

Announcement of Funding Availability

Justice Reinvestment Act –

Treatment Supervision Implementation

A partnership of the WV DHHR and the WV DMAPS



Prevention works! Treatment is effective! And Recovery happens!

Proposal Guidance and Instructions

AFA Title: Treatment Supervision Regional Capacity Development
AFA Number: AFA -001-2014-JRI

Published by the:

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:	February 14, 2014
TECHNICAL ASSISTANCE:	February 28th, 2014, 9:30am to 4:00pm – Days Inn, Flatwoods, WV (2000 Sutton Lane, 179 Exit 67)
Letter of Intent Deadline:	Monday, March 3rd, 2014 Close of Business – 5:00PM
EXTENDED Applications Deadline:	April 18th, 2014 Close of Business – 5:00PM
Funding Announcement(s) To Be Made:	On or before May 2nd, 2014
Funding Amount Available:	See Announcement for Details

The following is a guide for the submission of proposals to the Bureau for Behavioral Health and Health Facilities (BBHFF). The document includes general contact information, program information, administrative responsibilities, and fiscal requirements. Responses must be submitted using the required AFA Application Template available at DHHR.WV.GOV/BHFF/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 ensure that all documents are received by deadline dates. Proposals that fail to comply with the guidelines provided within this AFA, incomplete proposals or proposals submitted after the application deadline will not be reviewed. A signed Statement of Assurance must be submitted with each proposal. This document must be signed by the organization's CEO, CFO, and Project Officer.

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 **5:00 pm (EST) March 3rd, 2014** to the email address: DHHRBHHFAnnouncement@wv.gov prior to submission of the AFA application.

Please list the AFA title and number found on page 1 of this document in the email subject line. The letter should include the service/services that the applicant will be proposing and all partnerships that have been or will be developed for shared applications.

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 WV Bureau for Behavioral Health and Health Facilities with the WV Division of Justice and Community Services may renew or continue funding beyond the initial fiscal year award for up to one (1) fiscal year (October 1, 2014 - September 30, 2015). Future funding will be contingent on factors including, but not limited to, availability of funds, successful implementation of goals, and documented outcomes.

LEGAL REQUIREMENTS

Eligible applicants are public or private organizations with a valid West Virginia Business License and/or units of local government. If the applicant is not already registered as a vendor in the State of West Virginia, registration 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 grantee 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 AVAILABILITY

This funding announcement is part of a statewide Justice Reinvestment Implementation plan to expand community based services and supports for persons convicted of a felony crime. Approximately 3 million dollars has been allocated statewide for this initiative. The purpose of Justice Reinvestment Implementation is to expand community based services and supports for persons convicted of a felony crime who demonstrate a high risk to reoffend coupled with a need for substance use treatment. Classification as high risk with moderate to high substance use need will be determined by the Level of Service/Case Management Inventory (LS/CMI). There may be more than one grant awarded in any region, but targeted regional/county program funding availability will not exceed the amounts listed in Section Two: ***Service Description*** of this document.

Startup 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 initiation of a program. These include costs such as fees, registrations, training, equipment purchases, renovations and/or capital expenditures.

For the purposes of proposal review, all startup cost requests submitted by the applicant will be considered to be necessary for the development of the proposed program. If, when taken together, the startup costs and program costs exceed funding availability BBHMF will contact the applicant agency and arrange a meeting to discuss remedial action.

Funding Reimbursement

All grant funds are awarded and invoiced on a reimbursement basis. Grant invoices are to be prepared monthly and submitted with and supported by the Financial Report and Progress Report to receive grant funds. The grant total invoice should agree with amounts listed on the Financial Report and reflect actual expenses incurred during the preceding service period. All expenditures must be incurred within the approved grant project period in order to be reimbursed. Providers must maintain timesheets for grant funded personnel and activities performed should be consistent with stated program objectives.

REGIONS IN WEST VIRGINIA

The WVDHHR, Bureau for Behavioral Health and Health Facilities (BBHFF) and The Division of Justice and Community Services (DJCS) will utilize the six sub-state planning regions designated by Governor Earl Ray Tomblin consistent with the Governor's Advisory Council on Substance Abuse (GACSA) for the purposes of funding distribution.

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

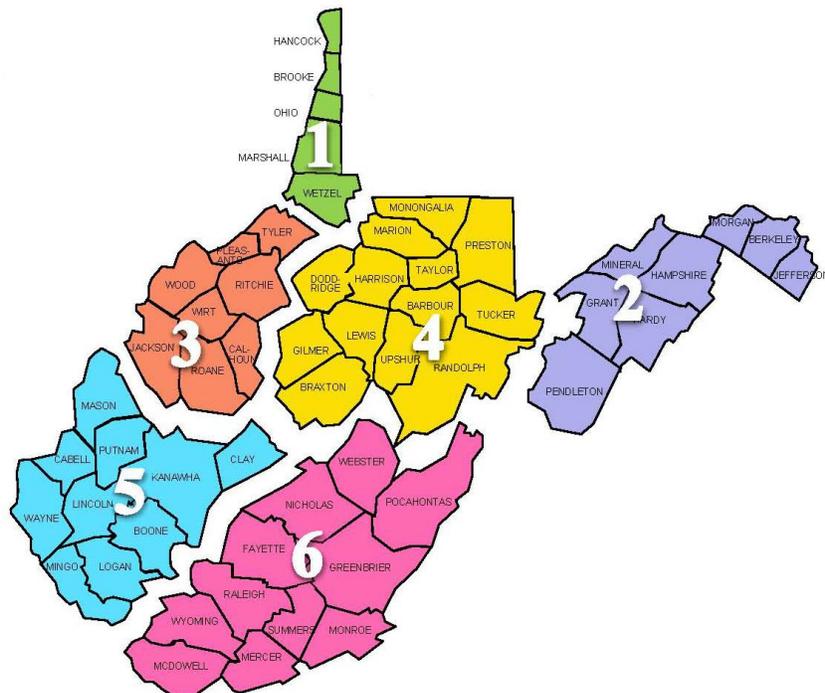
Region 2: Morgan, Berkeley, Jefferson, Mineral, Hampshire, Grant, Hardy, and Pendleton Counties

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

Justice Reinvestment in West Virginia

Overview *excerpted from the Justice Center, Council of State Governments website <http://csqjusticecenter.org/jr/wv/>*

Between 2000 and 2009, the number of people in West Virginia's prisons increased at a rate triple the national average, while the state's resident population remained flat. With the prison population expected to increase 24 percent by 2018, the state projected that accommodating this growth would cost at least \$200 million in construction costs and \$150 million in operating costs between 2013 and 2018.

In 2012, the CSG Justice Center began working with state leaders in West Virginia to develop data-driven, consensus-based policy options designed to reduce corrections spending and increase public safety. CSG Justice Center experts conducted a comprehensive analysis of West Virginia's criminal justice data and interviewed stakeholders across the criminal justice system to identify challenges facing the state:

- *The biggest driver of growth in the state's prison population between 2007 and 2011 is the number of people whose community-based supervision has been revoked, which is compounded by the length of time they spend in prison once reincarcerated.*
- *The number of people who complete their sentence in prison and return to the community without any post-release supervision has increased significantly during the same period. Inefficiencies in correctional intake and parole decision-making processes contribute to this trend.*
- *Failure to adhere to the terms of probation or parole often stems from an individual's substance use and addiction needs and contributes to the growing prison population. Few of those under supervision receive treatment in their communities.*

West Virginia's justice reinvestment framework includes policies designed to address these challenges. Senate Bill (SB) 371, the legislation incorporating these policies, was signed into law in May 2013. Among other things, SB 371:

- *Strengthens community-based supervision by requiring supervision agencies to use risk assessments to ensure that supervision practices focus on individuals most likely to reoffend and respond to probation and parole violations with swift, certain, and more cost-effective sanctions;*
- *Increases accountability by mandating that people convicted of violent offenses receive one year of supervision upon release from prison and by permitting judges the discretion to order that people convicted of nonviolent offenses and not previously paroled to serve the last 180 days of their sentences under community supervision;*
- *Streamlines correctional system processes by requiring the use of a pretrial screening instrument in jails that predicts risk of flight and risk of reoffending and by requiring the West Virginia Parole Board to interview parole-eligible individuals whose paperwork is not yet complete; and*
- *Expands access to substance abuse treatment by creating a new “treatment supervision” sentencing option that provides substance abuse treatment to individuals under supervision and by expanding the use of drug courts throughout the state by 2016.*

These policies are projected to avert up to an estimated \$200 million in construction costs and \$87 million in operating costs between 2014 and 2018. SB 371 also positions West Virginia to reinvest \$3 million of the projected savings into substance abuse treatment for people under community supervision in FY2014. At the state’s request, the CSG Justice Center continues to provide assistance in the implementation of these policies.

http://www.legis.state.wv.us/Bill_Text_HTML/2013_SESSIONS/RS/pdf_bills/SB371%20SUB2%20ENR%20PRINTED.pdf

Implementation Planning:

The implementation of the Justice Reinvestment Act (JRA) will provide a foundation for change in serving the criminal justice population effectively and efficiently. The WV DHHR, Bureau for Behavioral Health and Health Facilities and the WV DMAPS, Division of Justice and Community Services were asked by the Office of the Governor to develop an action plan required for implementation of the treatment supervision sentencing option as outlined in the JRA. The partnership focuses on engagement of behavioral health service treatment providers, and

provision of targeted training for offender populations. The increased collaboration between providers and community corrections professionals will expand effective substance use treatment services and reduce recidivism among the offender population. This collaborative approach to services development and coordination forges a long overdue partnership and avoids service system duplication. Extensive research on national best practice, key stakeholder interviews and data analysis were used to inform this treatment supervision implementation plan. It is important that national, state and local efforts be considered in the development and alignment of service systems. A copy of the Plan can be found on the funding announcements page.

The purpose of the West Virginia Justice Reinvestment Treatment Supervision Implementation Plan is to set forth strategies to reduce recidivism of offenders with substance use disorders, thus decreasing the overrepresentation of individuals with behavioral health disorders within the recidivist population. This will be accomplished through the development of a common structure for community supervision agencies and behavioral health treatment providers in an effort to enhance collaborative partnerships and coordinate care for offenders being supervised in the community. Senate Bill 371 provides a foundation for the development of a joint plan between the Department of Military Affairs and Public Safety (DMAPS) and the Department of Health and Human Resources (DHHR) to implement an effective system of treatment supervision for high risk felons with substance use need.

Understanding the Need

According to the Substance Abuse Mental Health Services Administration (SAMHSA), Director Pam Hyde states in her presentation, Behavioral Health and Criminal Justice: Challenges and Opportunities, half of all incarcerated people have mental health problems; sixty percent have substance use disorders and one third have both. Two thirds of people in prison meet the criteria for substance use disorders yet less than fifteen percent receive treatment after admission. Twenty four percent of individuals in state prisons have a recent history of mental illness yet only thirty four percent receive treatment after admission. Over 700,000 federal and

state prisoners are released to communities in the United States every year. Correctional behavioral health problems become community behavioral health problems.

The treatment supervision sentencing option was designed to address several issues identified by the Justice Center. They concluded that more intensive treatment options are needed at the community correctional level. They further identified a need for more robust sanction options for violating the terms of community supervision besides incarceration. Between 2005 and 2011, revocations from community supervision increased by 47 percent at a cost of \$150 million in incarceration costs from 2007 to 2011.

For offenders who demonstrate a high risk of recidivism, treatment supervision serves as an option of first resort. If a sentencing judge determines that substantial behavioral health issues are driving a criminal's behavior, he or she may utilize the high level of treatment services afforded by this option as an alternative to incarceration. This option may also be used for parolees who demonstrate similar behavioral health issues prior to release.

In addition, this option may also be utilized as an alternative to revocation from community supervision. If a judge or the parole board concludes that an offender's violation of their community supervision was driven by behavioral health issues, treatment supervision may serve as an alternative to revocation.

The offender population will now have greater access to healthcare coverage through health insurance exchanges and Medicaid expansion. There will be more opportunities to coordinate new health coverage with other efforts targeted at the offender population. Addressing behavioral health needs can reduce recidivism and expenditures in the criminal justice system while increasing public health and safety outcomes.

<http://store.samhsa.gov/product/Behavioral-Health-and-Criminal-Justice-Challenges-and-Opportunities/SMA12-PHYDE072112>

Key Implementation Plan Recommendations and Strategies

To better understand the scope of work that is being undertaken at all levels within the justice system and to align and complement those efforts the following recommendations were developed. These recommendations will guide efforts to fully and effectively develop statewide capacity to serve offenders as part of reentry efforts.

1. *Guide quality improvement and capture consistent process and outcomes through shared assessment, evaluation and information sharing practices across the criminal justice system by:*

- Developing system and project-wide information sharing protocols among/ between justice services and community service providers
- Creating a single dashboard for capturing consistent agreed upon measures providing a readily accessible snapshot of performance and cost savings. (see example, Vermont Model)
- Building on extant DJCS: Office of Research and Strategic Planning (ORSP) quality assurance processes to ensure adherence to risk-need-responsiveness principles
- Utilizing standardized fidelity measures for implementing assessments and service delivery
- Enrolling all treatment providers in the LS/CMI online system and Online Learning Management System to administer and track (re)certifications of all training requirements
- Implement a standardized treatment planning document, to compliment and provide supplementary information for LS/CMI case plans

2. *Improve person-centered, individualized care for offenders with behavioral health needs by implementing evidence-based programs and practices by:*

- Administering Clinical assessments would be given to 100% of individuals prior to sentencing and release who are considered for community treatment and support services

- Providing consistent evidence based practices (EBP) training and interventions across the criminal justice and behavioral health systems
- Building on existing quality assurance systems to improve monitoring of assessment quality, case plans, provider/Day Report Center (DRC) staff credentials, and outcomes

3. *Ensure that all behavioral health and criminal justice providers/facilities (jails, prisons, drug courts, day report centers) offer a consistent continuum of assessment, treatment and community peer/recovery support services by:*

- Conducting consistent risk/needs and clinical assessments in all systems to individuals at risk for substance use/co-occurring disorders
- Offering consistent behavioral health services individuals diagnosed with substance use/co-occurring disorders
- Assigning 100% of individuals considered for community supervision a peer recovery/support specialist prior to release from any institution and/or upon placement into community corrections directly
- Providing funding targeted to engagement and out- patient services
- Providing targeted funding for community peer/recovery support services
- Providing funding targeted to recovery residences to provide safe and stable housing for individuals in community support services

4. *Improve consistency in community and peer support expansion by enhancing the monitoring and supervision of local day report centers by:*

- Developing a clear policy framework for the implementation of treatment supervision
- Co-monitor behavioral health services in coordination with BBHFF

Section Two: **SERVICES DESCRIPTION**

Treatment Supervision and Service Selection

The purpose of Justice Reinvestment Implementation is to expand community based services and supports for persons convicted of a felony crime who demonstrate a high risk to reoffend coupled with a need for substance use treatment. Partnership development and service system integration are key components essential to the initiative's success. Through a collaborative effort behavioral health providers and community corrections professionals will expand effective substance use treatment services and reduce recidivism among the target population. In doing so, a customized, statewide continuum of care will develop that addresses the unique treatment and recovery needs of these individuals. Recovery, as defined by the Substance Abuse and Mental Health Service Administration (SAMHSA), is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in the community while striving to achieve their full potential.

This initiative will utilize the SAMHSA's service definitions to guide service development. Outpatient and Intensive Outpatient Support services, Community Support services and Recovery Support services were identified as the continuum of community based programming necessary to provide access to treatment systems and to promote the recovery of the target population. Table 1 provides a list of eligible services for project development, while Appendix A provides additional guidance and credentials. Evidence-based, community treatment and recovery support services, coupled with a safe and sober living environment will improve the target population's chances for remaining in the community as well as a lasting recovery.

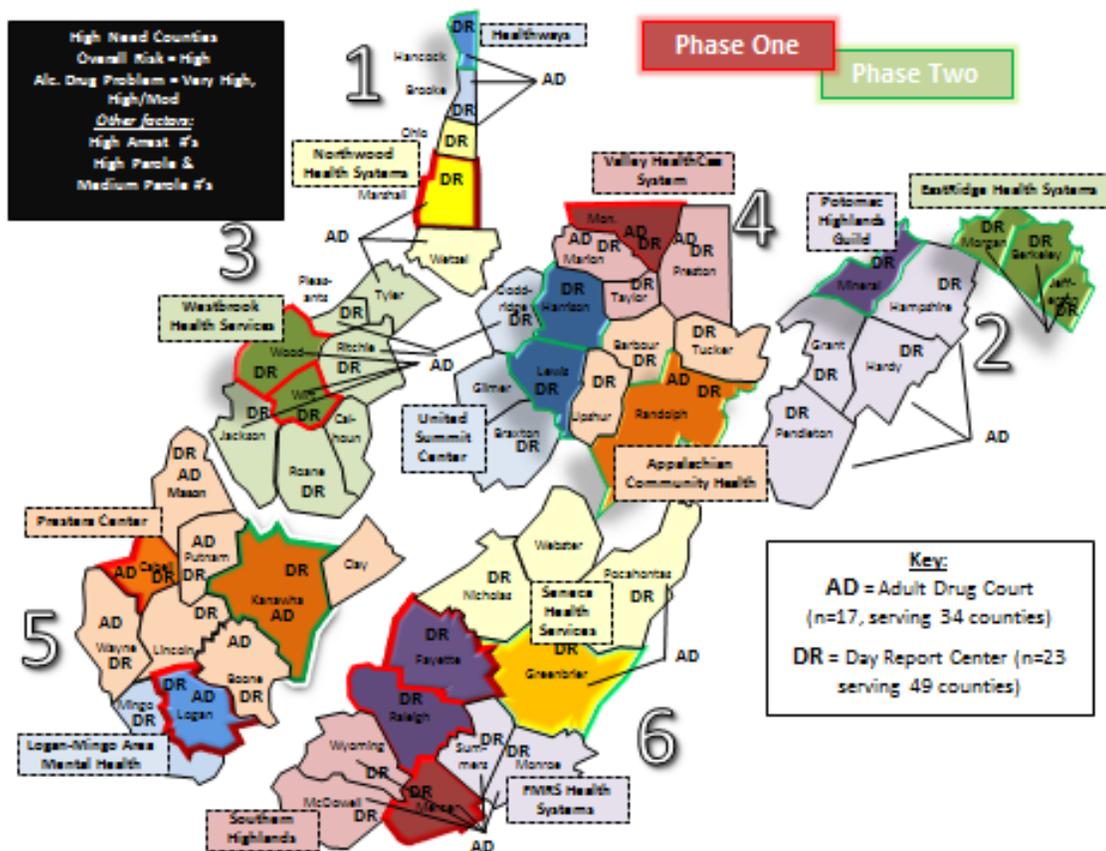
Table 1. Eligible Services for Project Development and Estimated Cost

Eligible Services for Project Development	
1. Outpatient & Intensive Outpatient Support Services	<p>Outpatient and Intensive Outpatient site development with service capacity and support for those who are not Medicaid eligible/uninsured</p> <p><i>See Appendix A. Service Definitions/ Credentials/ Standards</i></p>
Est. Cost \$50,000.00 per site	
2. Community Support Services: Community Engagement Specialists	<p>Addition of Community Engagement Specialists to provide community support services</p> <p><i>See Appendix A. Service Definitions/ Credentials/ Standards</i></p>
Est. Cost \$45,000.00 per position	
3. Community Support Services: Recovery Housing	<p>Level II. 8-10 bed recovery facility with recovery supports</p> <p>Level III. 60-100 bed recovery facility with recovery supports</p> <p><i>See Appendix A. Service Definitions/ Credentials/ Standards</i></p>
Est. Cost Level II-\$125,000.00(max) Level III-\$300,000.00 (max)	
4. Recovery Support Services: Recovery Coaching	<p>Addition of Recovery Coach staff to provide on-going recovery support</p> <p><i>See Appendix 1. Service Definitions/ Credentials/ Standards</i></p>
Est. Cost \$35,000.00 per position	

Selected Phase One and Phase Two Project Sites

Due to barriers most often associated with community re-entry, a two-phase approach has been adopted to support gradual and carefully monitored implementation. With over nine million individuals cycling through jails in the United States each year and two thirds of state prisoners rearrested within three years of release, this graduated process is necessary to support comprehensive systems change. Collaboration among community based providers will be the key to successful program implementation. Through cross-training opportunities and intense technical assistance monitoring, the capacity of phase one treatment providers will be increased. These highly trained individuals will serve as mentors and share lessons learned with phase two providers. Data collected during the first phase will also help inform and improve future and on-going practice.

The map below and Table 2 represent the pilot sites targeted for phases one and two of this project and specific service designations. These sites were selected for their respective phases based on extensive review of State and local data, current research, and capacity to implement evidence based practices relevant to the target population. The selection of pilot sites was guided by information made available through the WV Department of Military Affairs and Public Safety, Division of Justice and Community Services, Division of Corrections, Regional Jail Authority, the WV Supreme Court of Appeals and the WV Department of Health and Human Resources, Bureau for Behavioral Health and Health Facilities. Given the collaboration set forth in SB 371, §62-15-6a (d) regarding the interface between the DJCS and the Governor’s Advisory Council on Substance Abuse the Governor’s six regions have been utilized to support alignment of all substance use related service system development initiatives that have been underway and planned through this effort.



Eligible Service Designations by Region

Table 2 identifies eligible service recommendations for Phase one by region that may be proposed by applicants. Table 3 provides equivalent information for identified Phase two targeted areas. **Organizations may apply for one or multiple service areas but are encouraged to demonstrate partnership efforts through the development of shared proposals.** The allocation amounts and service designations were determined based on the review of projected individuals entering community supervision, current treatment service availability and provider capacity to provide all services indicated. Applicants will only need to complete 1 proposal when applying for multiple services.

Example1: *A Day Report Center enters into a partnership with the local Substance Use Service Provider and a Faith Based Organization to offer: Out-Patient and Community Support Services combined with a Level I- Recovery Residence. In this instance, one application would be sufficient with an application total of \$220,000. based on service costs.*

Example2: *A Substance Use Service provider capable of offering all program/project requirements described within a region. In this instance, one application for all projects would be sufficient however Memoranda of Understanding with the required community partners must be developed as part of the application process.*

Table 2. Service Selection Phase 1

Region	Site Location	Service Selection
One	Marshall	1 Site OP/IOP
		1 FTE Community Engagement Specialist
		1 Recovery Residence Level II
		1 FTE Recovery Coach
Two	Phase 2 Planning	
Three	Wood, Wirt	1 Site OP/IOP
		1 FTE Community Engagement Specialist
		1 Recovery Residence Level II
		1.5 FTE Recovery Coach
Four	Monongalia	1 Site OP/IOP
		1 FTE Community Engagement Specialist
		1 FTE Recovery Coach
Five	Cabell/ Logan	1 Site OP/IOP (Logan)
		2 FTE Community Engagement Specialist
		1 FTE Recovery Coach
Six	Fayette, Mercer, Raleigh	1 Site OP/IOP
		2 FTE Community Engagement Specialist
		1 Recovery Residence III (Mercer)

Table 3. Service Selection Phase 2

Region	Site Location	Service Selection
One	Hancock	1 Site OP/IOP
		1 FTE Community Engagement Specialist
		1 Recovery Residence Level III
Two	Morgan, Berkeley, Jefferson, Mineral	1 Site OP/IOP
		1 FTE Community Engagement Specialist
		2 FTE Recovery Coach
Three	Development completed in Phase One	
Four	Harrison, Lewis, Randolph	1 Site OP/IOP
		2 FTE Community Engagement Specialist
		1 FTE Recovery Coach
Five	Kanawha	1 Site OP/IOP
		1 FTE Community Engagement Specialist
		1 Recovery Residence III
Six	Greenbrier	1 Site OP/IOP
		1 FTE Community Engagement Specialist
		1 Recovery Coach

Collaboration and Memoranda of Understanding Requirements

Applicants must demonstrate that a coordinated and integrated service system is in place to meet the complex needs of the identified target population. In doing so, Memoranda of Understanding (MOUs) **must** be completed among key partnering agencies indicated* and other organizations, which may include but are not restricted to:

- Behavioral Health (Substance Use and Mental Health)*
- Recovery Housing Programs and/or Local Public Housing Authorities *
- Primary Health/ Health Department*
- Hospitals
- Obstetric/Gynecological (* If women’s program)
- Pediatric
- Childcare (* If women’s program)
- Medication Assisted Treatment (MAT) Providers
- Individual/Family Assistance Programs*
- Early Intervention and Home Visiting Programs
- Family and/or Drug Courts (Adult or Juvenile)*
- Criminal Justice (Day Report, Regional Jails, Probation)*
- Employment, Education and/or Vocational programs*

Training Requirements

According to SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation, there are specific evidence-based programs and practices which have been deemed effective for treating substance use and dependence among the offender population. Cross-training among criminal justice and behavioral health providers who share responsibility for supervision and treatment of offenders in the community is critical. An offender population has unique characteristics that contribute to their risk for reoffending and it is important that community behavioral health providers are well-versed in the principles and treatment strategies associated with effective correctional intervention.

All awarded applicants will be required to participate in grantee orientation training and will also attend training in a minimum of 1 evidenced based curriculum to be determined by the planning and implementation team. Travel costs for essential program staff attending the required grantee training need to be included in the budget for 5 days in Charleston not to exceed more than \$1075 per person. Additional trainings will be covered by the funding organizations.

Grantee Required Training
Cognitive Behavioral Therapy
Offender Risk Assessment
Motivational Interviewing
Relapse Prevention
Medication Assisted Treatment
Offender Case Coordination
Clinical Assessment
Understanding Criminogenic Risk/Need and Principles of Effective Correctional Intervention
Community and Peer Based Supports

Section Three: PROPOSAL INSTRUCTIONS / REQUIREMENTS
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Eligible applicants must provide proof of 501(c) 3 status, a state or government entity, and/or a valid West Virginia business license.

Proposals must be submitted using the required AFA Application Template available at <http://www.dhhr.wv.gov/bhhf/AFA/Pages/default.aspx>. Responses must be submitted electronically via email to DHHRBHHFAnnouncement@wv.gov with the AFA Title and Number in the subject line. Paper copies of proposals will not be accepted. All submissions must be received no later than 5:00 PM on the application deadline. Notification that the proposal was received will follow. It is the sole responsibility of applicants to ensure that all documents are received by the application deadline. Proposals that fail to comply with the guidelines provided within this AFA, incomplete proposals or proposals submitted after the application deadline will not be reviewed. A signed Statement of Assurance must be submitted with each proposal. This document must be signed by the organization's CEO, CFO, and Project Officer.

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. There is maximum length for the abstract, see Table 4 for formatting requirements.

All applications will be reviewed by the BBHMF and DJCS 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. Applicants must utilize 12pt. Arial or Times New Roman font, single line spacing, and one inch margins. There is page limit for Section A - E, see Table 4 for formatting requirements. 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 (Section A-E) page limit; however, see Table 4 for formatting requirements of Sections F and G.

- 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)

Table 4. Formatting Requirements

	Single Service Proposal	Multi-Service/Joint Proposal
Abstract	Max. 35 Line	Max. 50 Line
Project Narrative (Section A – E)	Max. 25 Page	Max. 45 Pages
Supporting Documentation (Section F – G)	Max. 20 Page	Max. 30 Page

Section Four: **PROPOSAL OUTLINE**

All proposal submissions must include the following components without exception.

Abstract:

Provide a brief description of the project proposed as set forth in this announcement.

Project Narrative and Supporting Documentation:

A. Population of Focus and Statement of Need:

- Provide a comprehensive demographic profile of your population of focus in terms of race, ethnicity, language, gender, age, socioeconomic characteristics, and other relevant factors, such as literacy and other health disparities.
- Describe the stakeholders and resources in the geographic catchment area of the proposed project which can help implement the needed infrastructure development and intent of this AFA.
- Demonstrate an understanding of the target population (felons with a high risk of recidivism and a substance use need). Explain how this population relates to those currently served by your organization and how organizational capacity will be developed or enhanced to meet the needs of the target population.
- Describe the nature of the problem, including service gaps, and document the extent of the need (i.e. current prevalence rates or incidence data) for the population(s) of focus based on data. Identify the source of all data referenced. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for quantitative data that could be used are local epidemiologic data, state data, and/or national data.
- Document the need to implement, sustain, and improve effective substance use and co-occurring substance use and mental health disorder treatment and recovery services in the proposed catchment area that is consistent with the purpose of the program and intent of the AFA.
- Document the need for the proposed project in the proposed catchment area. Clearly

indicate which region and county(ies) that will be served by the proposed project.

- Discuss your agency's current level of participation in the Governor's Regional Task Force Meetings in the proposed region and document your ability to attend future meetings.

B. Proposed Evidence-Based Service/Practice:

- Describe how proposed project will address the need(s) outlined in the previous section.
- Clearly state project goals, objectives and strategies. These must relate to the intent of the AFA and each of the performance measures identified in Section E: Data Collection and Performance Measurement.
- Describe all 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. To verify/review EBPs visit SAMHSA's National Registry of Evidence-based Programs and Practices at <http://www.nrepp.samhsa.gov/> , SAMHSA's GAINS Center for Behavioral Health and Justice Transformation <http://gainscenter.samhsa.gov/>, <https://www.bja.gov/>, <http://www.crimesolutions.org> and <http://csgjusticecenter.org/mental-health-projects/behavioral-health-framework/>.
- Describe how the proposed practice(s) will address the following issues in the population 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.
- Explain how your program will implement each practice with fidelity.
- Discuss any screening tools that will be used and basis for their selection.
- Describe how health disparities will be addressed including information related to sub-populations identified in the proposed region. Describe strategies to decrease differences in access, service use, and outcomes. One 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 BBHMF 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.

C. Proposed Implementation Approach:

- Reference **Appendix B** for the Substance Use Recovery Residence Standards, Desired Program Models and other relevant program information. Reviewers will look for applicants documented awareness/knowledge of and commitment to upholding these standards within this section of the Project Narrative.
- Describe how achievement of the project goals will produce meaningful and relevant results in your community (e.g. increase access, availability, prevention, outreach, pre-services, treatment and/or recovery) and support BBHMF's intent for the program.
- Describe the proposed program activities, how they meet your infrastructure needs, how they fit within or support the development of the statewide continuum of care and how they relate to your goals and objectives.
- Provide a gantt chart or graph depicting a realistic timeline 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 immediately after the beginning of the grant period, and no later than three (3) months after award. [Note: The timeline should be part of the Project Narrative. It should not be included as an attachment.]
- Describe how you will screen and/or assess individuals for the presence of co-occurring

substance use and mental health disorders and use the information obtained from the screening and/or assessment to facilitate appropriate referral to treatment.

- Describe how you will ensure the input of target population in assessing, planning, and implementing your project. Describe the feedback process between the consumers, your organization, project partners/key stakeholders, and the BBHMF 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(s) in **Attachment 1**.
- Clearly state the unduplicated numbers of individuals you expect to serve (annually) with grant funds. Include the type and quantity of services to be provided. Explain how the level of services provided will correspond to individual risk and needs. Include projections for sub-populations (family/primary supports) served separate from projections for the targeted population.
- Describe briefly how all required program components will be developed, and how they will be coordinated with one another to provide for a full continuum of care for the target population.
- Describe additional training to be sought and utilized in the development of the project, identifying key training components as indicated in section 2 (Grantee Requirements) (by title) and their relevance.
- Describe how you will ensure the utilization of other revenue realized from the provision of substance use treatment and recovery services to the extent possible and use BBHMF 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 BBHMF grant funds). Also describe how you will facilitate the health insurance application and enrollment process for eligible uninsured individuals.
- 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 continuity 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 including 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 BBHMF 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 BBHMF regarding what options may exist, the discussions must occur prior to submission of the proposal. Any architectural plans or diagrams that may exist may be included as **Attachment 2**

D. Staff and Organizational Experience:

- 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.
- Confirm that all staff has been trained in population specific risk/need/responsiveness and care, as listed in Section Two of this application. Additional training requirements include: cultural competency, suicide prevention, trauma informed and person centered care
- Supply sufficiently trained/ credentialed peers/staff available to provide programming

as outlined in Section Two of this application

- Discuss how key staff has demonstrated experience and are qualified to serve the population(s) of focus and are familiar with the applicable culture(s).

E. Data Collection and Performance Measurement:

- 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 at a systems level and assure that the goals and objectives 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. Budget Form and Budget Narrative: *All requirements set forth in Section F must be included in **Attachment 3** and will not count toward the Project Narrative page limit*

- Include a proposed Target Funding Budget (TFB) with details by line item ***for each Eligible Service***, including sources of other funds where indicated on the TFB form.
 - Include expenses for attending Quarterly BBHFF Provider Meetings.
- Include a proposed Detailed Line Item Budget (DLIB) with details for the all programming.
- 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 attach this separate TFB to the coordinating Budget Narrative document.
- Additional financial information and requirements are located in **Appendix C**.

All forms referenced in Section F: Budget Form and Budget Narrative can be accessed through the BBHF web-site at: <http://www.dhhr.wv.gov/bhhf/forms/Pages/FinancialForms.aspx>

G. **Attachments 1 through 3:** *Will not count toward the Project Narrative page limit*

- **Attachment 1:** Letters of Support
- **Attachment 2:** Facility/site diagrams (if applicable/available)
- **Attachment 3:** 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 10th of each month, in accordance with National Outcome Measures (NOMS), state guidelines and timeframes established by the WVDMAPS and the WVDHHR.

Performance Measurement and Quality Assurance

The implementation of evidence-based practices requires evaluator involvement in the measuring of staff and program performance. Performance will be monitored throughout each phase of implementation, providing periodic feedback to DJCS, BBHFF, correctional supervision agencies, and funded services providers.

Capturing and Reporting Outcomes

The BBHFF will provide clinical and fiscal oversight of the awarded grantees in combination with the DJCS. The DJCS will also continue to monitor day report centers and collect data on service delivery and offender outcomes. Efforts will be made to develop joint monitoring procedures that account for treatment integrity specific to offender populations and common behavioral health modalities. Joint monitoring procedures will provide consistency in measurement and reporting for treatment providers and community supervision agencies. The assumption is that if provider staff is trained in best practice interventions, and quality programming is implemented, individual outcomes will improve.

Therefore, it is critical that training specific to offender populations occurs and continues on an ongoing basis and that training efforts and service delivery are closely monitored for quality. As mentioned in the recommendation, in order to report on the effectiveness of the JRA and understand cost savings, it will be necessary to capture consistent measurements program-wide that include, but are not limited to:

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

In addition to the summary measures above, correctional interventions require the consistent measurement of relevant, evidence-based practices accompanied with feedback to both providers and individuals. Relevant practices for offender populations include, but are not limited to, monitoring the quality of offender assessments, case plans, motivational interviewing, and staff interactions. Use of core correctional practice and adherence to the risk-need-responsivity principles is also necessary for influencing outcomes. Therefore, DJCS and BBHF will adjust performance measures throughout the project. Changes in performance measures will be informed by preliminary monitoring and outcomes results as well as evidence-based practices and research from both the correctional and behavioral health fields. |

Peer Review Process

All grantees must discuss their willingness to participate in a peer-review process to assess the quality and appropriateness of substance use 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 (BBHFF)** in partnership with the **Division of Justice and Community Service (DJCS)** 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 requests may also be submitted via email to: DHHRBHFAnnouncement@wv.gov. All emailed technical assistance inquiries will be addressed by the BBHFF and DJCS and posted to a Frequently Asked Questions (FAQ) document on the BBHFF website available at DHHR.WV.GOV/BHFF/AFA.

1. Additional data resources are available at the BBHFF and DJCS website. 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>

<http://www.djcs.wv.gov/Pages/default.aspx>

2. **WV Behavioral Health Profile** (also accessible by clicking 'Resources' on DADA webpage): Contains Statewide data pertaining to Substance Use 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>

Appendix A

Service Definitions and Credential Requirements (Refer to WV Medicaid Manual

Service Title	Definition	Education and Credential
Engagement Services	Includes the evaluation and service planning support needed to address the complex needs of individuals and their families impacted by mental disorders, substance use disorders and associated problems with specific services that include: Assessment, Specialized Evaluations including Psychological, Service Planning including Crisis Planning, Consumer and Family Education and Outreach and Advocacy	<p>WV Medicaid Manual:</p> <ul style="list-style-type: none"> STAFF CREDENTIALS - Staff must have a minimum of a master's degree in a field of human services or a bachelor's degree in a field of human services with proper supervision and oversight by an individual with a minimum of a master's degree. Staff must be properly credentialed by the agency's internal credentialing committee.
Outpatient	Out-Patient Services- is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual with mental, substance and other disorders aimed to achieve and maintain sobriety, physical and mental health with maximum functional ability with services that may include: Individualized Evidence-Based Therapies, Group Therapy, Family Therapy, Multi-Family Counseling, and Consultation with Care-Givers	<p>WV Medicaid Manual:</p> <ul style="list-style-type: none"> STAFF CREDENTIALS - Must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Use treatment issues. To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines STAFF CREDENTIALS – same as above

<p>Community Support Services</p>	<p>Community Support Services- meaningful daily activities such as a job, school, volunteerism, family caretaking or creative endeavors that are usually developed through the participation in social networks; gaining independence, income and resources to support participation in a safe and stable environment. Services include: Social, daily living and cognitive skill building, case management, continuing care, behavior management, supported employment, supportive housing, recovery housing and therapeutic mentoring</p>	<p>WV Bureau for Behavioral Health and Health Facilities:</p> <p>COMMUNITY ENGAGEMENT SPECIALIST</p> <ul style="list-style-type: none"> STAFF CREDENTIALS – High school graduate and working toward BBHMF Community Support Specialist Certification
<p>Recovery Residence</p>	<p>Substance Use Recovery Residences sometimes referred to as Transitional Living, Oxford Houses, Recovery Homes, and Healing Place* models provide safe housing for individuals, age eighteen (18) and older who need or are in recovery from substance use and/or substance use and co-occurring mental disorders. These services follow and/or are concurrent with short-term treatment (typically short-term residential) and is intended to assist those individuals for a period of twelve (12) to eighteen</p>	<p>WV Bureau for Behavioral Health and Health Facilities:</p> <p>RESIDENCE STAFF</p> <ul style="list-style-type: none"> STAFF CREDENTIALS – High school graduate with lived experience Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master’s degree in a clinical field, but only when directly addressing Substance Use treatment issues. To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines *

	(18) months or until it is determined that an individual is able to safely transition into a more integrated environment. All applicants for funding to operate a Level II Recovery Residence must provide statements agreeing to meet the BBHHF's Substance Use Recovery Residence Standards that are aligned with national standards.	
Recovery Support Services	Provide opportunities of change whereby individuals work to improve their own health through social inclusion or engaging in supportive recovery communities with services that may include: Peer Support, Recovery Support Coaching, Recovery Support Center Services, Supports for Self Directed Care	WV Bureau for Behavioral Health and Health Facilities: RECOVERY COACH <ul style="list-style-type: none"> STAFF CREDENTIALS – High school graduate with lived experience and working toward BBHHF Peer Support Specialist Certification

APPENDIX B:

Required Level II and III 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 Use 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 the Level II Recovery Residence standards:

1. Organizational/Administrative Standards
1.1 The Recovery Residence is a legal business entity, as evidenced by a 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 has 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 plan
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 all 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 posted 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 of 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 3 rd party clinical services in accordance with 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 also 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 at least 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 in areas where street parking is scarce.

The following are the **Level III 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 plan;
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 3 rd party clinical services in accordance to State laws;
4.16 The Recovery Residence offers life skills development services;
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 C

Definitions

Assessment- An integrated series of procedures conducted with an individual to provide the basis for the development of an effective, comprehensive and individualized treatment plan.

Behavioral Health System-The service system that offers a continuum of mental health promotion, substance abuse prevention and early intervention programs universally for the general public as well as community based treatment and recovery support services for individuals with mental health and substance use disorders.

Care Coordination- A service which identifies, connects and provides personal and community supports to individuals with a diagnosis of mental illness, substance abuse, or co-occurring disorders, and who are committed, have a history of commitment, or are in danger of commitment to a state psychiatric or private diversion facility and would benefit from discharge planning and/or community based services

Community Corrections- An umbrella term for the supervision of criminal offenders in the community that includes probation, parole, home confinement, and day report centers but excludes institutional corrections. Community corrections is also referred to as community supervision.

Community Support Services- meaningful daily activities such as a job, school, volunteerism, family caretaking or creative endeavors that are usually developed through the participation in social networks; gaining independence, income and resources to support participation in a safe and stable environment. Services include: Social, daily living and cognitive skill building, case management, continuing care, behavior management, supported employment, supportive housing, recovery housing and therapeutic mentoring.

Conditions of Supervision- Stipulations with which persons placed on community supervision must comply or face possible sanctions up to and including revocation of their community supervision. General conditions, such as not engaging in criminal activity, apply to all individuals under supervision. Special conditions, such as participation in drug or mental health treatment, are added on a case-by-case basis.

Correctional Control and Supervision- The monitoring and management practices exercised by corrections agencies over individuals for whom they are responsible both in an institution and the community in order to maintain order and safety and to carry out the mandates of the criminal justice system.

Correctional Rehabilitation- Intervention targeting and individual's attitudes, thinking, behavioral, or other factors relating to their criminal conduct to reduce the likelihood of reoffending.

Criminogenic Needs- The characteristics or circumstances (such as antisocial attitudes, beliefs, thinking patterns and friends) that research has shown are associated with criminal behavioral, but which a person can change. These needs are used to predict risk of criminal 25

behavior. Because these needs are dynamic, risk of recidivism can be lowered when these needs are effectively addressed.

Criminogenic Risk- The likelihood that individuals will commit a crime or violate the conditions of their supervision. Risk does not refer to the seriousness of a crime.

Criminogenic Risk Factors- Characteristics, experiences and circumstances that are predictive of future criminal activity such as criminal history, antisocial attitudes, thinking, patterns and friends. Through risk assessments the presence of these characteristics can be used to predict the likelihood that the individual will reoffend.

Diversion- Offers persons charged with criminal offenses alternatives to traditional criminal justice proceeding and it permits participation by the accused only on a voluntary basis and it occurs no sooner than the filing of formal charges and no later than a final adjudication of guilt and it results in a dismissal of charges or its equivalent, if the individual successfully completes the diversion process.

Day Report Centers- The West Virginia Community Corrections Act (Chapter 62, Article 11C of the WV State Code) provides a means for communities to develop, establish and maintain community based corrections programs to provide the judicial system with sentencing alternatives for those adult offenders who may require less than institutional custody.

Drug Courts- Intended to address addiction, and thus seek as participants offenders who are both high risk (of future offences) and high need (severity) of substance problems. Key team members include ADC Judge, Prosecutor, Probation Officer and Treatment Professionals

Engagement Services- includes the evaluation and service planning support needed to address the complex needs of individuals and their families impacted by mental disorders, substance use disorders and associated problems with specific services that include: Assessment, Specialized Evaluations including Psychological, Service Planning including Crisis Planning, Consumer and Family Education and Outreach and Advocacy

Evidence-Based Practices- Clinical interventions or administrative practices for which consistent scientific evidence demonstrates that, when they are implemented correctly, expected and desired outcomes are achieved. EBPs stand in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

Out-Patient Services- is the use of any planned, intentional intervention in the health, behavior, personal and/or family life of an individual with mental, substance and other disorders aimed to achieve and maintain sobriety, physical and mental health with maximum functional ability with services that may include: Individualized Evidenced-Based Therapies, Group Therapy, Family Therapy, Multi-Family Counseling, and Consultation with Care-Givers

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Recovery Residence- Recovery Residences sometimes referred to as Transitional Living, Oxford Houses and Recovery Homes, provide safe housing for individuals, age eighteen (18) and older who are in recovery from substance use and/or substance use and co-occurring mental disorders. These services follow and/or are concurrent with short-term treatment (typically short-term residential) and is intended to assist those individuals for a period of twelve (12) to eighteen (18) months or until it is determined that an individual is able to safely transition into a more integrated environment.

Recovery Support Services- provide opportunities of change whereby individuals work to improve their own health through social inclusion or engaging in supportive recovery communities with services that may include: Peer Support, Recovery Support Coaching, Recovery Support Center Services, Supports for Self Directed Care

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	DHS codified at 45 C.F.R. § 74 ; USDA codified at 7 C.F.R. § 3019 ;

circular use the cost principles in OMB Circular A-122 .	EDUC codified at 34 C.F.R. § 74 ; 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

	<p>at 34 C.F.R. § 80;</p> <p>Environmental Protection Agency (EPA) codified at 40 C.F.R. § 31.</p>
<p>Private nonprofit organization, institutions of higher education, or a hospital use the uniform administrative requirements in OMB Circular A-110.</p>	<p>DHS codified at 45 C.F.R. § 74;</p> <p>USDA codified at 7 C.F.R. § 3019;</p> <p>EDUC codified at 34 C.F.R. § 74;</p> <p>EPA codified at 40 C.F.R. § 30.</p>
<p>For-profit organization use the uniform administrative requirements in OMB Circular A-110.</p>	<p>DHS codified at 45 C.F.R. § 74</p> <p>USDA codified at 7 C.F.R. § 3019;</p> <p>EDUC codified at 34 C.F.R. § 74;</p> <p>EPA codified at 40 C.F.R. § 30.</p>

Appendix E

References and Resources

- WV State Legislative Website
- Justice Reinvestment in WV, Policy Options for Consideration, January 2013
- DOC and Supreme Court Website Review
- ORAS, University of Cincinnati Assessment Tool
- Regional Jail Medical Assessment Tool Review, 2013
- DCJCS Data and Maps
- Interviews with John Lopez-Regional Jails, Mike Lacy, Lora Maynard and Robert McKinley-Adult Drug Courts and Probation, Jennifer Ballard, Amanda McGrew, Judy –DOC, Judy Fitzgerald-Parole Services
- SAMHSA GAINS Center for Criminal Justice Services
- Adults With Behavioral Health Needs Under Correctional Supervision: In 2012, the Council of State Governments Justice Center, the National Institute of Corrections, The US Department of Justice's Bureau of Justice Assistance and the US Department of Health and Human Service's Substance abuse and Mental Health Services Administration cooperatively produced a white paper, Adults With Behavioral Health Needs Under Correctional Supervision, serving as a model for state systems development