Research Specification
An evaluation of Alcohol Arrest Referral Schemes

1. Mission statement

1.1 The key research question is to determine the efficacy of brief interventions in reducing alcohol consumption and re-offending in individuals arrested for alcohol-related crimes, within the context of the night time economy (NTE). The evaluation will also be expected to deliver key lessons around service delivery, implementation and cost effectiveness to inform decisions around future roll out of referral schemes.

2. Purpose of research

2.1 The Government is committed to developing a co-ordinated approach for interventions targeted at individuals whose offending is related to alcohol. New interventions will use a combination of penalties and health/education programmes to reduce harmful drinking and subsequent offending (see *Safe, Sensible, Social: The next steps in the National Alcohol Strategy* - June 2007: http:/ http://www.ias.org.uk/resources/ukreports/revnational-strategy.pdf). The commitment to tackling alcohol-related repeat offending is being addressed by further piloting of arrest referral schemes *(Alcohol Harm Reduction Strategy for England* – Prime Minister's Strategy Unit, March 2004)

2.2 Whilst there has been extensive research into the efficacy of brief interventions for alcohol within healthcare settings (see DH-sponsored *Review of Effectiveness of Treatment for Alcohol Problems* http://www.nta.nhs.uk/publications/documents/nta_review_of_the_effectiveness_of_treatment_for_alcohol_problems_fullreport_2006_alcohol2.pdf) few robust research studies exist that examine the effectiveness of brief interventions in reducing re-offending in CJS settings.

2.3 The Anti-Social Behaviour and Alcohol Unit (ASBAU), the policy unit within the Home Office which has responsibility for work on alcohol, has therefore funded four alcohol arrest referral pilots to explore the benefits of referring alcohol-related arrestees to brief advice sessions as a means of reducing re-offending Individuals become eligible for alcohol referral via voluntary, conditional cautioning or arrest routes and then undergo two brief interventions with an alcohol specialist. The aim of sessions will be to help the individual control their alcohol consumption and thus reduce subsequent re-offending. The evaluation of referral schemes will fill a gap within the research evidence base, whilst crucially providing the policy lead with evidence on which to base recommendations to Ministers on the wider roll out of referral schemes.

2.4 Opportunities for partnership working exist between the current evaluation and the Screening and Intervention Programme for Sensible drinking (SIPS), funded by the Department of Health. This project aims to improve the way hazardous and harmful drinkers are identified (screened) and supported to reduce alcohol consumption within both healthcare and some criminal justice system (CJS) settings, which have, at the time or writing, have not yet been determined (see http://www.sips.sgul.ac.uk). Home Office representatives on the SIPS steering group with an express aim to sharing learning and, where practical and appropriate, standardising research protocols between SIPS and the Alcohol Referral Project.

2.5 The Anti-social Behaviour and Alcohol Unit (ASBAU) has funded four alcohol arrest referral pilots to address the lack of research into the benefits of referring alcohol arrestees to brief advice sessions as a means of reducing re-offending. The Alcohol Referral Project aims to:

- Provide brief interventions that reduce re-offending amongst adults who have been arrested for alcohol related offences.
- The interventions should also reduce hazardous and harmful drinking (a score >8 on the AUDIT instrument (a validated tool to measure alcohol consumption));
- Improve engagement of hazardous and harmful drinkers in brief advice sessions;
- Learn implementation and delivery lessons that can be applied to their further expansion and continuous improvement;
- Deduce information around the cost-effectiveness of such schemes.

2.6 Bids for grants to establish pilots were invited from Drug and Alcohol Action Teams (DAATs) in areas suffering from high levels of alcohol-related crime and disorder within the context of the night-time economy, where conditional cautioning was available as a referral route. The bids were scrutinized by an expert steering group, including representatives from the Home Office, alcohol referral experts and Alcohol Concern. The four selected pilot areas are **Cheshire, Ealing, Liverpool and Manchester**. These DAATs will receive funding from the Home Office to begin alcohol referral pilots for 12 months from 22 October 2007.

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2.7 Brief intervention sessions in the current project are based on the Models of Care for Alcohol Misuse guidance detailed above (MoCAM: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4136809.pdf). They will be delivered over the course of two 1 hour sessions by a trained alcohol specialist in a neutral location away from the custody suite. More specifically each session will involve:

- AUDIT screening tool administration to identify levels of hazardous or harmful drinking
- Information on alcohol unit strengths
- Information on the effects on the body, other people and behaviour of unsafe alcohol consumption
- Assessment of the subject's current drinking patterns
- Advice on the links between unsafe drinking and offending (including the subject's experience of arrest)
- Advice on planning strategies for avoiding future situations that present a high risk of unsafe drinking.

It should be noted that both Cheshire and Ealing are implementing exactly the same intervention (so the samples could be aggregated) whilst the interventions in the other two areas differ with regard to implementation to each other and to Manchester and Ealing. Ideally, the evaluation would assess the impact and implementation of the interventions in each of the pilot areas.

3. Methods

The key research questions to be answered are:

- To determine whether brief intervention sessions reduce levels of harmful and hazardous drinking, defined as a score >8 on the validated AUDIT instrument, in adults who have been arrested for alcohol-related offences
- To determine whether brief interventions for alcohol improve general health outcomes, as measured by the GHQ-12
- To determine whether brief interventions for alcohol reduce rates of re-offending in alcohol arrestees, measured via local police records (and perhaps PNC) and self-reported offending, at 6 months post-intervention.
- To determine which lessons can be learned from the process of delivering alcohol referrals that will improve client/practitioner experience and engagement with the schemes

3.1 Given the evaluation aims to assess impact the Home Office is keen to ensure the methodology employed is a robust as possible and outcomes can be attributed to the alcohol intervention. After careful consideration of a range of evaluation approaches it has been decided that the most efficient and practical design is to employ is a quasi-experimental approach, which will provide a counter-factual and will result in an element of the design meeting the level 4 criteria on the Maryland Scientific Scale. Random assignment was rejected due to the extra burden it would place on the custody officer having a detrimental effect on data quality, and ethical issues surrounding withholding an intervention shown to have positive health benefits within healthcare settings.
A between-sites comparison design was rejected as it would be difficult to reliably conclude whether any observed differences in offending were the result of brief interventions or due to unobserved effects caused by differences between areas. This design would also mean approaching police forces in another four areas, developing data access and sharing agreements which would take time and resources that are not available within current project constraints.

3.1.1 **Potential Contractors are invited to propose alternative designs to the ones discussed above and detailed below**. Proposed designs, or elements of the design, need to **meet the requirements of at least a level 3, though preferably a level 4, on the Maryland Scientific Scale.**

3.1.2 The Home Office is proposing the intervention sample will comprise individuals eligible for referral onto referral schemes from the key inflow points (arrest/voluntary/conditional caution) recruited over a twelve month period between October 2007 and October 2008.

The suggested design involves a retrospective sampling method, whereby local police crime records (arrest and charge data for all offending, including alcohol-related offences) for individuals who have similar offending profiles to the intervention sample will be selected up to two years before the start of the alcohol arrest referral pilots commence - forming a **retrospective comparison sample**. Retrospective sample members will be given a 'dummy' intervention date (before the start of the alcohol arrest referral intervention) matched to a true intervention date. For example, an individual arrested in October 2007 and undergoing brief intervention (intervention group) during this month will be matched to a comparison individual (comparison group) arrested in October 2006 and given dummy intervention in the same month. Offending outcomes would then be compared.

The variables to be used to match individuals include:

- Age
- Gender
- Offence type (offences likely to be linked to alcohol and the night time economy (NTE) e.g. violence against the person, criminal damage)
- Time of offence (this serves as an indicator of alcohol related crime within the context of the NTE (e.g. between 9pm and 5am))

Individuals are expected to be matched on the basis of either the 'one-to-one' or 'closest' match system. Individuals from both samples will then be tracked to determine their offending profile at 6 months (and 12 months if resources allow), post actual or 'dummy' intervention date.

It may be possible to conduct an evaluation using Propensity Score Matching (PSM) and potential Contractors are requested to comment on the viability and strengths and weakness of PSM and/or selecting a retrospective comparison sample without calculating propensity scores.

The current research design permits information on alcohol consumption to be collected from the intervention sample only and not for the comparison sample. It is acknowledged that this limits the scope and robustness of the design. Potential Contractors, are however, invited to propose alternative designs and solutions.

Once again, Contractors are asked provide a detailed outline of how they aim to undertake this work, including but not limited to:

- Previous experience of retrospective comparison sample designs
- Possible methods and alternative designs for matching individuals within intervention and control samples, especially the use of Propensity Score Matching (PSM) and the strengths and weaknesses of the proposed methods
- Possible methods for analysing individual level offending data, including confirmatory self-report offending data and the strengths and weakness of the approach.

Contractors are also encouraged to put forward other suitable methods for recruiting a comparison sample which bear in mind the constraints of the current project.

3.1.3 RDS within the Home Office have undertaken work to determine the minimum throughput of clients required for the evaluation. A recommendation has been made to sample for an 8-10% effect size with regard to reduced offending and Contractors are asked to put forward their own calculations for the minimum throughput of clients required to measure: 5%, 8% and 10% effect sizes (using 80% power and a 5% statistical significance level) taking into account attrition at the various stages of the intervention and response rates. The Contractor is asked to detail how they plan to work with HO and local partners to monitor the throughput of clients onto referral schemes.

3.1.4 An Alcohol Intervention Record (AIR) has been developed by the HO in consultation with local partners. Alcohol Specialist Workers will administer the paper based AIR during the brief intervention session to collect informed consent, basic demographics and baseline information on: alcohol consumption, general health data, readiness to change their alcohol consumption and a basic assessment of self-reported offending.

Contractors are to note that although baseline data is to be collected by the Alcohol Specialist Worker within each pilot area, the six-month post implementation follow AIR will be will be administered by the Contractor. The Contractor will be also expected to enter the data from the paper based AIR (baseline and post-implementation) onto a database and conduct the analysis. The Contractor will also have to provide details about how they will collect and store the data and provide guarantees that these processes and procedures will meet the requirements of the Data Protection Act 1998.

3.1.5 Information to be collected via AIR

- **Basic demographics:** name, address, age, gender, ethnicity, religion, disability, referral route and level of compliance with interventions. The Contractor should detail how they will work with Alcohol Specialists to develop methods for avoiding inaccuracies, dealing with missing data and other relevant issues.

- **Alcohol consumption:** Each individual will be asked to complete the AUDIT instrument, a validated instrument used to screen for hazardous and harmful drinking (see WHO: http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf). The Contractor will be asked to detail options for when to best collect alcohol consumption data and how this will be analysed.

- **General Health/Well being:** It is proposed that the short, 12-item General Health Questionnaire be administered (GHQ-12: http://www.publications.doh.gov.uk/hsecodebook/general_health/ghq_12.htm

- **Readiness to Change Ruler:** Client's readiness to change their behaviour with regard to consuming alcohol is considered as an indicator of behaviour change. Individuals are asked to complete one question (know as the Readiness to Change Ruler), which asks respondents to rate their readiness to change on a scale of 0 to 100 (100 being the most ready to change).

- **Self reported offending:** Basic self-report information on offending levels over the last six months will be collected. The respondents will be asked to complete a grid comprising questions on offending for seven different offence types and for each offence type they will be asked to indicate the frequency of committing the offence, whether they thought the offence was alcohol related and also whether the police were involved. In addition they will be asked to, via an open question, whether they had committed any other offences in the last six months.

3.1.6 A crucial function of the AIR will be to collect **informed written consent** from the individuals to share their information (demographics, audit, GHQ-12 and readiness to change and self-reported offending behaviour information) with the Home Office and the Contractor.

Contractors are invited to submit alternative methods and designs.

3.1.7 Use of administrative data

3.1.8 Police recorded crime data

- The information collected via the AIR will be matched by the Contractor to the individual's police offending records, which are held by local forces (incidents, arrest and charge data) and also on the PNC (convictions). The records will be 'soft matched' by using the initial and date of birth of the individual, which will be supplied by the AIR.
- Contractors are required to detail how they will conduct this element of the evaluation and also outline in their tender any previous experience of working with local police data.
- The Contractors are also expected to detail proposals to link individual personal data to information stored on the Police National Computer (PNC) e.g. convictions.
- Contractors are expected to explain how their processed method of accessing the data, processing and analysis complies with the Data Protection Act 1998.
- Contractors are invited to submit alternative methods and designs.

Process evaluation

3.2 The process evaluation will aim to

- Assess referral pathways;
- Assess how DAATs are delivering services to clients;
- Identify levers and barriers to service delivery and the reasons for these;
- Identify differentials between pilot sites in terms of service delivery and reasons for these
- Make recommendations for good practice to inform future roll out and policy.

3.2.1 Contractors are expected to detail a research design for the process evaluation that uses a combination of quantitative and qualitative measures to fulfil the objectives outlined. Submitted designs will be expected to deliver:

3.2.3 Client perceptions of service delivery quality: RDS is keen to collect some basic quantitative information from clients on the services received and their perceptions of these as determinants of their outcomes. In-depth information around client perceptions and experience of services will be elicited through qualitative means which may include focus groups to examine service delivery issues in more depth and, depending on whether attrition can be kept to a minimum, a 'case tracking' study which will follow a small sample of clients over time (follow up at about 6 months).

3.2.3 Interviews with stakeholders: Semi-structured interviews will be undertaken with all key stakeholders in the alcohol referral pilot areas at two points in time: within the first six months and at around twelve months. It is felt that this method of data collection allows more in-depth consideration of relevant issues raised than can be elicited from self-report questionnaires. Therefore, interviews will be conducted with representatives from the DAAT, the police including custody sergeants, alcohol specialists and other key stakeholders. Interviews will last for around one hour and will cover a range of topics including how well the different stakeholders are working together; levers and enablers to providing a good service; barriers to effective service delivery and how these might be overcome within the context of more strategic issues around future service delivery during possible wider implementation of alcohol referral schemes. All interviews will be tape recorded and fully transcribed.

The contractor is asked to put forward details of a design that succeeds in evaluating both client and practitioner/stakeholder perceptions on the quality of each component of the service. RDS is keen that bidders add value to tenders by detailing

- How respondents will be contacted and interviews arrangements made to minimize opt-out;
- How specific data collection will be developed and used at each stage;
- Who will undertake interviews and their experience in doing so and
- How throughput data from the AIR will inform the process evaluation.

Contractors are invited to submit alternative designs.

3.3 Cost Effectiveness evaluation

3.3.1 The Home Office would like to asses the cost of implementing the project as well as the cost-effectiveness of the intervention.

3.3.2 RDS have developed a short paper based proforma for pilot areas to use to record detailed information of any expenditure above £500 in relation to referral schemes. Contractors are expected to detail ways of ensuring the correct recording of expenditure, their plans for entering the information from the paper proforma onto a database, data analysis and how this will be used to inform the cost-effectiveness analysis.

3.3.3 Contractors are expected to detail in their proposals how this element of the evaluation will be conducted. In addition to this, RDS will expect to receive within tenders details of previous CEAs undertaken by research teams with regard to reducing crime evaluations, detail their outcomes and also provide information on any specific economic expertise held by team members.

3.4 Data analysis

3.4 Proposed methods for analysing data put forward by the Contractor should be linked clearly back to the research questions under examination. Therefore, tenders are expected to detail which descriptive and multivariate statistical techniques they aim to undertake on the quantitative data to address research questions around the impact of referral schemes. Once again, the proposal needs to clearly highlight any data quality issues and present details about the processes they will use to minimise poor quality and missing data.

All qualitative research interviews will be tape-recorded and transcribed by the Contractor, before undergoing thematic analysis. Interviews will be conducted and data analyzed in accordance with GSR guidelines on conducting, analysing and using qualitative research (*Quality in Qualitative Evaluation: A framework for assessing research evidence:* http://www.policyhub.gov.uk/docs/qge_rep.pdf*).* The Contractor will be expected to detail how they will analyse the data.

3.5 Risks

3.4 A number of risks have been identified in relation to the current project, the most important of which are an insufficient throughput of clients onto referral schemes and subsequent client attrition between intervention sessions. The Contractor will be expected to monitor the throughput of clients onto schemes through close liaison with agency partners. Pilot managers have also confirmed that here will be sufficient throughput of clients to enable the measurement of at least an 8% effect size. The risk of attrition can be mitigated by collecting client mobile telephone and other forms of contact information.

The pilot projects went live in late October 2007 and so the evaluation timeline is short. ASBAU and RDS will liaise with successful Contractors to provide as much support as possible to enable data collection systems to be in place.

4. Project issues

4.1 The Contractor will be committed to a tight time scale to ensure that preparations are in place for data collection to commence as soon as pilot areas have gone live.

4.2 The responsibility for the ethical conduct of the research lies with the Contractor, who will be expected to obtain the relevant ethical clearance for the evaluation from relevant local ethics committees. Additionally guidelines from the Government Social Research Unit (www.gsr.gov.uk/professional_guidance/ethics.asp), the British Society of Criminology (www.britsoccrim.org/ethical/htm) and Social Research Association (www.thesra.org.uk/ethical.htm) will be followed in relation to ethics. There are number of ethical issues related to the project which include, but are not limited to: informed consent for taking part in interventions, transportation of pro-formats that contain personal and sensitive information; access to individual offending records; confidentiality of personal data for all members of sample, informed consent for tape recording interviews and using data for research purposes.

5. Project management

5.1 Greg Braun (RDS project manager, Crime and Drugs, Analysis and Research) shall act as the formal point of contact between the Home Office and the researchers. All requests, information and questions should flow through the project manager to minimise the research burden on policy colleagues within HO, the research customers. Details on the outputs required and associated timescales are detailed in the Outputs section. The project management role may also involve ad-hoc request for fieldwork documents, presentations or responses to enquiries. These will be handled by the project manager.

5.2 A project implementation group will meet quarterly to monitor the implementation of alcohol arrest referral schemes within pilot areas and the Contractor would be expected to attend these meetings. The Contractor will be required to provide an update report for these meetings, and furthermore be required to attend meetings corresponding to key milestones within the project, such as, for example, delivery of the baseline report etc. The Contractor will be given sufficient notice to prepare for meetings.

5.3 The project manager will expect regular, at least once a month, telephone updates from the Contractor. Once again, these will be expected to correspond with key milestones i.e. project planning, go live dates and submission of baseline report

5.4 RDS and Home Office policy colleagues will require sight of all research instruments, sampling plans, consent forms, questionnaires, topic guides, analysis plans reports and other key documentation prior for the purposes of quality assurance. It is important that Contractors are able to build into their plans the time need for the Home Office to clear these outputs, thereby ensuring that research is progressing well and answering the questions needed.

6. Project resources

6.1 Each tender is expected to provide information about the skills and experience of the project team deemed relevant to the current evaluation. The following information is requested:

6.1.1 **For the project lead** (the most senior person on the project team who is ultimately responsible for project delivery)

- Major projects undertaken in the last five years
- RAE rating (if contractor is a university department)
- Names of two individuals for whom they have done similar projects and who could be approached for a reference.
- Brief details of any previous Home Office research (no more than 200 words per project)

6.1.2 **For each member of the project team**

- Name and position
- Experience of related research (either within the subject area or with statistical and / or methodological relevance)
- Any supervisory experience

All project staff will be requested to produce a CV as this allows further opportunity to show relevant skills and experience in addition to the detailed information above.

6.1.3 The tender will also provide detailed information on how the contract will be managed from the Contractor end. This will include information on who will be the day to day contract manager and act as the main contact for the Home Office project manager. Furthermore, there exists a need to detail staffing issues including, if applicable, clear details of whether staff still need to be recruited onto the project and contingency arrangements in the event of staff changes.

6.1.4 Tenderers are asked to complete the financial pro forma (attached in Schedule 2) which requests clarification on the number of days allocated to each member of the project team across key areas of the project. Although the exact framework may vary, as a minimum the following areas should be considered in depth

- Project design and implementation
- Fieldwork
- Data entry and processing
- Analysis
- Reporting
- Travel
- Management and quality assurance

6.2 It is hoped that this specification is sufficiently detailed for the Contractor to make a realistic assessment of cost. Tenderers are asked to provide information on daily rates for each member of the research team using the financial pro forma in Schedule 2. Full details for overheads and other related costs for carrying out the work should also be included in the fee schedule. Milestone payments are detailed in **Schedule 2 of the Invitation to Tender** and a minimum of 20% will be kept back on final payment until acceptance of the final report.

6.3.1 Key project milestones and stages are set out as follows:

Stage	**Timetable**
Award contract	January 2008
Develop and finalise methodology (sample recruitment; data collection tools; methods for negotiating access to offending data; structure of interviews) To be quality assured by Home Office	February 2008
Baseline report submitted	May 2008
Fieldwork period-completion of all fieldwork	December 2007-October 2008
Receipt of outputs: interim research reports	December 2008
Receipt of outputs: final research reports	March 2009
Contract completion	July 2009

Research teams submitting tenders are asked to submit a project plan/spreadsheet detailing the key milestones identified within their methodology. Please note that where time is needed for HO to agree outputs, this should be included in the project plan. Please note that due to commitments made in a Ministerial submission, the delivery date for interim findings is immovable, as the policy lead requires timely information on which is base recommendations to Ministers about further roll-out of AA referral schemes.

6.3.3 Successful tenderers will be awarded the contract on condition that they accept a break clause specifying that the Home Office may discontinue the project or revise the specification if

- Work completed does not meet the expected quality standard.
- There is insufficient sample in one or more of the pilot areas to allow a robust assessment of the impact of intervention schemes.

6.4 It is essential that research team outline in their bids plans for appropriate levels of supervision and control by senior members of the project team. Key stages of the project will also need to be subject to input from, and approval by, senior members of the project team. A quality control plan is required to include details on how the research team will work with the Home Office to:

- Assure the quality of each stage of the research process from project design through to reporting stages.
- Implement supervision arrangements for members of staff including details of the research team structure and internal quality assurance of work.
- Highlight any particular difficulties and risks at each stage of the research process and suggest ways for overcoming these.
- Detail how the work will be allocated and delivered on time when a consortium is presenting a tender.

7. Outputs

7.1 A number of outputs will be expected by the Home Office across the life of this project in addition to the final report. These will provide an opportunity to quality assure the work being undertaken, review and agree key conclusions/decisions, and sign off payments where these are linked to deliverables. The following outputs will therefore be expected from the Contractor:

- A written baseline report in May 2008 (no more than 25 A4 pages). A presentation and briefing on any issues arising
- A written interim report in December 2008 (no more than 25 A4 pages), detailing preliminary findings into offending at 6months. A presentation and briefing on any issues arising.
- A final written research report in March 2009 in the Home Office RDS publication format: 1:3:25 with additional appendices which detail technical issues and methodology **(see contract Terms and Conditions)** (one page of key implications; a three page summary of key findings and 25 pages of main findings. Technical appendices can also be included). Contractors are expected to detail any previous reports they have submitted, preferably to Government Departments, in this format. All reports will be subject to external review and will only be published if they attain the required Home Office standard. Presentations and a workshop for practitioners on issues arising out of the evaluation.
- A concise practitioner guide is report is expected to form an addendum to the final written report.
- As a matter of course in all externally commissioned report a copy of the dataset and research transcripts will be expected.

7.2 There is a critical deadline related to the interim report, which is expected by December 2008 in order to allow the Policy lead to advise Ministers about future roll out of AA referral schemes in time for the start of the new financial year.

7.3 Contractors are invited to consider or suggest other relevant outputs of the research project which may provide added value and cost these separately.

8. Evaluation Criteria

8.1 Tenders will be awarded on the basis of value for money. The following factors for consideration when evaluating the tenders will include, but not be limited to:

- Service Proposals including:
  - Delivery and Quality
  - Demonstrated understanding of the requirement.
  - Suitability of proposed methodology.
  - The knowledge and experience of the Contractor and their team
  - Ability to deliver the required product to the agreed timetable.
  - An understanding of the possible problems/ issues and reasonable proposals to attempt to solve them
  - Staffing and copies of CVs of key personnel
- Business Continuity
- Environmental considerations (if applicable)
- Equal Opportunities policy