Casey Family Programs Request for Proposals
Regarding a Study of Evidence-Based Treatment for Youth in Foster Care

Abstract

Providing early mental health assessments and increasing access to a broad array of services and supports could help youth in foster care overcome the trauma of child maltreatment. Effective treatment will also help some youth improve their functioning so they can more easily return home, be adopted, or achieve another kind of permanency. Youth travel different pathways to healing but culturally competent, evidence-based mental health services should be a core pathway. To address the need for research in this area, we are hereby seeking interested organizations to assist Casey Family Programs (Casey) in testing the effectiveness of one or more evidence-based treatment approaches in community settings for youth in foster care. Priority will be given to proposals that focus on children of color in foster care, that are located in jurisdictions with large foster care populations and a Casey Field Office, and that involve alumni and birth-parents on their planning and advisory teams. One research study will be funded.

The ideal project will test one or two evidence-based interventions for depression, PTSD and other forms of anxiety, social phobia, or externalizing behaviors. Evidence-base interventions include:

- research-based psychosocial therapies, such as cognitive behavioral therapies or interpersonal therapies
- research or guideline driven medication therapies

A desirable outcome would be to determine what works best for certain types of youth, possibly enhancing the intervention with added components such as group work and/or targeted use of psychotropic medications. The age range of most interest is 8-17 years old. While this project will span more than one year, it should be designed to provide benefits to Casey and collaborating organizations by incorporating key milestones and producing interim products. Additionally, it should incorporate a cost-benefit component.

Anticipated funding will be up to $275,000 per year, for up to three years, with the last three months of the project period devoted to report finalization and dissemination. We are open to joining a study already in progress if Casey determines that such study is aligned with, and would significantly advance Casey’s objectives and goals. The dissemination process will include a national conference presentation at Child Welfare League of America or the Florida Mental Health Institute, and the submission of one or more articles to a professional journal.
Casey Family Programs Background Information
Casey Family Programs’ mission is to provide and improve—and ultimately to prevent the need for—foster care. We are an organization committed to serving youth, families, and communities while supporting and improving the systems through which they are served.

The foundation draws on 40 years of experience and expert research and analysis to improve the lives of children and youth in foster care. The Seattle-based foundation was established in 1966 by U.P.S. founder Jim Casey. We provide direct services to youth and families through nine field offices that directly deliver foster care services to families, and several contract agencies. We promote advances in child-welfare practice and policy through our systems improvement efforts in over nine states and a Washington, D.C. office.

In all the work we perform, we consciously seek to learn from and collaborate with youth in care, foster parents, alumni of care, kinship providers, and adoptive parents to provide safe, loving homes and opportunities for youth to thrive and flourish. We also collaborate with counties, states, and American Indian and Alaska Native tribes to improve services and outcomes for young people in out-of-home care across the U.S.

Drawing on four decades of front-line work with families and alumni of foster care, we develop tools, practices, and policies to nurture all youth in care and to help parents strengthen families at risk of needing foster care. More information about the organization can be found at http://www.casey.org.

Background: The Need for and Use of Mental Health Services for Youth in Foster Care

The Need for Mental Health Care
Research suggests that between one half and three-quarters of the children entering foster care exhibit behavioral or social competency problems warranting mental health care. This rate of mental health problems is significantly higher than the general population, but comparable to that of children living below the poverty level.

Mental Health Stability
Children with poorly treated mental health disorders may be less likely to be reunified or adopted, and may experience a higher rate of placement change. Additionally, the Casey

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1 All of the information in the introduction section on the need for and the use of mental health care services, the need for evidence based treatments, and recommendations from national experts is taken directly from the literature review prepared for Casey Family Programs by John Landsverk, Barbara Burns, Leyla Stambaugh, and Jennifer Rolls Reutz. (2006). Mental Health Care for Children and Adolescents in Foster Care: Review of Research Literature, available from Casey Family Programs.

Special thanks to the Casey staff and alumni of foster care who commented on an early draft of this document; and to Lucy Berliner, Judith Cohen, Mark Fraser, Kimberly Hoagwood, Peter Jensen, and Mary Beth Rauktis for sharing literature and insights from their research and writings.
National and Northwest alumni studies and the Chapin Hall Midwest Study have documented that when mental health needs of youth in foster care are not adequately addressed, youth carry those challenges with them into adulthood. Such challenges can significantly impact educational and employment outcomes for young adults.

The Use of Mental Health Services

Regional studies, together with early data from the National Survey of Child and Adolescent Well-Being (NSCAW) national study, demonstrate very high rates of mental health service use for children in child welfare. The highest rates appeared in late adolescents who had been in out-of-home care for an average of six years. Studies using Medicaid data confirmed this much higher rate for children in foster care in contrast to the relatively low rates seen in children receiving Aid to Families with Dependent Children (AFDC) children.

Findings from the NSCAW study indicate that, despite these high rates in comparison with community studies, three out of four youth in child welfare who met a stringent criterion for need were not receiving mental health care within 12 months of a child abuse and neglect investigation. More encouraging are the results of the Casey Northwest Alumni Study indicating that, over time, 80% of youth placed in care receive some mental health services. Over 77% of these alumni were served primarily in state foster care, which indicates that youth served in public agencies are accessing at least some mental health services. However, recent studies have questioned the quality and effectiveness of those services.

Among foster care youth utilizing traditional mental health services, most receive outpatient treatment, many are placed in group homes or residential treatment centers, and a small proportion is admitted to hospitals. While it may be helpful to obtain a diagnostic assessment and long term psychotherapy with a trusted professional, there are more effective treatment approaches. Research on comprehensive diagnostic-specific interventions suggests that brief clinic-based and group-based interventions for youth with complex needs can be effective (Weisz, Jensen-Doss, & Hawley, 2006).

The Need for Evidence-Based Treatments in Community Settings

Overall, there is little evidence to suggest that a measurable benefit in lowered mental health symptom levels or increased functioning can be expected from the receipt of traditional mental health care in public mental health community settings that serve children and adolescents who experience foster care. In contrast to the evidence demonstrating the efficacy of psychotherapeutic interventions; evidence supporting the effectiveness of mental health treatment delivered in community settings is quite weak. This lack of evidence has led to a sharp focus on bringing into community settings therapeutic interventions that have the potential for addressing mental health problems of youth in foster care.

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2 See Pecora, Kessler, Hiripi et al. (2006).
Children in foster care frequently experience several specific conditions that require targeted treatment. The most prevalent conditions include depression, anxiety disorders such as Post Traumatic Stress Disorder (PTSD) and abuse related trauma, disruptive behavior disorders (including Attention-Deficit/Hyperactivity Disorder (ADHD), social phobia, and substance abuse. There is a strong evidence base in the general population for successfully treating each of these conditions with interventions that are largely behavioral or cognitive-behavioral and which address symptoms, behavior and functioning. Such interventions tend to be relatively brief and most are more effective when a caregiver is actively involved. In fact, dropping a child off at a clinic for individual therapy is of very limited value, particularly for externalizing disorders. At the present, however, effective behavioral or cognitive-behavioral interventions are not uniformly available across the country, especially through the Medicaid-funded providers with whom many youth in care work.

Evidence-based interventions that have been identified to address the mental health needs of youth in foster care are delivered largely by the mental health system. In many jurisdictions, however, the mental health and child welfare systems are disconnected; consequently, the special needs of youth in foster care often go unmet. Youth in foster care could greatly benefit from the provision of specific mental health interventions within the child welfare system. At the very least, they would benefit from a targeted collaboration between the two systems to provide these much needed services in community mental health systems in a way that incorporates the unique needs of youth in foster care. Youth in foster care must be able to rely on the public mental health system to provide them the medically necessary mental health services to which they are entitled.

**Recommendations from National Child Welfare and Child Mental Health Experts**

In 2005, Casey commissioned several experts to conduct a review of the research literature on the intersection of child welfare and child mental health. As part of their report, these experts outlined several key recommendations that would move evidence-based practice forward:

- Examine the evidence base for interventions to treat common clinical conditions and more complex conditions experienced by youth in foster care.

- Assess the availability of evidence-based interventions at the local level and nationally to assure relevance and explore adaptations needed for youth in foster care. This includes (1) tracking the progress of dissemination studies of mental health interventions in foster care; and (2) testing clinical interventions relevant to the needs of children in foster care to determine readiness for large scale adoption.

- Learn from the challenges of intervention, adoption and dissemination efforts prior to making policy decisions (e.g., stakeholder buy-in, the importance of policy and organizational factors, and factors contributing to sustainability).

- Identify promising evidence-based interventions to meet mental health needs at the local level, including additional interventions that should be implemented within child welfare, in contrast to those typically provided in the mental health system.
For evidence-based interventions that require the expertise and resources of the mental health system, develop a partnership between mental health and child welfare with clearly explicated roles of each system, preferably with joint child welfare and mental health and/or Medicaid funding (Landsverk et al., 2006).

Based on the clearly articulated need for continued development in the ways that child welfare and child mental health intersect, Casey is in a prime position to make a meaningful contribution to these areas, especially in forming stronger collaborations to deliver more effective interventions.

Defining Evidence-Based Treatment
The intent of this RFP is to evaluate the effectiveness of evidence-based practice models meeting the criteria proposed by the Division of Clinical Psychology of the American Psychological Association for youth in foster care (Brown, Pearlman, & Goodman, 2004; Chadwick Center for Children and Families, 2004; Chambless, & Hollon, 1998). Essential criteria include use of a treatment manual, positive findings from at least two rigorous studies, evidence of long-term outcomes beyond treatment termination, and use of standardized therapist training and adherence monitoring. (See for example, Stambaugh, Burns, Landsverk & Reutz, 2007.)

Testing the Promising Evidence-Based Mental Health Treatments for Youth in Foster Care

Overview
Providing early mental health assessments and increasing youth access to a broad array of services and supports may help youth overcome the trauma of child maltreatment and placement. Youth travel different pathways to healing: a core pathway should include culturally competent evidence-based mental health services. But physical, athletic, and artistic activities and strategic, conservative use of psychotropic medications can also be powerful modes of healing. Ethical, random assignment cost-benefit studies can and should be done with community-based programs to address the need for research in this area.

We are seeking an organization that can test one or two evidence-based interventions for youth in foster care. The ideal project would test one or two different evidence-based interventions for depression, PTSD and/or other forms of anxiety, social phobia or disruptive disorders to determine what works best for certain types of youth, possibly enhancing the intervention with added components such as group work and/or targeted use of psychotropic medications. The age range of most interest is 8-17 years old. Priority will be given to proposals that focus on children of color in foster care, which are located in jurisdictions with large foster care populations and a Casey Field Office, and involve alumni and birth-parents on their planning and advisory teams.
The ideal project will test one or two evidence-based interventions for depression, PTSD and other forms of anxiety, social phobia, or externalizing behaviors. Evidence-based interventions include:

- research-based psychosocial therapies, such as cognitive behavioral therapies or interpersonal therapies; or
- research or guideline driven medication therapies

While the following could be components of the project, we are not soliciting proposals that would only focus on research-based engagement, educational, family support or retention strategies; or data driven assessment, outcome or monitoring systems.

During the first phase of the study, the project team will carefully outline the intervention models, develop written agreement(s), sampling criteria, and measurement instruments; and secure human subjects review approval(s). The second phase of the study will focus on measuring short-term and longer-term outcomes. The project should be designed to provide interim products and benefits to Casey and collaborating organizations by reporting key lessons learned every six months. To the extent possible, the research design should also incorporate a cost-benefit analysis component.

The study should address the following questions:

1. What evidence-based interventions work well among youth in foster care, particularly in those areas where youth are most commonly diagnosed (e.g., PTSD, depression, anxiety, and disruptive behavior disorders)?

2. What are the challenges of implementing evidence-based interventions in settings typically accessed by youth in foster care (e.g., community mental health programs)?
   a. What are the systems/organizational challenges?
   b. What are the funding challenges?
   c. What are the sustainability challenges? Summarize the program’s plans for sustainability beyond funding and identify research-based strategies for sustainability (e.g., organizational supports and team building that reduce staff turnover such as organizational culture and climate interventions proposed by Glisson & Hemmelgarn, 1998).

3. What are the costs and benefits of different approaches?

We are open to joining a study already in progress if Casey determines that such study is aligned with, and would significantly advance Casey’s objectives and goals. Thus we are inviting organizations currently conducting studies to consider preparing an in-depth proposal outlining the study design, sampling, data collection methodologies, and the role of Casey as a new collaborator; as well as organizers of a possible new study.

**Funding Levels and Budget Restrictions**
Anticipated funding will be up to $275,000 per year, for up to three years, with the last three months of the project period devoted to dissemination, including a national conference.
presentation at Child Welfare League of America or the Florida Mental Health Institute, and the submission of one or more articles to a professional journal.

Note that indirect costs cannot exceed 15%, and total project costs that will be borne by Casey can not exceed $275,000 per year (direct and indirect costs). Because of tax and accounting requirements, Casey funds cannot be carried over from one calendar year to another, so no-cost extensions (carry-over of funds from one calendar year to another) are not allowed. Thus, careful project planning, reporting, and budget monitoring will be needed. It is anticipated that for the first project year (June 1, 2007 to May 31, 2008) up to $275,000 will be available for funding. A similar amount will be available for the second and third project years, if needed, all subject to project progress, and the terms and conditions of the written agreement.

**Mental Health Treatment Design, Implementation and Evaluation Issues**

McBride (2004) reported that participating in a randomized clinical trial of Parent Child Interaction Therapy (PCIT) presented many challenges for her community mental health center. Several of her “lessons learned” were that the assessments and paperwork were “additive” since other paperwork was not removed. Additionally, therapists needed to integrate data in their practice and decisions rather than use their theoretical orientation as the rationale for their work. Maintaining fidelity was essential and required monitoring, supervision, support and re-training as the treatment team experienced turnover. Supportive discussion and encouragement also proved to be important in maintaining fidelity.

Treatment fidelity and implementation measurement will be crucial in determining what the intervention was, if it was successful, and for conducting dose-response analyses. Inevitably, there will be variation in service delivery. We invite applicants to discuss how they will measure treatment fidelity and implementation, as well as how they will conduct efficacy subset analyses. Some of the likely challenges to conducting this study are listed in the following sections.

**Balancing faithful replication and relevance.** Aarons (2004) has studied the organizational, individual and model factors that support or inhibit adopting evidence-based approaches into community based practices. He found that practitioner openness to using new innovations may be facilitated by the intuitive appeal of the model and that practitioners with positive attitudes toward adopting evidence based practices may be more likely to comply with changes in the work requirements (e.g., increased paperwork). If practitioners feel that the evidence based practice isn’t relevant, then they are less likely to adopt it as a practice, even when it is a job requirement.³

There is a dynamic tension between the faithful replication of evidence-based interventions and the need to tailor them for youth in foster care. Replication of an intervention with strong evidence of success is a priority of this project, but we invite applicants to argue for modifications of evidence-based interventions if they can link intervention adjustments to risk factors common among youth served in child welfare. These challenges are not unique to mental health services but they can be formidable obstacles (Fixen et al., 2005, Hoagwood,

³ Special thanks to Dr. Rauktis of Pressley Ridge for sharing the McBride and Aarons materials.
Burns & Weisz, 2002). We are seeking proposals that are specific with regard to the intervention skills and behaviors that will be implemented.

**Agency selection will need to be done carefully.** The context of the agency setting may be cumbersome given that the project will need to choose the treatment approaches, steps, etc. within a system that is already overloaded. Some agencies serving youth in foster care are training and employing their own counselors to provide mental health services rather than primarily using external resources. This approach, however, is rare; therefore, the therapist(s) for this project should be based in a community mental health setting, school-based, or in another community setting.

**How will issues of ethnic and other diversity be addressed?** How will your proposed study improve outcomes for youth of color? We ask applicants to include considerations for serving youth and families of color. Further, based on study findings, what recommendations will be provided relevant to the intervention and research design for working with youth in care from different cultural and ethnic backgrounds, while taking into account other contextual variables such as socio-economic status?

**Counselor selection and training will need to be carefully considered.** Unfortunately, children who need the most specialized treatment often have the least prepared counselors. Counselor turnover may adversely affect the project. Specify the therapist turnover rates in the agency and unit(s) being considered and your plan for addressing turnover.

**Family involvement and caregiver empowerment are essential.** Given that individual therapy approaches without caregiver involvement are not very effective, proposals should include information about how caregiver engagement will be a core strategy in implementing the EBT intervention(s). (See http://www.kidsmentalhealth.org/)

**A feasibility and strategic implementation assessment is needed.** Most mental health providers for youth in foster care are paid by Medicaid, but Medicaid requirements are cumbersome and make implementation of evidence-based treatment approaches difficult. It is essential to have conversations with experts about how to make the evidence-based treatment implementation successful and to anticipate what barriers will need to be overcome. This discussion and planning will need to take place and be satisfactorily addressed prior to the award of a study contract.

**Sample size and composition estimation will be essential.** An incredibly diverse group of children are served in foster care. The child welfare system under-refers youth with internalizing behavior (e.g., PTSD, anxiety) to mental health providers, and instead refers children mostly for externalizing disorders (e.g., disruptive, aggressive or delinquent behavioral problems). We will need to know with some certainty whether a prospective agency is serving an adequate number of children with the target mental health disorder and the target ethnic groups to be considered for the study. Power analyses will be essential to determine if the proposed sample will be large enough to detect meaningful differences in key outcome variables among the groups selected for statistical comparisons.
Organizations participating in the study will need to support someone who works in the agency intake unit to be responsible for assessing and flagging youth with disorders of interest to this study. A careful assessment may be needed for every child accepted for service to detect eligible children who would otherwise not be screened thoroughly, and would not be flagged as eligible for the treatment study. This evidence-based treatment project will require that staff at intake help flag youth and direct them to initial screening. A careful screening and recruiting process will therefore be essential.

Measurement methods need careful planning. First, therapists are not trained in the use of assessment and measurement methods in the same way as researchers. Some mental health agencies are using assessment scales but are experiencing difficulties because few therapists know how to use the assessment results to shape treatment. Second, the assessment results may not make sense because of the way the assessment data are scored. For example, some therapists are not able to distinguish the clinical from the non-clinical range of children’s functioning because of how the assessment data are analyzed and/or the graph does not provide a clear clinical cut-off score. Third, commonly available assessment tools are not being used. For example, if a brief PTSD checklist is not used, staff may not recognize that a child is experiencing the aftermath of trauma. The project team will need to address these challenges with practical and easy to use assessment measures that are valid for research.

Human subjects protections must be addressed. Obtaining the proper human subjects clearances from the child welfare agency, the family, the foster family, the youth, the Medicaid agency, and/or the behavioral health provider, as needed, has been made more difficult in recent years. The proposal should document how you have considered those issues, the human subjects reviews that will need to be done, any special consent issues that will need to be addressed, and how these issues may affect the study timeline.

The limited effect size found by many EBTs in relation to the effect contributed by having a caring and engaged person involved with a child needs to be recognized. Recent reviews of EBT research have noted significant effect sizes for some interventions, especially in controlled conditions, but have also noted the power of having a caring, engaged counselor and a strong therapeutic alliance (Jensen, Weersing, Hoagwood & Goldman, 2005). Practice research should improve the “standard of evidence” for establishing that a treatment is evidence based. Specifically, the study design should ideally test if the intervention is efficacious over and above the effects of therapeutic alliance and other common factors. A study comparing tests of equally credible forms of treatment should have planned analyses to identify and test the mechanisms of change. And finally, the study design over time should enable the systematic

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4 For example, Miller has stated that “Research points to the existence of four factors common to all forms of therapy despite theoretical orientation (dynamic, cognitive, etc.), mode (individual, group, couples, family, etc.), dosage (frequency and number of sessions), or specialty (problem type, professional discipline, etc.). In order of their relative contribution to change, these elements include: (1) extratherapeutic [40%]; (2) relationship [30%]; (3) placebo, hope, and/or expectancy [15%]; and (4) structure, model, and/or technique ([15%].” For more information, see Escape from Babel (Norton, 1997); The Heart & Soul of Change (APA, 1999).” Retrieved February 27, 2007 from: http://www.talkingcure.com/docs/What_Works.doc
elimination of specific competing hypotheses of reasons for treatment efficacy (Jensen et al. 2005, p. 71).

**Key outcomes related to foster care need to be measured.** We are interested in how improved mental health functioning affects key youth outcomes such as placement stability, improved educational functioning, less need for higher levels of care, and achievement of a permanent placement for foster youth. I.e., compared to a non-intervention group are youth who are more effectively treated not only able to function better but are they also able to secure a “permanent placement” such as return home, kinship care with guardianship, non-relative care with guardianship, or adoption more quickly and/or with less recidivism in terms of placement disruption?

**Major statistical analysis challenges must be addressed, such as accounting for worker effects.** When workers deliver a service to more than one family/child/caretaker, there are significant challenges related to nesting of youth or families within workers. Analytic models must account for nesting, and power needs to be conditioned on the expected cluster structure.

### Request for Proposal Outline

**Introduction**

This evaluation study will be used to make program improvement and investment decisions pertaining to mental health among youth in foster care. Proposals should include the following sections listed below. (More detail is provided on page 12.)

1. **Setting:** Organization and community description required. Why is this a promising setting? (Include organization(s) letter(s) of commitment in an appendix).

2. **Study Focus:** Mental health disorder and treatment approach(es) to be tested.

3. **Project Design and Timeline:** Research design, measures, and data collection summary table (e.g., measuring who completes what, when, and the time needed to complete each measure).

4. **Sample Description:** Discussion of how a sufficient sample size can be established and a detailed timeline for accomplishing this task. Include a power analysis and estimates of study attrition/mortality, as well as how youth will be screened and referred.

5. **Fidelity:** How will treatment fidelity be maximized and measured?

6. **Staffing Plan:** Describe the study team and consultants with brief descriptions of

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For example, in a new EBT project at Pressley Ridge School therapists complete a PRACTICE “fidelity checklist” for TF-CBT which reinforces key model components using the PRACTICE acronym (psycho education and parenting; relaxation; affective modulation; cognitive processing; trauma narrative; in vivo desensitization; conjoint parent child sessions and enhancing safety and social skills). Selected therapists “journal” on their experience of how they are implementing TF-CBT, their perception of its effectiveness, and how they perceive it to be implemented within the TFC model. In particular, the journal questions focus on how or if they use information from the assessments to guide treatment, and what challenges they encounter as they implement the PRACTICE components.
roles, FTE, and professional background.

7. **Data analysis and reporting of evaluation questions.**

8. **Budget and Funding:** Line item budget that includes indirect costs of less than 15%. List funds or in-kind resources that are contributed by others.

9. **Possible Challenges:** Challenges to be overcome or problems that may arise in the study and how the researchers and collaborating agencies will address them.

10. **Deliverables:** Project deliverables include, but are not limited to:
    a. Quarterly reports of progress, budget spending status, sample status, challenges encountered, and other relevant updates;
    b. Annual report of preliminary findings, lessons learned, practice implications, and study status;
    c. Technical report with 2-page executive summary;
    d. Presentation of findings at a professional conference (CWLA or the Mental Health Conference in Tampa);
    e. Journal article manuscript that summarizes the study methods and main findings with a concise literature review and discussion sections (35 double-spaced pages or less for this product).

11. **Appendices:**
    a. Letter(s) of support from all participating agencies;
    b. List four professional references to be contacted regarding previous work (Name, title, organization, phone and email addresses);
    c. Supplemental materials - Please provide separately:
       - Example of a brief report;
       - A recent professional journal article from the two primary team members, which closely resembles the current study focus
RFP Schedule of Activities
The following schedule outlines the approximate time frame of the planned events (subject to change):

- Issue RFP: March 1, 2007
- Deadline for RFP responses: April 23, 2007
- Evaluate RFP responses: April 23-30, 2007
- Conduct interviews with finalist(s): May 1-2, 2007
- Select service provider: May 4, 2007
- Refine contact terms: May 15, 2007
- Finalize contract: May 30, 2007
- Complete Year 1 of evaluation: June 1, 2008
- Complete Year 2 of evaluation and interim findings and lessons learned: June 1, 2009
- Complete Year 3 of evaluation and submit final report with recommendations: June 1, 2010

Finalist Interviews and Selection of Research Contractor
The responses to this document will be used to identify the top finalists who may be asked to provide additional information during a phone or video-conference interview. Finalists will be notified April 30, 2007. Finalist interviews may be conducted during May 1-2, 2007. Following these activities, a service provider will be selected and a final agreement will be negotiated to cover the evaluation study and deliverables.

The service providers’ response shall remain in effect for ninety (90) days from the final submission date of April 23, 2007. Casey reserves the right to reject any or all proposals and to enter into negotiations with any service provider(s) that Casey, in its sole discretion, may choose. The review procedure will continue until a service provider is selected or until Casey chooses to reject all proposals. Casey reserves the right to select more than one contract.

Casey reserves the right to issue amendments to the RFP at any time. Casey reserves the right to award no contract as a result of this RFP, or to award a contract for any portion of the proposal’s intended work. By selecting a service provider to supply program evaluation services to Casey, Casey is neither endorsing nor suggesting that the service provider’s product is the best or only solution. Service provider(s) agree not to make any reference to Casey, this RFP and/or any of its contents in any literature, promotional material, brochures, sales presentations, or the like without the express and prior written consent of Casey.

Any selected service provider(s) and Casey will enter into a mutually agreed-upon written agreement. Service provider(s) must agree to comply with all applicable laws and regulations and confidentiality requirements.
Response Requirements and Conditions

Response Submittal Date: Completed RFP responses must be emailed to Delia Armendariz (darmendariz@casey.org) by 5:00 PM (PST), Monday, April 23, 2007.

Proposal Document Format Requirements: The proposal must be sent electronically using a Microsoft Word or Adobe PDF file in 12 point font with 1.5 spacing. Proposals must be a maximum length of no more than 45 pages, including appendices. Note: The sample program evaluation report and journal article will not be counted in the 45 page maximum length requirement.

Questions and Project Contacts
All questions or requests for additional information regarding this RFP should be directed to:

Dr. Peter Pecora, Senior Director of Research Services
Email: ppecora@casey.org
Phone: (206) 270-4936
Proposal Outline Requirements

Please provide information as requested below:

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<th>Requested Information:</th>
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<tr>
<td><strong>1. Setting</strong></td>
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<tr>
<td>1.1. Name, address, and telephone number.</td>
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<td>1.2. Form of business organization (e.g., public corporation, private corporation, partnership).</td>
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<td>1.3. Dun &amp; Bradstreet Number (If applicable).</td>
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<td>1.4. Confirmation of compliance with all applicable licenses (and copies of all such licenses)</td>
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<td>1.5. Number of years in business.</td>
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<td>1.6. Total number of employees (part time and full time).</td>
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<td>1.7. Annual revenue or budget for last fiscal year.</td>
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<td>1.8. Name and title of the person authorized to execute a contract on behalf of the organization.</td>
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<td>1.9. Is there any pending litigation against the organization? If so, please summarize.</td>
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<td>1.10. Please provide a brief history of evaluation work pertaining to evidence-based mental health treatment of vulnerable youth.</td>
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<td>1.11. Please provide a brief description of the agency(ies) and community(ies) in which you plan to conduct the project. Include information about the client demographics, community served, etc. Describe why this is a promising setting for this work.</td>
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<th><strong>2. Study Focus</strong></th>
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<td>2.1. Identify and describe why this is an appropriate mental health disorder to address. Provide background information on the prevalence of the disorder in the general population and in the foster care population.</td>
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<td>2.2. Describe the treatment approach(es) to be tested and why they are appropriate to test with youth in foster care. Provide a brief literature review of other research that has tested the approach(es), and if any studies have included children of color.</td>
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<td>2.3. Document if the following is or will be in place:</td>
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<td>b. Positive findings from at least two rigorous studies.</td>
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<td>c. Evidence of longer term outcomes beyond treatment termination.</td>
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<td>d. Standardized therapist training.</td>
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<td>e. Quality/fidelity monitoring for the treatment model.</td>
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<td>2.4. Human subjects protections and consent procedures.</td>
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<td>2.5. How will you handle any needed transitions to a new therapist if you are not totally focused on youth without a therapist or those youth just entering foster care with no current therapist?</td>
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<th><strong>3. Project Design and Timeline</strong></th>
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<td>3.1. Provide an overall summary of the research project design, including evaluation questions and how you will ethically use a control or comparison group.</td>
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<td>3.2. Describe the plan for training therapists in the treatment approach(es). If new training and techniques are given to a particular therapist, will they treat youth in both the</td>
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### Requested Information:

**3.3.** Provide detail on what measures will be used to screen/assess client mental health status. Include background information such as results of previous research with the measure, time to administer, sensitivity to change, and psychometric data.

**3.4.** Provide a project timeline, including time devoted to training, recruitment, counseling with clients, and follow-up data collection. Include project deliverables (see section 11, below).

**3.5.** Some youth receive mental health treatment because it is the only intervention that an agency can pay for. The youth, however, may actually need a stable family, a better school, more friends, adequate clothes, or a variety of interventions that are not mental health treatment. How will you help guard against situations where an agency might be spending time and money on psychotropic drugs and therapy but not enough resources on strengthening families or dealing with poverty.

**3.6.** Supply a project timeline.

### 4. Sample Description

**4.1.** Describe how, where, and based on what criteria, the samples will be selected.

**4.2.** Discuss how a sufficient sample size can be established, including a detailed timeline for accomplishing this task.

**4.3.** Include a power analysis and estimates of study attrition/mortality.

**4.4.** Describe in detail the process for screening and referring youth.

### 5. Fidelity

**5.1.** Describe a plan for measuring and maximizing treatment fidelity.

### 6. Staffing Plan

**6.1.** Provide a complete staffing plan including both study team and consultants. For each person, provide a brief description of their role, background, and FTE.

### 7. Data analysis and reporting of evaluation questions

**7.1.** Describe the data analysis approach for the major research questions.

### 8. Budget and Funding

**8.1.** Include a line item budget (limiting indirect costs to less than 15%). List funds or in-kind resources to be contributed by others. Please provide a line item budget for year 1 (June 1, 2007 to May 31, 2008) of your proposed evaluation study based on the information provided in this RFP. Include all components in the cost proposal that are required to meet study intent and outcomes. Also provide budget estimates for Years 2 and 3.

The proposed line item budget should include all costs associated with travel, interviews, document collection and review, data collection and analysis, benchmarking activities, report preparation, presentation of findings and recommendations, and indirect/administration charges. Please state any assumptions made in developing the cost estimate. Attach any supporting documents as needed.

Note that Casey funds for this study should **not** be used to pay for direct services, but instead should be used to pay for capacity building (e.g., mental health screening).
REQUESTED INFORMATION:

- clinical training or technical assistance for the mental health providers, agency policy change, parent and youth involvement in the project) and the evaluation study costs.

9. Possible Challenges

9.1 Describe challenges to be overcome or problems that may arise in the study and how the researchers and collaborating agencies will address them. Possible challenges include difficulty recruiting participants, therapist turnover, collection of follow-up data, and adhering to the project timeline.

10. Project Deliverables (This list of deliverables should be reflected in the project timeline included with your proposal).

10.1 Quarterly reports of progress, budget spending status, sample status, challenges encountered, and other relevant updates.

10.2 Annual report of preliminary findings, lessons learned, practice implications, and study status.

10.3 Technical report with 2-page executive summary.

10.4 Journal article manuscript that summarizes the study methods and main findings with a concise literature review and discussion sections (35 double-spaced pages or less for this product).

10.5 Present final report to Casey designated audiences such as at a professional conference.

11. Appendices

11.1 Letter(s) of support from all participating agencies.

11.2 Contact information for at least three professional references to be contacted regarding previous work. Include name, title, organization, phone, email address, and nature of the evaluation work that was conducted.

11.3 Supplemental materials. Please provide:

-- Example of a brief program evaluation report.

-- A recent professional journal article from the at least one of the primary team members which closely resembles the current study focus.

Proposal Evaluation Criteria

The following criteria will be used to rate each proposal:

- Focus on youth of color in foster care.
- Located in jurisdictions with large foster care populations, and if possible, near a Casey Field Office.
- Involvement of alumni, resource parents, and birthparents.
- Cost-benefit component.
- Completeness and feasibility of the evaluation design, measurement protocol, and work plan.
- Well-validated and culturally competent evidence-based mental health services approach will be implemented.
- Viable agency collaborations are evident.
Experience with developing interviews and other data collection protocols with youth and parents as key stakeholders.

Experience with data collection of mental health treatment process and outcomes, including conducting interviews with identified stakeholders.

Experience with analyzing mental health and foster care program outcome data and cost-benefit information.

Clarity and usability of prior reports in terms of findings and recommended program refinement options.

Line item budget is specific, clearly related to the work plan, uses a 15% or less indirect cost rate, and is reasonable.

References


(Revised: 2-26-07)
Appendix A
Casey Family Programs Research Projects
Related to Mental Health

Overview
This document summarizes other current research projects that will advance Casey's strategic goals and objectives related to mental health.

1. **Case record reviews for Casey youth served in the Field Offices.** This study measures the use of psychotropic medication and other mental health services for field-office youth in Comprehensive Care, as well as the documentation practices associated with those areas. (Child and Family Services, with Research staff providing technical assistance)

2. **Casey Field Office Mental Health Project.** This project is now in the data analysis and dissemination phase. The prevalence of mental health disorders is being assessed in youth ages 14 to 17 in Casey foster care. The survey uses a rigorous instrument that has been used worldwide, which results in mental health diagnoses (the Composite International Diagnostic Interview). Data about ethnic identity, spirituality, gender identity, and sexual orientation will also be reported. (Research Services and Child & Family Services)

3. **Casey Young Adult Survey.** This survey includes strengthened measures of mental health functioning. A sample of 17, 22 and 25 year old Casey foster care alumni will be interviewed in 2007. This will be the fourth year of the study

4. **Foster Care Clinical R&D Mental Health Demonstration Project.** In collaboration with Columbia University, Annie E. Casey Foundation and North Shore University Hospital, birth parents, foster parents, staff and mental health therapists are being trained to advocate for youth with mental health disorders using the Parent Empowerment and Self Advocacy (PESA) curricula. Evidence-based practice models will be implemented in New York City. A youth empowerment training curricula has also been built and will be piloted. (Research Services and Child & Family Services)

5. **Replicate the PESA and youth empowerment training in San Diego and in Seattle.** Implement these curricula in additional sites, such as San Diego and Seattle, along with youth mental health assessment tools. (Child & Family Services and Research Services in collaboration with Columbia University and other partners)

6. **Pressley Ridge Trauma-Focused Cognitive Treatment project.** Collaborate with Pressley Ridge to monitor the process and results of a small qualitative project to train their therapists to provide the Cohen and Mannarino trauma-focused cognitive behavioral treatment model in a complex agency setting. (Research Services and Child & Family Services)

7. **Field Office Mental Health Advocacy Project** This project involves targeted advocacy on behalf of youth in Casey foster care when they are denied access to treatment. Casey Child and Family Services will partner with local experts to provide individualized demonstrations of the medical necessity of specific mental health treatments for youth in Casey foster care, and will submit appeals (informal or formal) to the public mental health system when it denies access to those treatments. (Child and Family Services with support from Research Services for project evaluation)