



REQUEST FOR PROPOSALS:

## **Reimagining America's Crisis Response Systems**

September 2018

## PROJECT OVERVIEW AND REQUEST FOR PROPOSALS

### Overview

The Laura and John Arnold Foundation (LJAF) is committed to leveraging the power of data, research, and innovation to improve community safety by reducing crime, increasing police effectiveness, and working to ensure that laws are enforced in a fair and equitable way.

Individuals experiencing mental illness, substance use disorders, or homelessness require evidence-based, preventive treatment to achieve improved outcomes. Too often, the needs of these vulnerable populations are not only unmet, but inadvertently worsened by emergency response systems. With police having to act as the primary responders to a crisis, individuals often end up in situations that lead to the use of force, arrest, and/or incarceration. These approaches fail to address individuals' underlying health, societal, and financial struggles; are cost-inefficient; and cause significant harm to both the individual and the community.

Governments need better data, tools, and systems to direct vulnerable people to appropriate and effective resources outside the criminal justice system. Providing more options to police when they have discretion over whether to use the power to arrest will benefit law enforcement as well as the individuals and communities they serve. We are working to identify and help implement evidence-based policies and programs that can reduce the use of force, arrest, and/or incarceration, and instead connect vulnerable populations to evidence-based treatment programs and services for improved outcomes.

To support this goal, LJAF seeks proposals for evaluations of **(1) emergency response programs for individuals in moments of crisis, (2) post-crisis stabilization facilities, and/or (3) treatment programs and services funded by governments or other entities.** Evaluations should focus on outcomes for individuals whose vulnerabilities include mental illness, substance use disorders, and/or homelessness.

### RFP Background and Objectives

Many communities across the country recognize that without access to preventative treatment programs or services to address mental illness, substance use disorders (SUDs), and homelessness, people with these complex needs often experience crises that require emergency response by police, fire, and

Emergency Medical Services/Emergency Medical Technicians (EMS/EMT). LJAF's ultimate goal is to identify and scale effective, preventative treatment and services in lieu of justice system involvement. However, as we work toward that goal, we believe there is a significant opportunity to leverage moments of contact with first responders to redirect vulnerable people facing charges for low-level offenses away from places where treatment is typically unavailable—such as jails and hospital emergency departments—and towards places that have specialized recovery services such as mental health stabilization and substance use detoxification, and/or which can provide connections to longer-term evidence-based treatment programs and services.

LJAF is committed to working with jurisdictions to evaluate interventions that leverage partnerships between police, fire departments, and EMS/EMTs to divert individuals who are homeless or who experience mental illness and/or SUDs—with a particular attention to those with opioid use disorder (OUD)—to evidence-based treatment and services. We are specifically interested in approaches that: (1) seek to improve **emergency responses** for individuals in moments of crisis, (2) provide immediate **post-crisis alternatives** to arrest or unnecessary hospitalization, and (3) connect individuals with evidence-based **treatment programs and services**. In addition to the brief summaries below, project categories are described thoroughly in **Appendix A**.

- **Emergency Response:** We seek proposals to evaluate programs that aim to increase the capacity of police, fire, or EMS/EMTs to recognize signs of mental illness and/or substance misuse, safely de-escalate and stabilize emergency situations, and maximize diversion to treatment and services. We are particularly interested in opportunities to evaluate:
  - Specialized training programs for police officers such as: (1) Crisis Intervention Team training; and, (2) Mental Health First Aid; and,
  - Police-initiated crisis response units such as: (1) Crisis Intervention Teams, that partner specially trained sworn officers with community, health care, and advocacy groups; (2) Co-responder models that partner an adequately trained sworn police officer with a mental health professional or clinician for crisis response; and, (3) Mobile crisis teams, a group of mental health professionals who are available to respond to calls for service at the request of law enforcement officers.

- **Post-Crisis Stabilization:** Many communities have redesigned or are in the process of redesigning their crisis response system to include alternatives to jails or emergency rooms for people experiencing a mental health or substance induced crisis, with the goal of transitioning these individuals to targeted long-term treatment and services. We seek proposals to study alternate facilities (such as Crisis Stabilization Units, Crisis Response Centers, and Crisis Diversion Facilities) that offer a range of co-located services, which can include mental health crisis stabilization, sobering facilities, medically-monitored detoxification, and referrals to treatment and services to address behavioral health and housing needs. We are interested in better understanding the effectiveness and cost-benefit of these facilities as they are used to stabilize an individual post-crisis, decrease arrest rates and use of acute emergency services (*e.g.*, EMS/EMT transports and hospitalizations), and increase engagement with longer-term treatment.
- **Treatment Programs and Services:** We would like to continue to build the evidence base for treatment programs and services—for individuals with mental illness, substance use disorders, and/or who are homeless—that reduce unnecessary encounters with the criminal justice and emergency response systems, improve individual outcomes, and generate public cost savings. Additionally, we are interested in better understanding approaches to increasing uptake and continued engagement in these programs. We are particularly interested in rigorous evaluations of programs backed by promising prior evidence, such as Housing First, Forensic Assertive Community Treatment/Assertive Community Treatment (FACT/ACT), Critical Time Intervention, Coordinated Care, and Cognitive Behavioral Therapy (CBT).

Proposals should address research questions that can inform decisions about the efficacy and cost-effectiveness of interventions in one or more of the aforementioned project categories. Proposals should be developed by researchers working in close partnership with practitioners, service providers, and government agencies. When possible, LJAF encourages research projects that incorporate administrative data sources (*e.g.*, arrest and recidivism rates, use of medical services such as emergency room visits and hospitalizations, health outcomes, housing stability, and economic well-being) into robust outcome measurement strategies; we also encourage measures of how programs affect costs.

Funded proposals will help LJAF fulfill multiple objectives:

- Build the evidence base within the three project categories to inform the work of jurisdictions that seek to improve emergency responses and crisis stabilization for individuals with mental illness, substance use disorders, and/or who are homeless.
- Cultivate communities of practice among jurisdictions that are testing strategies to improve interactions between police and individuals with mental illness, substance use disorders, and/or who are homeless; increasing the use of alternatives to arrest and reducing the use of acute emergency services.
- Foster relationships between researchers, government agencies, and providers in order to establish a knowledge base for effective programs, trainings, and strategies within the three project categories.

## **Project Tiers**

LJAF invites evaluation proposals in three tiers across the three project categories detailed in **Appendix A: emergency response, post-crisis stabilization, and/or treatment programs and services**. Applicants should apply based on the nature of the program they are evaluating and the specific research questions they are attempting to address.

### ***Impact Evaluation Tier:***

The funding aim for the Impact Evaluation Tier is to evaluate interventions with moderate evidence to determine if sizable effects are achievable, and to support larger-scale evaluations of interventions with strong evidence to assess causal impact and cost-benefit. For interventions with moderate evidence (*e.g.*, a few well-designed studies point to significant desired effects), we are interested in randomized controlled trials (RCTs) and rigorous quasi-experimental designs such as comparative interrupted time series. For interventions with promising or strong evidence (*e.g.*, several rigorous studies, including at least one randomized trial, point to significant desired effects), we are interested in funding RCTs to test for causal impact as well as support cost-benefit analysis. While well-conducted RCTs that aim to measure effects on important outcomes over a sustained period of time are preferred in this tier, rigorous quasi-experimental designs (QEDs) will be accepted as an alternative to determine impact when randomization is not possible. Studies

using a RCT or QED design should address the criteria and follow the submission instructions in **Appendix B**.

***Innovation Tier:***

The funding aim for the Innovation Tier is to define and standardize relatively untested interventions and prepare interventions for impact evaluations. For interventions with limited prior evidence—such as mobile crisis teams, co-responder models, post-crisis stabilization/diversion sites, and care coordination—we are interested in funding studies such as process evaluations and feasibility studies that could lead to a follow-up rigorous impact study. We prefer studies in this tier that assess interventions across multiple sites/jurisdictions, and take additional steps to prevent false positives. Proposals within this category should address the criteria in **Appendix B**. If the applicant proposes a follow-up impact study, and demonstrates that the study cannot be carried out using an RCT design, the applicant should describe an alternative methodology that uses the most rigorous research design feasible. For examples of non-experimental study designs and their appropriate applications, please refer to the papers published by the [Society of Prevention Research](#) and by scholars [Susan Athey and Guido Imbens](#). For additional guidance on which non-experimental methods yield credible evidence, see [“Which Comparison-Group \(“Quasi-Experimental”\) Study Designs Are Most Likely to Produce Valid Estimates of a Program’s Impact?”](#)

***Descriptive Tier:***

The funding aim for the Descriptive Tier is to address the field’s lack of accurate and updated descriptive statistics. The absence of accurate descriptive data on emergency response systems and outcomes prevents researchers and practitioners from identifying potential interventions and research questions. For instance, rarely do jurisdictions or states track, measure, or report on the following questions: How often are police dispatched for situations involving a person experiencing mental illness, substance use disorder, or homelessness? Where and when do such encounters occur most often? What are the final dispositions for these encounters? In many cases, administrative data alone will be unable to answer such questions; however, we encourage proposals that contemplate whether, and to what extent, existing administrative data sources can be combined or manipulated to approximate difficult-to-track emergency response systems outcomes. This tier will fund descriptive research projects that fill knowledge gaps in the field,

identify reliable outcome measures, and inform the work of peer jurisdictions seeking to understand and improve their own emergency response systems. We prefer descriptive projects that provide maximum benefit to practitioners and researchers across the country, such as those that document how an intervention is implemented across a wide range of geographies, focus on rapidly-evolving or previously unexamined interventions, or thoroughly document previously unknown needs and/or barriers. We are particularly interested in proposals that would point the way towards more systematic and large-scale improvements in data systems, data collection, and interoperability.

### **Funding Priorities**

Preference will be given to proposals that evaluate interventions targeting the following outcomes of interest:

- A. *Short-term outcomes*: individual-level criminal justice outcomes such as arrest and recidivism rates; use of medical services such as emergency room visits, hospitalizations, and community-based resources; safe de-escalation and stabilization; diversion of individuals with SUD and/or mental illness to locations with treatment capacity to meet those needs; and, increased access to evidence-based treatment and services.
- B. *Long-term outcomes*: acute emergency service resource utilization, clinical and public health outcomes, criminal justice outcomes, housing status, and economic well-being.
- C. *Cost-benefit analyses*: documenting savings based on valid estimates of intervention effect sizes; and/or more basic cost assessments that record expenditures and savings related to these programs.

Overall, we seek a balanced set of research projects that build evidence bases and generate results applicable to jurisdictions that range in size and capacity.



## Matrix with Examples of Potential Proposals

	Project Categories		
	Emergency Response Programs	Post-Crisis Stabilization	Treatment Programs
Impact Evaluation Tier	<i>RCT of Crisis Intervention Team trainings</i>	<i>RCT of Crisis Response Centers</i>	<i>RCT of Housing First model</i>
Innovation Tier	<i>Multi-site process evaluation of abbreviated mental health first aid model</i>	<i>Implementation and impact analysis for new Crisis Stabilization Units across three similar jurisdictions</i>	<i>Feasibility study of co-responder model with proposed follow-up RCT</i>
Descriptive Tier	<i>Documentation of encounters between first responders and individuals with independent and co-occurring disorders</i>	<i>Documentation of crisis stabilization units and available service offerings</i>	<i>Documentation of attributes and experiences of individuals turned away from affordable housing services</i>

### Process

This RFP will proceed in two stages: Letters of Interest (LOI) will be accepted on a rolling basis through November 5, 2018. A prospective applicant Q&A webinar will take place on October 5, 2018. If the LOI meets specified criteria, the applicant will be invited to submit a full proposal that will be evaluated by a review panel. LOI and full proposals should adhere to the format specifications and fully address the requirements and selection criteria outlined in **Appendix B**.

## APPENDIX A: DESCRIPTION OF PROJECT CATEGORIES

LJAF requests proposals to evaluate interventions that: (1) seek to improve **emergency responses** for individuals in moments of crisis, (2) provide immediate **post-crisis alternatives** to arrest or unnecessary hospitalization, and (3) connect individuals with evidence-based **treatment programs and services**. Evaluations should focus on outcomes for individuals whose vulnerabilities include mental illness, substance use disorders, and/or homelessness. Applicants should clearly describe how their proposed project fits into one or more of these three project categories:

### **1. Emergency Response**

Since police officers are almost always the first responders to individuals experiencing a behavioral health crisis in the United States, our emergency response systems have evolved to treat health crises as a criminal justice matter. It is estimated that one percent of police calls for service involve people with mental illness and six to ten percent of all police contacts with the public involve persons with serious mental illnesses.<sup>1</sup> A study of four Chicago Police Department districts found that 60 percent of officers reported at least one encounter with a person with mental illness in the past month and officers averaged four such encounters per month.<sup>2</sup>

Emergency response to people in mental health crisis can be fraught and result in negative consequences for the responding officers, individuals, and the community. Recent Department of Justice (DOJ) pattern and practice investigations have revealed instances of excessive use of force by police against persons experiencing a mental health crisis. In an investigation of one department, the DOJ found that 70 percent of situations in which officers used excessive or unnecessary force in minor arrest cases involved persons with mental illness or those under the influence of alcohol or drugs.<sup>3</sup> According to data collected by researchers at *The Washington Post*,<sup>4</sup> in 2017 at least 25 percent of all fatal officer-involved shootings

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<sup>1</sup> Livingston, J.D. (2016). Contact between Police and People with Mental Disorders: A Review of Rates. *Psychiatric Services* 67:850–857. Retrieved from <https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201500312>

<sup>2</sup> Kerr, A., Morabito, M., & Watson, A. (2011). Police Encounters, Mental Illness and Injury: An Exploratory Investigation. *Journal of Police Crisis Negotiations* 10: 116-132. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2991059/>

<sup>3</sup> The United States Department of Justice. Special Litigation Section Cases and Matters. Retrieved from <https://www.justice.gov/crt/special-litigation-section-cases-and-matters0#police>

<sup>4</sup> In 2015, The Post created a database cataloging every fatal shooting nationwide by a police officer in the line of duty, collecting data on those who were killed and details of the shootings. The effort began because data

involved a person with mental illness.<sup>5</sup> These encounters also result in injuries to officers, accounting for about 3.4 percent of cases where officers were assaulted in the line of duty in 2016.<sup>6</sup>

In addition to responding to mental health related calls, police have been increasingly engaged in responding to drug overdoses and other substance-related emergencies. According to the Centers for Disease Control and Prevention (CDC) in 2017, drug overdose deaths totaled 69,948, a 13.2 percent increase over the year before, with approximately three-fourths of all drug overdose deaths caused by opioids.<sup>7</sup> Police departments are frequently responding to overdoses and directly intervening to save lives. According to a 2017 survey by the Police Executive Research Forum (PERF), 63 percent of responding agencies have trained officers to carry and administer naloxone, the nasal spray medication that can reverse the effects of a heroin overdose (compared to four percent of agencies surveyed in 2014).<sup>8</sup>

While existing research illustrates the frequency of interactions between police and people with mental illness or substance use disorders, little is known about the nature of these interactions, their influence on long-term outcomes for public safety and the affected individuals, and effective interventions. There is scant national data on the emergency response system and appropriate alternatives, leaving many important questions unanswered. Therefore, efforts to develop knowledge related to this system and specific emergency response strategies should be expanded through improved data collection, research, and evaluation.

To this end, we seek proposals to evaluate programs that aim to increase the capacity of police, fire, or EMS/EMT to recognize signs of mental illness or substance misuse, safely de-escalate and stabilize emergency situations (including overdoses), and maximize opportunities for the use of alternatives to arrest—such as no further enforcement action and/or diversion to treatment and services.

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compiled by the federal government was unreliable and incomplete. The project was awarded the [2016 Pulitzer Prize for National Reporting](#). This database is based on news reports, public records, social media and other sources. [Click here](#) to read more about the Washington Post's methodology.

<sup>5</sup> Washington Post. (2017). Fatal Force project. *Washington Post*. Retrieved from <https://www.washingtonpost.com/graphics/national/police-shootings-2017/>

<sup>6</sup> Federal Bureau of Investigation. (2016). 2016 Law Enforcement Officers Killed and Assaulted. *Uniform Crime Report*. Retrieved from <https://ucr.fbi.gov/leoka/2016/officers-assaulted/tables/table-74.xls>

<sup>7</sup> Ahmad FB., Rossen, LM., Spencer, MR., Warner M., & Sutton, P. (2018). Provisional Counts of Drug Overdose Death Counts. *National Center for Health Statistics*. Retrieved from <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

<sup>8</sup> Police Executive Research Forum. (2017). The Unprecedented Opioid Epidemic. *Police Executive Research Forum*. Retrieved from <http://www.policeforum.org/assets/opioids2017.pdf>.

## 1.1 Training

Trainings such as Crisis Intervention Team (CIT) trainings are a common approach to building first responders' capacity to recognize the signs of mental illness or substance use-related psychosis and safely stabilize emergency situations. The goals of the CIT model, for example, are to reduce use of force and injuries and divert individuals away from the justice system and towards appropriate mental health services.<sup>9 10 11</sup> While the CIT model is a collaborative partnership that includes multiple core elements, the most widely known and implemented is a 40-hour specialist training that teaches select officers to recognize signs and symptoms of mental illness, de-escalate persons in crisis, and link individuals to services.<sup>12</sup> We are interested in rigorous evaluations of CIT and other training models, including strategies that are less intensive than CIT and provide basic mental health awareness and de-escalation training; for instance, Mental Health First Aid (MHFA) for Public Safety (8 hours). We are also interested in evaluations of other agency-developed 8-, 16-, and 40-hour mental health awareness and de-escalation trainings. Importantly, we recognize that commonly-used outcome measures of training program effectiveness are inadequate for gauging the effectiveness of CIT and related trainings, so it will be important for applicants to plan robust outcome measurement strategies.

## 1.2 CIT, Co-Responder and Mobile Crisis Response Models

We are interested in evaluating emergency response programs such as Crisis Intervention Teams, a police-based crisis intervention response that partner with community, health care, and advocacy groups; and co-responder and mobile crisis teams, which incorporate civilian mental health workers, clinicians, and psychiatrists as co-responders to mental health and substance-

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<sup>9</sup> Hartford, K., Carey, R., & Mendonca, J. (2006). Pre-arrest diversion of people with mental illness: literature review and international survey. *Behavioral Sciences & the Law*, 24(6): 845-856. Retrieved from <https://onlinelibrary.wiley.com/doi/abs/10.1002/bsl.738>

<sup>10</sup> Steadman, H. J., Deane, M. W., Borum, R., & Morrissey, J. P. (2000). Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies. *Psychiatric Services*, 1(5): 645-649. Retrieved from <https://doi.org/10.1176/appi.ps.51.5.645>

<sup>11</sup> Watson, A. C., Morabito, M. S., Draine, J., & Ottati, V. (2008). Improving police response to persons with mental illness: A multi-level conceptualization of CIT. *International Journal of Law and Psychiatry*, 31(4): 359-368. Retrieved from <https://doi.org/10.1016/j.ijlp.2008.06.004>

<sup>12</sup> University of Memphis CIT Center (2017). CIT Center. Retrieved from <http://www.cit.memphis.edu/>

related emergencies, with a goal of diverting the individual in crisis to more appropriate service options.

### 1.3 Increasing Access to and Use of Evidence-based Treatment for Substance Use

We are interested in funding evaluations of programs that leverage emergency response as an opportunity to connect individuals with OUD and other SUDs to treatment and support services. We want to support evaluations of programs that increase access to and use of naloxone by first responders, as well as programs that provide readily-accessible clinically-proven treatment (such as buprenorphine) to individuals with OUD in a variety of emergency settings, including: emergency rooms, post-OD in the field, crisis stabilization centers and other detox facilities, and in other places with first responder presence (*e.g.*, police and fire stations).

## **2. Post-Crisis Stabilization**

Many communities have redesigned or are in the process of redesigning their crisis response system to include alternatives to jail or hospitals that provide more targeted services for people in mental health crisis or who have suffered a substance overdose. A growing number of communities are creating alternate facilities with a range of co-located services, which can include mental health crisis stabilization, sobering facilities, medically-monitored detoxification, and referrals to long-term treatment. While the names of these facilities vary by community (such as Crisis Stabilization Units, Crisis Response Centers, Crisis Diversion Facilities ), they serve as short-term care for people experiencing acute psychiatric and/or substance use crisis. Average stays range from hours to several days, depending on the need.<sup>13</sup>

We are interested in better understanding the effectiveness and cost-benefit of these facilities as they are used to stabilize an individual post-crisis, decrease arrest rates and use of acute emergency services (*e.g.*, EMS/EMT transports and hospitalizations), and increase engagement with longer-term treatment.

## **3. Treatment Programs and Services**

We would like to continue to build the evidence base of treatment programs and services—for individuals with mental illness, substance use disorder, and/or who are homeless—to reduce unnecessary

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<sup>13</sup> Substance Abuse and Mental Health Services Administration. (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. *Health and Human Services*. Retrieved from <https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>.

encounters with the criminal justice system and emergency systems, improve individual life outcomes, and generate public cost savings. Additionally, we are interested in better understanding approaches to increasing uptake and continued engagement in treatment programs. We are particularly interested in rigorous evaluations of the following models or programs due to their strong research evidence indicating effectiveness: Housing First, Forensic Assertive Community Treatment/Assertive Community Treatment (FACT/ACT), Coordinated Care, and Cognitive Behavioral Therapy (CBT).

## APPENDIX B: APPLICATION PROCESS AND SELECTION CRITERIA

### **Overview:**

1. LIAF will host a Q&A webinar on the RFP on October 5, 2018 at 3:00 PM EST. Prospective applicants are strongly encouraged to attend. Attendees should sign up for the webinar [using this online form](#).
2. LOIs will be accepted on a rolling basis through November 5, 2018. If the review team determines that your LOI meets the criteria outlined below, we will invite you to submit a full proposal.
3. Submissions: Applicants should submit LOIs and invited full proposals to [A2ARFP@arnoldfoundation.org](mailto:A2ARFP@arnoldfoundation.org).
4. Questions: Please send questions to [A2ARFP@arnoldfoundation.org](mailto:A2ARFP@arnoldfoundation.org). For responses to frequently asked questions, reference **Appendix C** which will be updated regularly [here](#).

### **Format:**

1. Before submitting an LOI, applicants must complete [this online form](#). The form will generate a cover page internally for your application materials.
2. LOIs and invited full proposals should address each of the requirements and selection criteria below. Applicants may use their own format, with single or double spacing, and an 11-point font or larger for the LOIs (maximum three pages). Applicants invited to submit a full proposal (maximum ten pages) will be provided a template. The page limit for LOIs and proposals does not include attached documents specifically requested in this RFP such as budgets, budget narratives, letters of support, or documents outlining data agreements and research credentials. Please submit these documents separately (*e.g.*, do not submit documents in one file).

### **Application Process and Selection Criteria:**

Requirements: Applicants must ensure the following requirements are met before submitting an LOI. Fulfillment of requirements should be demonstrated through the project narrative and supporting documents.

## **Selection Criteria:**

**For the LOI:** Although we ask applicants to address the five selection criteria detailed below, we are well aware of the short page limit, and we do not expect applicants to have finalized every aspect of the study design. Therefore, reviewers will focus on the first two selection criteria— “Importance” and “Experienced Researcher”—in determining which applicants to invite to submit a full proposal.

**For full proposals:** In general, applicants should include the items listed in the [LJAF Guide for Research Proposals](#). Reviewers will base their recommendations primarily on the following five criteria:

1. **STUDY DESIGN.** LJAF invites evaluation proposals in three tiers across the three project categories detailed in **Appendix A:** emergency response, post-crisis stabilization, and/or treatment programs and services. Applicants should apply based on the nature of the program they are evaluating and the specific research questions they are attempting to address.
  - a. *Impact Evaluation Tier:* The applicant’s proposed RCT or rigorous QED design should be well structured and contain all necessary elements to ensure validity. In other words, it should have a sufficiently large sample size (as shown through a power analysis that accounts for potential attrition and loss to follow up) and other elements needed to generate credible evidence about the intervention’s impact on one or more targeted outcomes. We strongly encourage designs that measure such outcomes in both the short- and long-term, as appropriate, to determine whether the effects endure long enough to constitute meaningful improvement in individual and/or community well-being. Research projects should build on past studies that already documented key elements of the intervention (including the program model, training, supervision, and cost) so that future practitioners and researchers will be able to replicate it. If no such documentation exists, researchers should include a discrete process and/or implementation study in their proposal.

Applicants, as part of their discussion of this criterion, should specify the study’s proposed recruitment process, randomization approach, expected sample size, primary outcome(s) of interest and associated measurement (*e.g.*, over what length of time), and planned analyses (*e.g.*, any subgroups to be examined or regression methods to be used).



Reviewers, in assessing an applicant's proposed design, will use [Key Items to Get Right When Conducting an RCT in Social Policy](#) as a reference.

- b. Innovation Tier:* Our Innovation Tier is designed to define and standardize relatively untested interventions and support feasibility testing for highly promising ideas not yet ready for more rigorous evaluation. Instead of asking whether an intervention is effective, this tier provides funding to answer whether an approach can be implemented with fidelity to a model in a real-world community setting and whether outcomes of interest can be measured reliably. Specifically, the feasibility study design should:
- i. Deliver an intervention at a small or modest scale in a real world context.
  - ii. Document the key elements of the intervention (including the program model, training, supervision, and cost) so that future practitioners and researchers will be able to replicate it.
  - iii. Collect data to show whether the intervention was successfully delivered, in close adherence to its key elements (*e.g.*, what tasks were performed to implement the intervention and how closely did those tasks match the model, which people were involved in each intervention task, and how widespread/intense was the intervention among the population targeted; for service-delivery interventions, the data should show who showed up, who received the targeted amount of services, and who completed the program).
  - iv. Measure proximal outcomes to assess whether the intervention may be affecting the elements of behavior the intervention seeks to change (*e.g.*, police decision-making).
  - v. Demonstrate the ability to measure ultimate outcomes of interest for those receiving the intervention that could be used for a more rigorous evaluation.

Along with defining and standardizing relatively untested interventions, the ultimate goal of the Innovation Tier is to prepare such interventions for more rigorous evaluation that can be seamlessly conducted after successful feasibility testing. Interventions that demonstrate success in achieving fidelity to a model in a real-world setting and can

measure key outcomes of interest will be good candidates for follow-on evaluation grants from the Foundation.

Priority will be given to more rigorous study designs that include a comparison group.

- c. *Descriptive Tier:* Study designs for this tier should articulate research questions of interest and analytic approach. Applicants should draw clear connections between the research questions and necessary data, and outline a path to data acquisition in criteria four (see below) that complements the study design.
2. **IMPORTANCE.** The applicant should propose to evaluate an intervention:
- a. That is backed by highly promising evidence, suggesting it could produce sizable impacts on outcomes of recognized policy importance such as crime rates, incarceration rates, recidivism, health outcomes, social service, and/or criminal justice system costs. For example, we specifically encourage proposals seeking to replicate findings from prior rigorous evaluations that are especially promising but not yet conclusive (due to only short term follow up, a single-site study design, and/or matched comparison groups, but not randomization). As a threshold condition for “promising” evidence, proposals should show that the intervention can be, or preferably has been, successfully delivered under real-world implementation conditions.
- or—
- b. For which there are other compelling reasons to evaluate its effectiveness (e.g., it is, or soon will be, widely implemented with significant taxpayer investment, and its impact on targeted outcomes is currently unknown; it is a promising low-cost strategy that could be readily implemented on a large scale if found effective; is supported by compelling logic, which is informed by the most relevant and rigorous evidence available, that the intervention has the potential to produce large impacts on the target area).

Please note that to meet this criterion, it is not sufficient to establish that the study addresses an important problem; applicants must also present compelling reasons to evaluate the specific intervention.

3. **EXPERIENCED RESEARCHER.** The applicant's team should include:

*Impact Evaluation Tier:*

- a. For RCTs and QEDs, at least one researcher in a key substantive role who has previously carried out a well-conducted RCT or QED of similar nature. A well-conducted RCT is one with low sample attrition, sufficient sample size, close adherence to random assignment, and valid outcome measures and statistical analyses. A well-conducted QED is one with sufficient sample size, a statistical model with strong theoretical justification, and the appropriate robustness and sensitivity checks (such as placebo tests). To address this criterion, applicants should provide a biographical sketch (CVs are useful additions, but not required) and reports from prior studies with similar design that the researcher has conducted. (Please send them as email attachments; no more than two reports in all.) Reviewers will rely primarily on the biographical sketches and reports in assessing this selection criterion.

*Innovation Tier:*

- a. An experienced practitioner or agency leader who has successfully implemented the intervention in a real world setting, with documented adherence to the model's key elements.
- b. One or more researchers who have previously conducted implementation studies and documented key elements of a program model for use in replication studies, and a consultant/adviser who has carried out a well-conducted QED or RCT, and who will help the team to design the feasibility study so that it can flow seamlessly into a more rigorous evaluation.
- c. Personnel familiar with necessary administrative data who can assist researchers in accessing and understanding the data, if such data will ultimately be needed to measure relevant outcomes.

*Descriptive Tier:*

- a. An experienced practitioner or agency leader who can support with the development of policy-relevant research questions and guide the acquisition administrative data.
  - b. One or more researchers who have previously conducted similar descriptive studies.
  - c. Additional personnel, as needed, who are familiar with the administrative data and can assist researchers in accessing and understanding these data.
4. **DEFINED POPULATION.** The applicant proposes to evaluate a predetermined population, which should include individuals with mental illness, substance use disorder, and/or who are homeless who come into contact with the criminal justice, emergency health and social service systems. If funded, the applicant will be required to document the cross-system datasets from criminal justice, health, behavioral health, and/or social services they plan to use to describe and define the intervention population. Criminal justice datasets can include 911 calls for service, arrests, or jail bookings. Health datasets can include ambulance/EMT calls for service and transports, hospital emergency room admissions, behavioral health services, homeless services, or records of substance use. We will prioritize proposals that use multiple datasets from the relevant systems.
5. **PARTNERS & DATA ACCESS.** As outlined in the requirements above, the applicant will need to demonstrate access to the necessary data, technical capacity, and partnerships to execute the study. Examples of necessary parties include: researcher(s), an agency or community organization to deliver the intervention, and a centralized entity housing the administrative data used to measure outcomes (*e.g.*, arrest records and emergency room visits). To verify the existence of such partnerships, reviewers will look for a description in the proposal in addition to attached letters of support showing, for example, that (i) an agency that delivers the intervention has agreed to participate in the study and has agreed to random assignment; and (ii) a data agency has agreed to provide the researcher(s) with access to the appropriate data.

**Other items to include in the submission:**

1. Applicants should specify the amount of funding requested. For the full proposal only, attach a project budget and budget narrative (a template will be provided). Applicants should specify whether there is a funding source identified to cover all, or a significant portion of the cost of the

intervention that is proposed to be studied. To reduce study costs, we encourage the use of administrative data to measure study outcomes wherever feasible, in lieu of more expensive original data collection. In addition, we will consider funding implementation research to complement an RCT of a well-established model; however, we suggest streamlined approaches that do not greatly increase the overall study cost. If additional funding from other sources is needed to carry out the study, we request that the applicant's budget shows (i) the total study cost, and (ii) the portion of that cost to be covered by LJAF. Applicants should include an attached letter or other communication showing that the additional funding will be in place prior to LJAF's grant award.

2. LJAF permits grantees to request funding for all of the direct costs associated with a project, including salaries and federally required benefits for employees, travel, meetings and conferences, data access fees, and payments to third-party consultants and sub-grantees that are directly attributable to or created specifically for the purpose supported by a particular grant. Moreover, LJAF recognizes that in order to successfully accomplish the purpose of a grant, grantees often need additional financial support to cover a portion of their indirect costs. LJAF's Indirect Cost Policy defines indirect costs as organizational costs incurred for a common or joint purpose benefitting more than one project and not exclusively attributable to or created for the project supported by a particular LJAF grant. The policy permits institutions of higher education, including community colleges, to receive an indirect cost rate of 15% of total direct project costs; all other organizations (e.g., non-profit, governmental, for-profit, etc.) may receive an indirect cost rate of 20% of total direct project costs.<sup>14 15</sup> Those invited to submit full proposals will receive LJAF's Budget Template which includes additional guidelines.
3. Applicants should specify the proposed recipient of the grant award, which must be a tax-exempt organization (e.g., a nonprofit organization, university, or governmental unit).
4. Applicants should address how their study meets recognized ethical standards for research with human subjects.

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<sup>14</sup> Grants with the primary purpose of providing general operating support are not subject to this Policy.

<sup>15</sup> Third-party consulting or subcontract expenses, sub-awards, and tuition (if applicable) shall not be included as part of the total direct project cost base for indirect cost calculation.

**Expectations for the Grant:**

Awardees will be asked, as a condition of award, to:

1. Pre-register the study on the Open Science Framework (OSF) website and upload a copy of the research and analysis plan detailed in their proposal.
2. Provide brief phone or email updates on the study's progress on a quarterly basis, and before any key decisions that could materially affect the study's design or implementation.
3. Submit concise reports on the impact findings at appropriate intervals. These reports should make it easy for readers to see the main results and gauge their credibility (*e.g.*, by showing the similarity of the treatment and control groups in pre-program characteristics, the amount of sample attrition, and the statistical significance of the impact findings). Reports and studies should include "[mechanism mapping](#)" so that the field gains a more nuanced understanding of how the program's implementation and context matched up with the logic model.
4. Make their datasets and related materials (*e.g.*, survey instruments and code used to clean and analyze datasets) publicly available on the OSF. Applicants will be asked to do this within one year of the last data collection, and only to the extent allowed under any confidentiality/privacy protections. To the extent anonymization or de-identification would allow the sharing of data, applicants should let us know what extra work would be entailed.

## APPENDIX C: FREQUENTLY ASKED QUESTIONS

### **How many awards will be given out through this RFP? What is the total available funding?**

LJAF does not have a firm limit on the total amount to be awarded or the number of awards.

### **What is the maximum allowable budget for each grant award?**

We do not have a maximum allowable budget for each grant award, but encourage applicants to conduct studies at low or modest cost whenever feasible. Applicants should propose a budget that adequately addresses the needs of the research project. If you are invited to submit a full proposal based on your LOI, we will send a template that outlines LJAF's standard budget requirements.

### **Does LJAF require matched funding?**

No, LJAF will fund all budget items that meet the criteria of the RFP. You may list alternative funding streams as indicators of the feasibility, success, and sustainability of the project.

### **Is there a limit on the grant performance period or study timeline?**

Format requirements for the LOI are specified on page 16. Although LJAF does not have a template for LOIs, we recommend that applicants use headings and subheadings that reflect the five criteria outlined in the RFP. If you are invited to submit a full proposal, LJAF will circulate templates for both the proposal and line-item budget.

### **Can a single organization and/or department submit more than one LOI?**

Yes.

**Can universities serve as research partners?**

Yes.

**Does LJAF require institutional review board (IRB) clearance for all studies?**

All studies should adhere to the appropriate compliance and ethical standards. If it is relevant to your proposed study, please include references to any IRB considerations and timelines in the LOI or invited full proposal.

**Should applications include letters of support in the LOIs?**

Letters of support are not required for the LOI. However, if you have received letters or other indications of support from key partners before the Nov. 5 deadline, please submit them as appendices, which do not count toward the page limit. For full proposals, we highly recommend letters of support that demonstrate a commitment from partners.

**Will this RFP or a similar RFP be released again, or is this a one-time call?**

We will continue to support work in this area and expect that there could be additional funding opportunities, including the release of a similar RFP, in the future through the Policing portfolio.

LJAF also issues other RFPs to fund rigorous research, both periodically and on a rolling basis. To learn more about these opportunities, please sign up for our email distribution list [here](#).

**Can I schedule a phone call with a representative from LJAF to discuss specific interventions, determine the strength of my project, or gauge LJAF's interest?**

No. We look forward to reviewing any projects that fit the criteria of the RFP and recommend that you submit an LOI. From these submissions, we will identify promising projects and reach out to continue the conversation should you be invited to submit a full proposal.