Transforming Rehabilitation
A revolution in the way we manage offenders

DrugScope Response (February 2013)

Introduction

1. DrugScope is the national membership organisation for the drug sector and the UK's leading independent centre of expertise on drugs and drug use. We welcome the opportunity to respond to this consultation on behalf of our 400 plus member organisations, predominantly (but not exclusively) voluntary, community and social enterprise sector (VCSE) agencies delivering drug and alcohol services on the 'frontline', including many working in prisons and with offenders in the community. DrugScope also incorporates the London Drug and Alcohol Network (LDAN). Our response is focussed on the issues for drug and alcohol services, particularly VCSE organisations.

2. DrugScope is a member of the Criminal Justice Alliance, and supports its response to the consultation. We are involved in the Bradley Group, an independent forum advocating for the recommendations of Lord Bradley's 2009 report on diversion of people with mental health problems and learning disabilities within the criminal justice system. DrugScope is a partner in the Home Office funded Safer Future Communities initiative, which is supporting VCSE organisations in England and Wales to work effectively with elected Police and Crime Commissioners and to contribute to reducing offending locally. DrugScope's Chief Executive is a member of the Criminal Justice Council and Association of Chief Police Officers (ACPO) Drugs Committee.

3. DrugScope is also a member of the Making Every Adult Matter (or MEAM) coalition, in partnership with Clinks, Homeless Link and Mind. MEAM is influencing policy and practice for adults facing multiple needs and exclusions, including many in contact with the criminal justice system. (The MEAM site is at www.meam.org.uk).

Process

4. The six week consultation period for 'Transforming Rehabilitation' is significantly less than the 12 week norm for consultations recommended in The Compact between the VCSE sector and Government. The Ministry of Justice justifies the shorter period on the grounds that there was a previous consultation 'on the principles behind many of the proposals'.

5. DrugScope appreciates other opportunities that we have had to shape the proposals, including our response to the 2010 'Breaking the Cycle' consultation and our participation in a roundtable with the Secretary of State for Justice. However, we feel that a six week consultation period gives insufficient time for organisations, including 'second tier' organisations, fully to consult their memberships and stakeholders and prepare a response. Our response is nonetheless informed by telephone interviews with Chief Executives and Senior Managers of VCSE providers of drug and alcohol services, and has been shaped by discussions with members of DrugScope's Chief Executives' Forum (a quarterly meeting of around 30 CEOs and Senior Managers) and the London Drug and Alcohol Network Senior Managers Group (a quarterly meeting for service managers in London).

6. We have also drawn on our involvement in the development and assessment of other Payment by Results (PbR) initiatives. In particular, we were involved in the Department of Health's co-design group for the eight Drug and Alcohol Recovery PbR pilots and our Director of Policy and Membership co-chaired a 'Gaming Commission' as part of this process. We also recently provided written and oral evidence to the House of Commons Work and Pensions Select Committee on the impact of the Work Programme for our sector based on extensive consultation with service providers and service users.

The role of drug and alcohol services for 'Transforming Rehabilitation'

7. Drug and alcohol services have a critical role to play in reducing crime, rehabilitating offenders and making our communities safer.

The National Treatment Agency (NTA) estimates that
- The total annual cost of drug-related crime in England is around £14 billion.
- Evidence-based drug treatment prevents 4.9 million crimes annually.
- This saves tax payers £960 million in costs to victims, businesses, the criminal justice system and the NHS.[1]

[1] All these figures have been taken from the National Treatment Agency's 'Why invest?' resource, which is at http://www.nta.nhs.uk/uploads/whyinvest2final.pdf

These figures do not take account of the impact of alcohol related crime, which has been estimated to be a factor in up to half of all violent crimes.

8. There is a high prevalence of drug and alcohol treatment need among short term prisoners and offenders on community sentences. This reflects the nature of offending by some people with substance dependency, in particular high volumes of acquisitive crime, drug supply offences and involvement in prostitution. In addition, many alcohol-related offences are lower level public disorder and violent offences that may attract either a community sentence or a short prison sentence.

The Prison Reform Trust's Bromley Briefing 2012 explains that
- Between a third and a half of new receptions into prison are estimated to be problem drug users (UK Drug Policy Commission).
- 14% of men and 18% of women in prison were serving sentences for drug offences at the end of March 2012 (Ministry of Justice).
- 55% of prisoners reported committing offences connected to their drug taking, with the need for money to buy drugs the most commonly cited factor (Home Office).
- 81% of people arrested who used heroin and/or crack at least once a week said they committed an acquisitive crime in the previous 12 months, with 31% reporting an average of at least one crime a day (UK Drug Policy Commission).
- Rates of using heroin, cocaine or crack were higher (44% to 35%) for prisoners sentenced to less than one year than for those serving longer terms (Ministry of Justice).

9. The 'Transforming Rehabilitation' proposals are being developed as part of the Government's overall response to drug and alcohol problems, with lead responsibility resting with the Home Office. We note that the Drug Strategy 2010 says that 'prison may not always be the best place for individuals to overcome their dependence and offending'. In this context, we note that, while the focus on improving resettlement for short-term prisoners is welcome, it is important that the role of community sentences as an alternative to short custodial sentences continues to be developed.

10. While there are circumstances in which a short prison sentence may be appropriate, this will tend to have a negative impact on 'recovery capital' (for example, relationships, housing, employment and future employability), which will, in turn, increase the risks of future offending. Specifically, going to prison means that offenders no longer have access to existing recovery support in the community; short-term prisoners have limited access to recovery support and treatment in prisons (while recognising recent improvements and the

potential within 'Transforming Rehabilitation' for integrating treatment in prison and on release); and they experience problems with resettlement on release.

11. We would also urge Government to continue to develop the 'Rehabilitation Revolution' proposals with reference to a number of landmark reports. DrugScope and its members have welcomed and supported the recommendations of The Patel Report on 'Reducing Drug-Related Crime and Rehabilitating Offenders' (2010)[2]; the Bradley Report on people with mental health problems and learning difficulties within the criminal justice system (2009)[3]; and The Corston reports on women offenders, including, most recently, the 'Second report on women with particular vulnerabilities in the criminal justice system' (2011).[4]

Consultation questions

DrugScope is responding to those questions of most relevance to our sector and membership.

C1: We are minded to introduce 16 Contract Package Areas. Do you think this is the right number to support effective delivery of rehabilitation services? Do you have any views on how the Contract Package Area boundaries should be drawn?

12. DrugScope welcomes the recognition in the consultation document that providers of offender management services will need to 'work closely with all local partners to ensure that the services delivered to achieve the reducing reoffending outcomes are aligned with other local services, whoever the commissioner – for example, PCCs, local authorities or NHS commissioners'.

13. From April 2013, responsibility for drug and alcohol services will be shared across a number of new commissioning bodies, following the abolition of the NTA, the absorption of the 'ring fenced' pooled drug treatment budget into the new public health budget and discontinuation of the Drug Interventions Programme (DIP) as a nationally managed or mandated initiative. If drug and alcohol services are commissioned through 16 Contract Package areas this will be one piece in a complex planning and commissioning 'jigsaw' that includes: Directors of Public Health and Health and Wellbeing Boards at upper tier local authority level; Police and Crime Commissioners in each of 43 police authority areas; 27 offender health teams with responsibility for drug and alcohol treatment in prisons and 15 regional Public Health England

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[2] http://www.dh.gov.uk/en/Publicationsandstatistics/DH_119851
[3] http://www.rcpsych.ac.uk/pdf/Bradley%20Report11.pdf
[4] http://www.howardleague.org/fileadmin/howard_league/user/pdf/Publications/Women_in_the_penal_system.pdf

centres. This local picture is overlaid, in particular, by the role of Work Programme prime providers in sub-contracting drug and alcohol services and interventions. (We note in this context that the 'Transforming Rehabilitation' programme could be one element of a network of contracted-out provision that is working with the same person or household and that there would appear to be a need for this to be integrated, co-ordinated and sequenced)

14. All else being equal, it is desirable to achieve the greatest possible 'co-terminosity' of commissioning agencies. For this reason, we support the intention to draw the Contract Package Area boundaries so that they are co-terminous with police authority areas, while noting that there will be more than one PCC in each Contract Package Area (at least outside London). We would therefore ask what consideration has been given (i) to introducing a Contract Package Area for each policy authority area, and (ii) delegating responsibility for commissioning offender management services to elected PCCs, while providing them with a ring-fenced budget to discharge this responsibility. While we recognise the potential risks in these arrangements – particularly (ii) - it would help to ensure support for the proposals if reasons for rejecting these options were explained.

15. We would welcome further cross-Government work to consider the challenges of integrated commissioning with so many structural changes occurring simultaneously. It would be helpful to produce (or support the production of) resources to support local commissioners to navigate the new commissioning landscape for offender management. Service providers would also welcome guidance and support to map this landscape.

16. Offender management systems in the Contract Package Areas will be commissioned by national Government. This follows the Work Programme approach, but runs contrary to 'localism' – including in the development of drug and alcohol services, where lead responsibility will transfer to Directors of Public Health employed by local authorities from April 2013, with elected PCCs expected to have an important role.

17. This again highlights the challenges of achieving integrated commissioning of local services. For example, Health and Wellbeing Boards will have a central role in bringing together commissioners to build local systems to support recovery from drug and alcohol dependency. How will centrally commissioned offender management systems in 16 Contract Package Areas relate to these local structures – for example, where they incorporate drug and alcohol services in supply chains? (DrugScope members have stressed to us the critical role that local commissioners can have in ensuring the effective delivery of integrated offender management at local level - for example, in

working to ensure the involvement of police and probation in Integrated Offender Management (IOM) services.)

18. We welcome the commitment in the consultation document to including as part of the formal evaluation in the selection of future providers a requirement for them to provide ‘evidence how they would sustain and develop local networks and partnerships and in particular existing IOM arrangements’.

19. There is a strong case for designing overall systems so that responsibility for developing and commissioning drug and alcohol services, including IOM provision, is with Health and Wellbeing Boards and PCCs at the local level, with the new offender management services referring offenders into these IOM systems and contributing appropriately to the funding of local IOM interventions. This is also consistent with the aim of increasing accountability for services through local democratic processes that is a key component of ‘localism’.

20. There is a concern that central commissioning through 16 Contract Package Areas could discourage, or make it difficult for, some VCS organisations (particularly small and medium-sized agencies) to be involved in delivery of ‘Transforming Rehabilitation’. We address this in our responses to questions C7 – C9 below.

C2: What payment by results payment structure would offer the right balance between provider incentive and financial risk transfer?

21. The approach proposed in ‘Transforming Rehabilitation’ has not been piloted.[5] To date, there is a limited evidence-base on PbR schemes in general.

22. It is particularly important to proceed with caution given that offender management services work with some offenders who could pose significant risks to the community. The Criminal Justice Alliance’s consultation response refers to a KPMG research paper on PbR that concludes that there is “a ‘bleeding edge’ in getting it right, as both the customer and the provider explore how to manage complex risks and rewards and the boundaries of cross-government and multi-year spending are transcended’. The introduction of the ‘Transforming Rehabilitation’ proposals during a period of far-reaching change to other commissioning structures will sharpen this ‘bleeding edge’. DrugScope members also highlight the challenges of getting on top of relevant data collection and management for PbR, particularly when taking on

[5] We note that the PbR scheme at HMP Peterborough is significantly different, with the financial risk transferred to social investors and not providers.

new contracts on this scale, and the time needed for culture change. There are also potential TUPE issues.

23. DrugScope recommends a cautious and gradual transition to a PbR approach, with the pace and direction informed by a cumulative evidence base, and safeguards built in to implementation to take stock in the light of experience, and potentially recalibrate systems. We would propose that no more than around 10-20% of contracts are on a PbR basis, at least in the initial phase of implementation.[6]

24. However, while we favour a cautious introduction of PbR, we recognise that this carries a risk, particularly that the intentions behind PbR could be lost with most of the contract value awarded as a 'block contract'. A concern is that large companies could profit from multi-million pound contracts with little or no financial risk or incentive to innovate if the PbR component is set too low. It will therefore be vital to develop other mechanisms and safeguards to counterbalance this. We discuss this issue in our response to C6 below.

C3: What measurements and pricing structures would incentivise providers to work with all offenders including the most prolific?

25. We welcome the commitment 'to develop our payment structures to incentivise providers to deliver effective services for all offenders, even the most problematic and repeat offenders'. (We note the importance of developing assessment and diagnostic tools that consider all aspect of need and risk – as demonstrated, for example, in a different context by the challenges of developing the Work Capability Assessment within the Work Programme.)

26. A consistent message from DrugScope members is that it is not possible to incentivise engagement with all offenders through a simple, binary offending outcome. This would disincentivise services from working with prolific and repeat offenders, and remove incentives to continue to work with an offender once they commit an offence (including a minor offence).[7] DrugScope therefore recommends that the offending measure takes account of frequency and severity. (It is possible, of course, to combine payments for progress on frequency and severity with a 'final' outcome payment for desistence, and we would not discount this kind of approach).

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[6] One DrugScope member organisation has suggested that there should be *no* PbR component in the first year in order to give organisations or mutuals assuming responsibility for contracts a period of time to take stock and to develop and put in place the infrastructures and mechanisms for implementation of PbR from year 2.

[7] An obvious issue for binary measures (and for other desistence measures) is what arrangements are made for 'resetting the clock' if a further offence is committed.

27. DrugScope would suggest that consideration is given to excluding some offences from the offending metrics altogether, and specifically minor offences with no relevance to the individual's offending history or rehabilitation (for example, some motoring offences).

28. We note that many of the issues involved in developing an effective PbR measure for reducing offending and reoffending were considered by the 'co-design group' in developing an offending measure for the Drug and Alcohol Recovery PbR pilots launched in April 2012. These included (i) the relative merits of cohort and individual measures and (ii) the length of time a reduction or desistence in offending needs to be sustained before a payment is triggered, which present potential financial management and cash flow problems for service providers (particularly given associated 'data lags'). We anticipate that the MoJ will want to build on this metric in developing an outcomes framework for 'Transforming Rehabilitation'. A full, independent evaluation of the Drug and Alcohol Recovery PbR pilots is being undertaken by Manchester University, which could provide an important evidence base for developing the metrics for 'Transforming Rehabilitation'. This is a three year study, with a final report expected in 2014-15.

29. This raises a general issue about the inter-relationship between different PbR schemes. What account has been taken, for example, of the inclusion of offending measures and payments in the Drug and Alcohol Recovery PbR pilots and how (if at all) this relates to payments under the 'Transforming Rehabilitation' programme? We note also the Ministry of Justice is 'piloting an approach where sustainable employment and reducing reoffending outcomes have been joined up by combining an MoJ payment to the Work Programme funding'. How will any payments through the Work Programme be combined with payments to offender management services?

C6: What mechanisms can be used to incentivise excellent performance and robustly manage poor performance to ensure good value for money?

C7: What steps should we take to ensure that lead providers manage and maintain a truly diverse supply chain in a fair, sustainable and transparent manner?

C8: What processes should be established to ensure that supply chain management is addressed?

30. DrugScope notes the intention to 'award contracts to those providers who demonstrate that they can deliver efficient, high quality services and improve value for money'.

31. Value for money is an important consideration in developing new services for short-term prisoners, particularly in a period when the Ministry of Justice is managing budget reductions. Our members believe that VCSE services can and should demonstrate value for money. Equally, this needs to be balanced with mechanisms to ensure 'efficient, high quality services' - as one service provider told DrugScope: 'if people end up mandated into "cheap and cheerful" services this will not be cost-effective, we will be throwing money away and potentially putting the community at risk'.

32. The consultation paper identifies a number of performance management mechanisms, including a requirement for 'lead providers to commit to supply chain management principles aligned with those identified by the Merlin Standard'; an undertaking to 'ensure that under PbR arrangements, disproportionate levels of financial risk are not passed down to VCS and SME providers'; and a commitment to 'ensure sustainable funding streams and support across to social investment'. We note in this context that discussions with DrugScope members suggest that Merlin has yet to demonstrate its effectiveness, given the balance of power between provider and purchaser in the Work Programme.

33. DrugScope highlighted a number of other lessons in our evidence to the Work and Pensions Select Committee inquiry into the Work Programme. These included:

    - Strengthening assessment and diagnostic tools;
    - More specific prime contractor minimum offers or a national minimum service offer (we noted that in comparative systems elsewhere, including in Australia, national minimum standards apply);

- Greater transparency and accountability in demonstrating the extent to which specialist support is being offered and provided and on the use of supply chains;
- A more proactive role for national Government in promoting good and effective practice among primes and subcontractors.

34. A range of PbR schemes are being introduced in rapid succession and the risk is that this limits the opportunities to learn from experience in designing new PbR schemes. For example, the drug and alcohol recovery PbR evaluation is not expected to be completed until 2014-15. An openness to pool experience and evaluation from different PbR approaches and the flexibility to adjust and adapt programmes in the light of the emerging evidence-base will be key to successful implementation, including the management of poor performance and the effective management of supply chains. This learning from experience requires effective cross-governmental co-ordination of PbR development, a commitment to independent monitoring and evaluation and a culture that encourages providers (including supply chain providers) to raise concerns.

35. While some VCSE agencies in the drug and alcohol sector are positive about PbR, we hear from others who have misgivings about aspects of PbR schemes with which they are involved, but are reluctant to voice these concerns as they fear being seen as defensive and/or potentially ruling themselves out for future PbR (or other) contracts. This can mean that messages or perceptions about how PbR is working do not always reflect the full reality on the ground. Second-tier organisations like DrugScope can contribute to a 'learning culture' by providing a communication bridge between service providers, local commissioners, officials and Ministers.

C9: How can we ensure that the voluntary and community sector is able to participate in the new system in a fair and meaningful way?

36. The VCSE is a diverse sector and support needs will vary depending on the size of VCSE organisations. Some larger DrugScope member organisations have indicated that they intend to participate fully in the 'Transforming Rehabilitation' programme, including bidding as prime providers or as partners in joint ventures or mutuals in some contract areas. By contrast, medium-scale and small local VCSE organisations are most likely to be involved in supply chains (see also C13 below).

37. As noted above, we welcome the assurance that providers will be required to commit to supply chain management principles aligned with those identified by the Merlin Standard, while noting some concerns about the effectiveness of Merlin to date within the Work Programme. We also welcome the

commitment of resources to develop support for VCS organisations to operate under PbR frameworks in future, with NOMs investing £150K of grant funding in 2012/13 in a capacity-building action plan for the sector, with a further grant of £350K available in 2013-14 to execute the plan. We also note the commitment to support access to social investment. We welcome the determination expressed by the Secretary of State to ensure that VCSE organisations are not used as 'bid candy' and to learn from the tendering process for the Work Programme primes.

38. On supply chain management, it is our understanding that, partly because of the commitment to a 'black box' approach, the Department of Work and Pensions retained limited leverage to intervene if Work Programme prime providers were not working with subcontractors as expected. This could be addressed in developing 'Transforming Rehabilitation' through a national minimum service framework, greater transparency and accountability on engaging with named subcontractors and supply chain involvement and a more proactive approach to monitoring and oversight from Government. 'Transforming Rehabilitation' contracts should include requirements for monitoring and reporting supply chain activity. This would need to be backed by recourse to effective mechanisms where supply chains are not operating as intended. These would include supporting subcontractors to invoke the Merlin Standard (or equivalent) and possibly additional safeguards to enable the Ministry of Justice to identify serious failures in delivery against contract and impose penalties on contract holders.

39. We welcome NOMs investment in capacity building in the VCSE sector, but note that the £500K for capacity-building is comparatively modest, given the likely scale of the VCSE's potential involvement and, for example, ensuring the appropriate mix of services and expertise locally. The action plan will also need to take account of the diversity of the VCSE sector, with capacity building needs varying depending on the size and resources of VCSE organisations, the sectors they are involved with, and nature of their potential involvement in PbR.

40. There is currently a lack of clarity about plans for the development of social investment – with one DrugScope member suggesting that references to social investment were 'a red herring'. We are aware of the social impact bond scheme for 'through the gates' provision at HMP Peterborough, and welcomed the piloting of this approach. We note, however, that this is a different model to that proposed in the 'Transforming Rehabilitation' consultation. In particular, at Peterborough it is the social investors who are paid by results, and bear the financial risks, not service providers. We note the lack of detail about current thinking on the role of social investment and would welcome opportunities to participate in any on-going discussions.

41. It is difficult to over-emphasise the extent to which concerns about TUPE issues are a recurrent theme in DrugScope consultation with members about their involvement in new commissioning arrangements, including PbR schemes. For example, will VCSE organisations potentially be responsible for assuming public sector pension liabilities where services are transferred from Probation Trusts? We are currently working with the National Council for Voluntary Organisations and DrugScope members to prepare a response to the Department for Business, Innovation and Skills consultation on TUPE. Its outcome could be highly significant for VCSE participation in PbR initiatives, including 'Transforming Rehabilitation'.

C13: What else can we do to ensure the new system makes the best use of local expertise and arrangements, and integrates into existing local structures and provision?

42. Local knowledge, partnerships and engagement within communities are key strengths of VCSE agencies. It is therefore important that supply chain and other arrangements effectively harness the skills of local VCSE services.

43. As discussed in our response to question C1 above, there will be a shift in responsibility for commissioning drug and alcohol services to local authorities from April 2013. Directors of Public Health employed by local authorities will be responsible for community services, while Offender Health services, under the aegis of the NHS Commissioning Board, will commission drug and alcohol treatment in prisons. It is anticipated that Health and Wellbeing Boards will help to join up local commissioning for substance misuse services, with the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy processes playing a key role. In addition, as discussed below, PCCs will have a strong interest in and a potential role in the commissioning (and co-commissioning) of drug and alcohol services (see response to C14 below). Careful consideration will therefore need to be given to how 'Transforming Rehabilitation' mechanisms are combined with or integrated into local strategic and commissioning arrangements for substance misuse services.

44. We would welcome an openness to consider alternative ways of implementing 'Transforming Rehabilitation'. For example, the model proposed in the consultation paper envisages the 16 centrally commissioned primes, joint ventures and/or mutuals developing their own supply chain arrangements in local areas to provide services like drug and alcohol treatment for their clients. An alternative might be for budgets to be transferred from 'Transforming Rehabilitation' providers to the relevant local commissioners of drug and alcohol services (for example, Directors of Public Health or PCCs), along with arrangements for representation of 'Transforming Rehabilitation' providers in

the local commissioning systems. This would be consistent with localism, simplify the commissioning arrangements and reduce the potential of several commissioners paying for the same or overlapping services (or, for example, Work Programme or 'Transforming Rehabilitation' providers 'free riding' on locally commissioned services to deliver results).

C14: Police and Crime Commissioners will play an integral role in our reforms. How best can we maximise their input/involvement and that of key partners locally?

45. The consultation document explains that PCCs will have an opportunity for local leadership to galvanise police, local authorities and the Crown Prosecution Service and courts to work together to reduce reoffending. This may include holding local partners to account via community safety partnerships and commissioning services at local level with other local agencies, such as local health commissioners. We support the focus on the relationship between PCCs and the 'Transforming Rehabilitation' programme, including the intention to ensure that contracting areas are co-terminous with police authority areas.

46. As discussed in response to C1, we believe that there is a case for introducing a Contract Package Area for each policy authority area, or even delegating responsibility for commissioning offender management services to PCCs. We would be interested to know whether this option was considered.

47. While there is potential for the 'Transforming Rehabilitation' providers to work closely with PCCs, there is a lack of detail in the consultation document about how this may work in practice, and a number of implicit assumptions appear to have been made about the ability and willingness of PCCs to allocate resources to offender management.

48. While PCCs will have a designated budget for community safety in 2013-14, we understand from the Home Office that: 'the Community Safety Fund is un-ring-fenced, which means PCCs have total freedom to use it as they wish'. The Home Office does offer reassurances that 'the PCC role is much wider than just policing, and PCCs will be seeking to establish their wider crime prevention role', and cites 'the announcements many have made already on community safety priorities and ideas'. Nonetheless there is clear risk of disinvestment, and particularly that community safety budgets could be used to fund policing at a time when police force budgets are under considerable pressure. These pressures could be even greater from April 2014, when the Community Safety Fund is absorbed into a single PCC funding pot.

49. Effective 'join up' between 'Transforming Rehabilitation' and PCCs may require some arrangements for 'ring fencing' (or other significant protections)

to ensure there is continued investment by PCCs in community safety, and specifically offender management, particularly from April 2014. This could be funded through a direct allocation of resources for offender management to PCCs by the Ministry of Justice, which might be re-allocated from within the budgets that would otherwise go to prime or other providers in the 16 Contract Package Areas.

50. This is of particular relevance for the drug and alcohol sector as PCCs have inherited around a third of the budget that previously funded the Drug Intervention Programme (DIP), with the remainder incorporated into the new public health budgets from which community drug and alcohol services will be commissioned. It is our understanding that former DIP funding now constitutes more than half of the total community safety funding 'pot' for PCCs.[8]

51. The DIP programme has been the principal policy vehicle for bringing together criminal justice and drug treatment services to direct and keep offenders with drug dependence in treatment. DIP has operated in every local authority area in England and Wales and worked as part of local Integrated Offender Management approaches. In 2010-11, DIP helped to manage over 62,000 offenders into drug treatment, including 9,647 short sentence prisoners who were managed into drug treatment following release. DIP has now been discontinued as a nationally mandated or managed programme, and no ring-fencing or any other protection is provided for former DIP allocations in either the PCC or public health budgets.

52. This is significant because one of the most obvious ways that PCCs could be engaged in offender management services in future is by building on the DIP legacy and allocating funding for DIP-style interventions from their budgets. There is likely to be disinvestment in at least some police authority areas in the absence of any further incentives or protections and 'Transforming Rehabilitation' could potentially be plugging the gap in resettlement provision for offenders with drug and alcohol problems left by disinvestment from DIP.

53. In October 2012, DrugScope hosted a roundtable consultation on DIP working closely with the Home Office. One of the key points to emerge from the discussion was that DIP could provide only a 'front door' into drug and alcohol treatment, and could only deliver outcomes if treatment systems and services

[8] DrugScope's London Drug and Alcohol Network has a particular involvement with the Mayor's Office for Policing and Crime (MOPAC), which is effectively discharging the Mayor's PCC function in London. A recent MOPAC document states that £12.8 million of a total community safety pot of £21.3million is from the Drug Intervention Programme. It should be added that the draft Police and Crime Strategy for London makes an explicit commitment to build on the DIP programme, with a greater focus on alcohol-related crime where that is the priority in individual London Boroughs.

were in place that could work effectively with offenders to support rehabilitation and recovery. In view of the very high proportion of offenders serving short sentences or on community orders who will have substance misuse problems, this highlights the critical importance of the commissioning decisions of Directors of Public Health and Offender Health, as shaped by local Health and Wellbeing Boards, to 'Transforming Rehabilitation' outcomes, and the need to consider the relationships with these structures. (It also raises obvious issues about causality and attribution for reduced offending. Where a range of services are supporting an offender the interventions delivered and/or co-ordinated by 'Transforming Rehabilitation' providers will only be one piece in the jigsaw).

C15: How can we ensure that professional standards are maintained and that the quality of training and accreditation is assured? A professional body or institute have been suggested as one way of achieving this. What are your views on the benefits of this approach and on the practicalities of establishing such arrangements, including how costs might be met?

54. DrugScope would highlight the potential role of sector specific workforce development, training and accreditation bodies. In our sector, these include the Federation of Drug and Alcohol Professionals (FDAP at www.fdap.org.uk) and Substance Misuse Skills Consortium (at www.skillsconsortium.org.uk).

55. There is a particular issue about training and support for peer mentors. There is strong support in our sector for developing this role. Drug and alcohol services have significant experience in developing peer mentoring and 'recovery champions', including some of the risks in this approach. In particular, we would emphasise the importance of ensuring that mentors are appropriately trained, managed, supported and matched with clients. We also note that coercing or mandating people into mentoring relationships is antithetical to the values and practice of 'mentoring' and places unreasonable demands on peer mentors.[9]

C17: How can we use this new commissioning model, including payment by results, to ensure better outcomes for female offenders and others with complex needs or protected characteristics?

56. DrugScope notes that women prisoners are more likely to be serving short prison sentences than men, with a high proportion serving sentences for drug

[9] These issues were recently considered in detail in an article by Harry Shapiro, DrugScope's Director of Communications and Information in an article on recovery champions in our DrugLink magazine. The article is available at www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Publications/WalktheLine.pdf

offences or acquisitive crimes that are drug related (for example, shoplifting). The Prison Reform Trust's Bromley Briefing reports that 52% of women surveyed for the Ministry of Justice in 2008 had used heroin, crack, or cocaine powder in the four weeks prior to custody, compared to 40% of men, adding that 'practitioners report that women may hide or underplay substance misuse through fear of losing their children.'

57. Short-prison sentences can have a particularly damaging and disruptive effect on women, particularly given than many female offenders have parenting responsibilities and are separated from their families. Due to comparatively low numbers, women are held in prisons that are on average 55 miles from their home address or the committal court. While we welcome the commitment to improving support for short-term prisoners on release, we would favour diverting more women out of the prison system and onto community sentences. The Corston Reports provide an evidence-base and framework for a new commissioning model for female offenders. DrugScope continues to support Baroness Corston's recommendations.

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DrugScope is the national membership organisation for the drug and alcohol field and the UK's leading independent centre of expertise on drugs and drug use. We represent around 450 member organisations involved in drug and alcohol treatment, young people's services, drug education, criminal justice and related services, such as mental health and homelessness.

DrugScope is a registered charity (number: 255030).

For further information about DrugScope – including becoming a DrugScope member and member benefits is available at: www.drugscope.org.uk
LDAN website: www.ldan.org.uk