPA) codified at **40 C.F.R. § 31**.
Private nonprofit organization, institutions of higher education, or a hospital use the uniform administrative requirements in **OMB Circular A-110**.	DHS codified at **45 C.F.R. § 74**; USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**; EPA codified at **40 C.F.R. § 30**.
For-profit organization use the uniform administrative requirements in **OMB Circular A-110**.	DHS codified at **45 C.F.R. § 74** USDA codified at **7 C.F.R. § 3019**; EDUC codified at **34 C.F.R. § 74**; EPA codified at **40 C.F.R. § 30**.

Appendix E
References

1. National Drug Intelligence Center (2011). The Economic Impact of Illicit Drug Use on American Society. Washington D.C.: United States Department of Justice. Available at: http://www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf
2. Centers for Disease Control and Prevention. (2005). Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States, 2000–2004. Morbidity and Mortality Weekly Report. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a3.htm
3. Rehm, J., Mathers, C., Popova, S., Thavorncharoensap, M., Teerawattananon Y., Patra, J. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. Lancet, 373(9682):2223–2233, 2009.
4. Thomas R. Insel, Assessing the Economic Costs of Serious Mental Illness, Am J Psychiatry, Jun 2008;165: 663 - 665.
5. World Health Organization (WHO). (2004). Promoting mental health: Concepts, emerging
evidence, practice. Summary report. Geneva, Switzerland: WHO. Retrieved March 25, 2011, from http://www. who. inti mental health/ evi dence/ en/promoting mhh. pdf
6. Substance Abuse and Mental Health Services Administration. (2010). Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.
7. Ibid.
8. Ibid.
9. Ibid.
10. WV Health Statistics Center (2013). Prescription drug overdose deaths. Unpublished data.
11. National Highway Traffic Safety Administration (NHSTA). (2013). Fatality Analysis Reporting System. www-fars.nhtsa.dot.gov
12. Kaiser Family Foundation. (2012). State health facts. Available at kff.org/statedata/?state=WV
13. WV Health Statistics Center. (2013). Prescription drug overdose deaths. Unpublished data.
14. WV Poison Control Center. (2012). Bath salt exposure calls. Unpublished data.
15. HCUP Home. Healthcare Cost and Utilization Project (HCUP). May 2013. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/home.jsp
16. Substance Abuse and Mental Health Services Administration. (2010). Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.
17. WV Coalition to End Homelessness. (2012). Unpublished data. Weston, WV.
18. Centers for Disease Control and Prevention. (2012). Youth Risk Behavior Surveillance System, 2011 Results. Atlanta, GA: Centers for Disease Control and Prevention.
19. Ibid.

20. Ibid.
21. WV Coalition Against Domestic Violence. (2012). Unpublished data.
22. United States Census (2010). West Virginia quick facts. Washington, D.C.: U.S. Census Bureau
23. National Center on Addiction and Substance Abuse at Columbia University, The Formative Years: Pathways to Substance Abuse Among Girls and Young Women Ages 8–22 (PDF) , February 2003
24. Substance Abuse and Mental Health Services Administration, 2009 National Survey on Drug Use and Health (NSDUH), September 2010
25. Office of the President, Office of National Drug Control Policy, http://www.whitehouse.gov/ondcp/women-children-families .
26. Brady, T. M., & Ashley, O. S. (Eds.). (2005). Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS) (DHHS Publication No. SMA 04-3968, Analytic Series A-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.
27. Excerpted from the Office of National Drug Control Policy (ONDCP) at http://www.whitehouse.gov/ondcp/women-treatment
28. (Substance Abuse and Mental Health Services Administration. (2010). Results from the 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings. (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4586Findings). Rockville, MD.)
29. Baxter, FR, Nerhood R, Chaffin, DG. Characterization of babies discharged from Cabell Huntington Hospital during the calendar year 2005 with the diagnosis of neonatal abstinence syndrome. West Virginia Medical Journal 2009: 105:16-21.
30. West Virginia Department of Health and Human Resources (2009). West Virginia Women's Health Highlights. www.womenshealth.gov
31. SAMHSA. (2013). The FASD center. www.fasdcenter.samhsa.gov
32. Hudak, M. L., & Tan, R. C. (2012). Neonatal drug withdrawal. Pediatrics, 129(2), 540-560.