CLINKS RESPONSE

CLINKS

supporting voluntary organisations that work with offenders and their families

Clinks' response to the Care Act (2014) consultation on the draft regulations and guidance for implementation of Part 1 of the Act in 2015/16.

August 2014

About Clinks

Clinks is the national infrastructure organisation supporting voluntary sector organisations working with offenders and their families. Our aim is to ensure the sector and those with whom it works, are informed and engaged in order to transform the lives of offenders and their communities. We do this by providing specialist information and support, with a particular focus on smaller voluntary sector organisations, to inform them about changes in policy and commissioning, and to help them build effective partnerships and provide innovative services that respond directly to the needs of their users.

We are a membership organisation with over 600 members including the sector's largest providers as well as its smallest, and our wider national network reaches 4,000 voluntary sector contacts. Overall, through our weekly e-bulletin Light Lunch and our social media activity, we are in contact with up to 10,000 individuals and agencies with an interest in the Criminal Justice System (CJS) and the role of the voluntary sector in the resettlement and rehabilitation of offenders.

Introduction

Clinks welcomes the opportunity to respond to this consultation brought by the Department of Health and is broadly supportive of the draft regulations and guidance. We are especially pleased that the policy basis for the Care Act (2014) and subsequent guidance is that 'all adults in custody, as well as offenders and defendants in the community, should expect the same level of care and support as the rest of the population.' This is essential and has a valuable role to play in addressing the high level of health and social care inequalities experienced by people in contact with the Criminal Justice System (CJS). Some headline statistics highlighting these inequalities include:

- In 2013, 51% of adults supervised in the community had a long term medical condition or disability, whilst 46% of women and 40% of all those aged 40+ had a mental health condition.[1]
- In a 2013 study, 49% of female and 23% of male prisoners were assessed as suffering with anxiety and depression. This can be compared to 12% men and 19% women in the general population.[2]

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[1] Ministry of Justice (2013) Results from the Offender Management Community Cohort Study (OMCCS): Assessment and Sentence planning, Online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/309959/results-omccs.pdf (last accessed 30.07.2014)

[2] Ministry of Justice (2013) Gender differences in substance misuse and mental health amongst prisoners, Online: https://www.gov.uk/government/publications/gender-differences-in-substance-misuse-and-mental-health-amongst-prisoners--2 (last accessed 30.07.2014)

- Of 1,435 prisoners interviewed in a Ministry of Justice study, an estimated 36% were considered to have a disability, whilst 18% of prisoners interviewed were considered to have a physical disability.[3]
- The level of brain injury is much higher amongst offenders in custody than in the general population. According to a report published by the Transition to Adulthood Alliance, 'a recent study in England found that 60% of young people in custody reported experiencing a traumatic brain injury, a finding consistent with others from around the world.'[4]

It is also important to note that individuals with protected characteristics[5] have unique health and social care needs that will require a specialist approach such as, for example, access to a gender, age or Black and Minority Ethnic (BAME) specific service.

This brief response focuses on a select number of questions from the consultation document that relate to the work and concerns of our members. We have based our recommendations on knowledge gained through previous and ongoing consultation and discussions with our members, as well as through our independent research. For example, Clinks recently published 'More than a provider: the role of the voluntary sector in the commissioning of offender services' which explores the reality for voluntary sector organisations trying to engage with the whole cycle of commissioning.[6] The report gives a series of recommendations to enable commissioning to support rehabilitation and the desistance process.[7]

Clinks, DrugScope, Homeless Link and Mind form the Making Every Adult Matter (MEAM) coalition, which was created to influence policy and services for adults facing multiple needs and exclusions. [8]The MEAM coalition defines this group as people who experience several problems at the same time, have ineffective contact with services and are living chaotic lives. The MEAM coalition has submitted an independent response to this consultation, which Clinks fully supports.

To contextualise Clinks' response to this consultation it is necessary to make reference to the Government's Transforming Rehabilitation (TR) reforms. This large-scale reform programme will dramatically alter the way probation and resettlement services are commissioned and delivered. The reforms involve replacing the previous 35 individual Probation Trusts with a single National Probation Service, responsible for the management of high-risk offenders; and 21 Community Rehabilitation Companies (CRCs) responsible for the management of low to medium risk offenders in their Contract Package Area. The CRCs will also have a new responsibility for supervising short-sentence prisoners after release.

It is important that local authorities are aware that the CRCs will have responsibility for 'signposting prisoners to relevant services offered by other service providers both in custody and in the community post-release and so will complement prisoner access to other mainstream/co-

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[3] Ministry of Justice (2012) Estimating the prevalence of disability amongst prisoners: results from the Surveying Prisoner Crime Reduction (SPCR) survey, Online: https://www.gov.uk/government/publications/estimating-the-prevalence-of-disability-amongst-prisoners (last accessed 30.07.2014).

[4] Transition to Adulthood Alliance (2012) *Repairing shattered lives: brain injury and its implications for criminal justice*, Online: http://www.t2a.org.uk/wp-content/uploads/2012/10/Repairing-Shattered-Lives_Report.pdf (last accessed 30.07.2014).

[5] Protected characteristics are defined by the Equality Act, 2010 as including age, disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, religion or belief, sex and sexual orientation.

[6] Clinks (2014) *More than a provider: The role of the voluntary sector in the commissioning of offender services,* Online: http://www.clinks.org/resources-reports/more-provider-role-voluntary-sector-commissioning-offender-services

[7] Desistance is an individualised process, experienced differently by different people and is very likely to involve an individual relapsing before they stop offending altogether.

[8] For more information about the MEAM Coalition please see here: http://meam.org.uk/

commissioned services i.e. those addressing health needs, substance misuse, employment, education and training'[9] and how this can impact on the services they deliver.

Clinks' response

Question (5) Views are invited about how local authorities should co-ordinate and target information to those who have specific health and care support needs

As highlighted earlier, people in contact with the CJS often have higher health needs and worse health outcomes than their counterparts in the general population. Public Health England also outline that 'a large proportion of the prison population have engaged in high-risk behaviour (unprotected sex, multiple partners and injecting drugs) [and] the prevalence of Blood Borne Viruses (BBVs) and Sexually Transmitted Infections (STIs) is higher than in the general population.'[10] As well as this, it is also the case that people in contact with the CJS are likely to experience educational disadvantage, as according to the Ministry of Justice, in 2012 21% of prisoners reported needing help with either reading and writing or with numbers. Information should therefore be accessible and targeted in a way that recognises and adapts to the unique needs of these service users.

Many people involved in the CJS, especially those with multiple and complex needs, have ineffective contact with services.[11] However, the ability to engage with hard to reach groups is a particular strength of the voluntary sector working in criminal justice, making it essential that local authorities work in partnership with organisations in their area to co-ordinate and target information to their service users. It is also important that health services go to where this group are already engaged with organisations and deliver services through outreach or by using the voluntary sector as a gateway.

Clinks' Directory of Offender Services is an online database listing over 1,000 voluntary sector organisations working with offenders and their families, which would help support local authorities to determine which organisations work in their area and support them by working in partnership with these organisations.[12]

Question (7) Does the statutory guidance provide a framework to support local authorities and their partners to take new approaches to commissioning and shape their local market?

Market shaping

Clinks is pleased to see point 4.5 in the guidelines articulating that 'market shaping activity should stimulate a diverse range of appropriate high quality services (both in terms of types, volumes and

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[9] Ministry of Justice (2014) *The Target Operating Model: Version 3*, Online: https://www.justice.gov.uk/transforming-rehabilitation/how-the-system-works (last accessed 31.07.2014)

[10] Department of Health (2012) *Public Health Functions to be exercised by the NHS Commissioning Board, Service specification No.29: Public health services for people in prison of other places of detention, including those held in the Young People's Secure Estate*, Online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213171/29-People-in-prison-specification-121025.pdf (last accessed 7.08.2014)

[11] Please see the response from the MEAM coalition for more information as to how this relates to people with multiple needs and exclusions.

quality of services and the types of provider organisation), and ensure the market as a whole remains vibrant and sustainable.' It is important to note that many voluntary sector organisations could potentially be part of the market, and it is essential that those organisations who work or deliver services in prisons or with offenders in the community are included in market shaping activities as specialist providers with expertise to contribute. As highlighted earlier, Clinks' Directory of Offender Services is a useful tool for determining which organisations carry out this work and what areas they operate in. It can be accessed here.

Commissioning
As outlined in Clinks' State of the Sector Survey, contracts 'overwhelmingly favour larger organisations with 50 or more staff'. Delivering services as part of a contract can leave organisations particularly exposed to shifts in the commissioning landscape and overall reductions in public spending, which can have a dramatic impact on voluntary sector organisations leaving them particularly vulnerable.[13] Grant funding, on the other hand, has huge benefits for the voluntary sector and can help small organisations to develop their services, enabling them to bid for contracts in the future; enable the voluntary sector to work intensively and for longer periods of time with those who are hard to reach; and can ensure organisations can carry out activity that delivers on desirable social outcomes, but which might be challenging to measure or define in a contract.

Therefore, and in line with our recent publication, 'More than a provider' we recommend that local authorities 'always consider both grants and contracts in the procurement of services, rather than using contracts as a default position. [local authorities should] use grants to support innovation and invest in the capacity of organisations to deliver services in the future.' This is especially relevant to point 4.6 in the guidelines, as it is important that grant funding is included as a key element of what commissioners provide, rather than just as an optional extra.

Clinks is supportive of point 4.82 in the guidance document that states 'local authorities should consider with partners, the enabling activities, functions and processes that may facilitate effective integrated services. These will include consideration of: joint commissioning strategies, joint funding, pooled budgets, lead commissioning, and collaborative commissioning.' To ensure this occurs, we recommend that commissioners from different departments meet regularly to communicate to each other what they are commissioning, collaborate on needs assessments, develop co-commissioning opportunities and also look beyond their specific areas to consider and address the implications of any recent commissioning changes.

Clinks would also recommend that adequate resources are provided to enable commissioning and procurement teams to operate effectively and be able to ensure joint commissioning can take place.[14]

It is also important to note that the voluntary sector does not only deliver services; in many cases, organisations have an advocacy function on behalf of their beneficiaries instead of or as well as service delivery. To reflect this, we would recommend that relevant voluntary sector organisations, both those which deliver services and those which do not, are involved at all stages of the commissioning cycle and not only as a potential provider at the procurement stage. This

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[13] Clinks (2013) *State of the Sector: October 2013*, Online: http://www.clinks.org/file/clinks-state-sector-full-reportpdf, (last accessed, 31.07.2014)
[14] Clinks (2014) *More than a provider: The role of the voluntary sector in the commissioning of offender services,* Online: http://www.clinks.org/resources-reports/more-provider-role-voluntary-sector-commissioning-offender-services

includes consulting them throughout, from needs assessment and service design, to procurement, service delivery and through to review and re-commissioning, or de-commissioning.[15]

Clinks is pleased to see reference to the Social Value Act (2012) in the guidelines. Our research, demonstrates areas of good practice where social value has been added to contracts through purchasing services from voluntary sector organisations. One example of this is purchasing a service, such as a drug and alcohol service from a voluntary sector organisation that by delivering such a service, also improves the reintegration of ex-offenders by tackling the stigma of criminal convictions.

'More than a provider' includes additional recommendations that local authorities could use to shape commissioning and their local market. They are as follows:

- Provide flexible but systematic routes for all voluntary sector organisations (not just service providers) to share intelligence about emerging needs, pitch ideas and advocate for service improvements.
- Involve service users throughout the commissioning cycle, and provide commissioning and procurement teams with the opportunity to meet directly with service users.
- Involve service users and voluntary sector organisations in equality impact assessments for people with protected characteristics under the Equality Act, throughout the whole commissioning cycle.
- Carefully consider the impact of contract size on market diversity, and wherever possible break large contracts into smaller lots.
- Ensure the procurement process is proportionate to the scale of the service being commissioned.
- Ensure all providers have clear information about procurement processes and reason for decision making, give advance notice of intentions to tender, and hold 'provider days' to facilitate partnership development and inform the specification.
- Carefully consider the effects of competitive tendering processes on local relationships, referral pathways and sharing of good practice.
- Where subcontracting is desired by commissioners, it should be made clear that bids will be selected and performance managed on the basis of a good supply chain, and how that will be measured.
- Maintain dialogue with subcontractors to ensure a direct line of communication with smaller providers.
- Support the development of formal and informal partnerships by providing technical support and capacity building grants.
- Ensure that decommissioning processes are carried out with good advance notice that bidders, providers, service users and communities are provided with clear information about retendering and decommissioning decisions.

Payment by outcomes

In relation to point 4.26 in the guidelines, Clinks is pleased to see the Department of Health outline that 'any move to payments by outcomes should be achieved such that smaller, specialist, voluntary sector and community-based providers are not excluded from markets or disadvantaged.' To ensure this will occur, Clinks recommends that wherever possible, contracted or subcontracted voluntary sector partners carrying out discrete pieces of work should receive

[15] A useful diagram outlining this can be found on page 6 of *More than a provider: The role of the voluntary sector in the commissioning of offender services. See Footnote 6 for full reference*

100% of the delivery fee upfront, with all outcomes-based risk remaining with the lead contractor. Where this is not possible, Clinks recommends that a maximum of 20% of the contractual fee to a voluntary sector provider should be left at risk, and that this should be flexible according to organisational capacity relating to risk. At the very least, we believe that the amount of risk at the lower tiers should not be allowed to exceed the amount held by a lead contractor. [16]

Service user involvement
Clinks welcomes point 4.57 in the guidelines as it is essential that 'Local Authorities should arrange engagement to include hard-to-reach individuals and groups, including those who have communication issues and involving representatives of those who lack mental capacity.' People who have been in contact with the CJS, especially those experiencing multiple needs and exclusions can find it hard to access services. It is important to be aware that even if there is not a prison in the local authority area, there will still be people living there that have had contact with the CJS.

Engaging those who have been in contact with the CJS in service user involvement can support the desistance process and help an individual to move away from crime. Many voluntary sector organisations facilitate service user involvement and use the process to inform the way their services are designed and delivered, thereby ensuring they meet the needs of the people using them.

Following Clinks' research into service user involvement in prisons and probation trusts,[17] we published a collection of best practice, which includes an example of patient and public involvement, developed through the introduction of health care representatives in HMP Leeds. This service user involvement project was initiated by the prison health care team in response to prisoners' views that health care provision in prison was inferior to that in the community. The project saw the creation of Health Care Representative (HCR) posts from the prison population to help shape the design and delivery of health services within the prison, provide information and support to new prisoners and liaise between prisoners and health care staff.

The project had positive outcomes including improved attendance rates for doctor and clinical appointments, a substantial increase in prisoners engaging with healthcare who had previously abstained and an improvement in prisoner self-esteem, health literacy and health promotion.[18]

Another example is the Pilot Prisoner Engagement Project at HMP Peterborough.[19] This project is in its initial stages, with two male and female Wellbeing Representatives on the male and female units at the prison having been trained since February 2014. The two key duties of the Wellbeing Representatives include being the point of contact for prisoners to share health and social care issues and highlighting and sharing national health and social care campaigns within prisons. Short term aims the pilot has achieved include the establishment of meaningful engagement with prisoners and prison staff, the training and identification of prisoners to become Wellbeing Representatives and the raised awareness for the Healthwatch network and prison organisations.

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[16] Clinks (2014) *Response to the Justice Committee inquiry into Crime Reduction Policies: A co-ordinated approach?,* Online: http://www.clinks.org/responses (last accessed 31.07.2014).
[17] Clinks (2011) *A review of service user involvement in prisons and probation trusts*, Online: http://www.clinks.org/criminal-justice/service-user-involvement (last accessed 31.07.2014).
[18] Clinks (2011) *Best practice in service user involvement in prisons and probation trusts*, Online: http://www.clinks.org/criminal-justice/service-user-involvement (last accessed 31.07.2014).
[19] Healthwatch Peterborough (2014) *Healthwatch Peterborough Annual Report 2013-14*, http://www.healthwatchpeterborough.co.uk/ (last accessed 07.08.2014)

Question (8) Are there any further suggestions of case studies or tools that can assist local authorities in carrying out their market shaping and commissioning activities?

Clinks have a range of resources and tools, including the recently published *More than a provider* report that can assist local authorities when market shaping and commissioning. These can be accessed via our website here.

As service user involvement is also an important aspect of both market shaping and commissioning, we would also like to signpost to our 'Service User Involvement: a volunteering and mentoring guide', which can be accessed here.

Clinks' Directory of Offender Services could also act as a useful tool for local authorities. It can be accessed here.

Question (56) Are there any good practice examples of local authorities working with their partners, including health, education, employment and housing?

Although not focused on partnership working with local authorities, Clinks have recently published two case studies that highlight how successful partnerships between different sectors, with the voluntary sector acting as an intermediary, have helped clients to navigate the complex health world and have therefore made services more effective and ensured individuals receive support.

The first case study is of Sahir House, which is a HIV charity based in Liverpool operating across Merseyside and North Cheshire. They provide support, information and training for individuals and families living with or affected by HIV. It can be accessed here.

The second case study is of Lancashire Women's Centres (LWC) which operates 10 One Stop Shop centres for women in the community throughout Lancashire, with plans to open three more across Cumbria in the coming months. It can be accessed here.

Case studies in Clinks' recent submission of evidence to the Care Quality Commission (CQC) demonstrate examples of successful partnership working with and between sectors and the impact this has on service users. It can be accessed here.

Both of these examples demonstrate models of engagement and partnership working that local authorities could adopt when working with their partners.

Question (60) When delivering care and support in custodial settings, how should local authorities go about reflecting the high prevalence of mental ill health, substance misuse and learning disabilities?

Responding to the needs of offenders in custodial settings

It is positive that the Department of Health has recognised the high prevalence of health needs experienced by offenders. Clinks are pleased to see that point 17.27 recognises 'prisoners, especially those serving long sentences, may also develop eligible needs over time.' This is especially important, as highlighted by a recent Justice Select Committee report, as older prisoners are the fastest growing age group in the prison population. Between 2002 and 2013, the number of prisoners aged 60 and over increased by 120% whilst for those aged 50-59, the number

increased by 100%.[20] Older prisoners require appropriate and responsive services to meet their health and social care needs, and Recoop[21] recommend that when working with older offenders, 'age-specific screening and assessment tools' are used. [22]

However, it is worth outlining that there is real concern that many prisons are ill equipped to meet the health and social care needs of older prisoners. One consequence of this is inappropriate dependencies developing between prisoners, making older prisoners increasingly vulnerable. [23]

It is also important to note however, that people in contact with the CJS often experience barriers to accessing health care. These include:

- A fragmented service response
- Poor continuity of care
- Low engagement with health services
- Problems navigating systems
- Failure to involve service users in care planning
- A 'one size fits all' approach
- Delays in receiving help
- Inflexible services
- High threshold of services
- Poor professional-client relationships

For more details on how this impacts offenders in the community, please see our submission to the CQC, which can be accessed here.

Voluntary sector organisations, as well as providing specialised support to service users with unique health and social care needs, often work as intermediaries, either between services users and statutory organisations or between organisations from different sectors. Please see the aforementioned case study into Sahir House as an example of this. As such, it is important that local authorities work in partnership with voluntary sector organisations to address the health and social care inequalities experienced by those in contact with the CJS.

Personalisation

It is essential that personalisation for those in custodial settings is not treated as an afterthought by the Department of Health. In regards to point 17.33 which highlights that 'local authorities should make it clear to individuals that the custodial regime may limit the range of care options available,' Clinks recommends that the Department of Health provides more clarity on this issue and outlines in more detail how this will impact people in custodial settings. One way this could be done is through the production of a case study.

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[20] Justice Select Committee (2013) *Older Prisoners,* Online: http://www.parliament.uk/business/committees/committees-a-z/commons-select/justice-committee/news/op-report/ (last accessed 31.07.2014).

[21] Recoop are a charity that promote the care, resettlement and rehabilitation of older prisoners, offenders and ex-offenders.

[22] Recoop and Clinks (2013) *Working with older offenders: A resource for voluntary, community and social enterprise organisations*, Online: http://www.clinks.org/criminal-justice/do-it-justice (last accessed 30.07.2014).

[23] Justice Select Committee (2013) *Older Prisoners,* Online: http://www.parliament.uk/business/committees/committees-a-z/commons-select/justice-committee/news/op-report/ (last accessed 31.07.2014).

Revolving Doors Agency[24] conducted a pilot project that developed a personalised approach to prison resettlement at HMP Everthorpe. It can be accessed here.

Resettlement and non-resettlement prisons
Under the TR reform programme, all prisons in England and Wales will be designated as either resettlement or non-resettlement prisons. It is anticipated that short-term prisoners will serve most or all of their sentence in a resettlement prison, whilst longer sentenced prisoners will spend a minimum of three months there prior to release.[25] Due to the nature of resettlement prisons, it is likely that they will experience a high turnover of prisoners and it is essential that the health and care needs of those serving short term sentences especially are identified and responded to.

Clinks is concerned that no distinction has been made between these prisons in the guidelines document, and would recommend that a clearer steer is given by the Department of Health as to how local authorities will assess the health and social care needs of prisoners in both resettlement and non-resettlement prisons, and how information sharing systems will be improved to ensure the health and social care needs are recognised as prisoners move around the system.

Joint Strategic Needs Assessments (JSNA)
Clinks recommends that health and wellbeing boards involve prisons, voluntary sector organisations, probation staff and service users (using prison councils where they operate) when developing a JSNA for an area. It is important that JSNAs for areas that have prisons always include an assessment of the overall needs in that prison, especially due to the high level of health and social care needs in custodial settings. Health and wellbeing boards should also be aware that although a prison may not be present in their area, people who are in contact and those who have been in contact with the CJS in the recent past will live there.

Question (61) How might these be best provided in custodial settings and how might responsibility for provision best be identified

As highlighted earlier, the voluntary sector provides a range of innovative and effective services in custodial settings. Such organisations and services can be identified using Clinks' Directory of Offender Services.

People in contact with the CJS often have high levels of health and social care needs and it is likely that many would fall into the following definition of a vulnerable adult, which is a person 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.'[26] As such, Clinks recommends that prison and probation staff, alongside voluntary sector organisations, are invited as members of Safeguarding Adults Boards. Please also see our response to Question 60 for more information regarding the needs of older offenders.

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[24] Revolving Doors Agency is a charity working across England to change systems and improve services for people with multiple problems, including poor mental health, who are in contact with the CJS.
[25] Ministry of Justice (2013) *Transforming Rehabilitation: A strategy for reform*, Online: https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation/results/transforming-rehabilitation-response.pdf (last accessed 30.07.2014).
[26] Department of Health and Home Office (2010) *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, Online: https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care (last accessed 30.07.2014).

Question (62) How could the initial assessment of a prisoner's care and support needs be best constructed to be useful in supporting proportionate reassessment and planning to meet any eligible care and support needs in subsequent custodial settings throughout the person's sentence? Are there triggers, particularly which might be identified in the health assessment which all prisoners receive on entering prison, which could help prison staff and/or health care partners to identify when it would be appropriate to refer a prisoner for a care needs assessment?

Use of appropriate screening tools

As demonstrated earlier, people in contact with the CJS are not a homogenous group, and those with protected characteristics are overrepresented in custodial settings. It is therefore important that appropriate screening tools, such as those that are age and gender specific for example, are used as part of an initial assessment of a prisoner's health care and support needs. It is also important that upon entering prison, a service user's mental health is assessed.

Peer support and advocacy

According to point 17.19 in the guidelines 'prisons and/or prison health services **should** inform local authorities when someone they believe has care and support needs arrives at their establishment.' Many voluntary sector organisations deliver a range of services in prisons, and therefore work very closely with prisoners. It is essential that there is a route through which representatives from these organisations are able to raise with prison or health staff when they believe someone has care and support needs.

Many voluntary sector organisations facilitate peer support within the services they provide, including those in custodial settings. Peer support occurs when 'people with the same shared experience provide knowledge, experience, or emotional, social or practical help to each other.' [27] Such schemes are often able to work with people who do not engage with other services and can be defined as hard to reach. Indeed, one benefit of peer support schemes can be that these individuals become more engaged in services, including health services, delivered by both the statutory and voluntary sectors.

Also, due to the nature of peer support services, trusting and open relationships often develop between the two parties. As such, it is important that there is a formal route through which those offering peer support can make their concerns known if they think someone they are working with might need to have a health and social care assessment.

Self-referrals

Clinks is supportive of point 17.23 in the guidelines which outlines that 'people in a custodial setting have a right to self-refer for an assessment and the managers of the custodial setting, together with the local authority, should consider how to handle self-referrals.' We are concerned that this is not clear and would recommend that the Department of Health give more detail in the guidelines as to how self-referrals in custodial settings will operate.

We would also like to refer to our answer to Question 5 as it is also important that people in custodial settings are able to access this information, and are able to understand it.

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[27] Clinks (2012) *Volunteer peer support: a volunteering and mentoring guide*, Online: http://www.clinks.org/file/708 (last accessed 30.07.2014).

CLINKS

supporting voluntary organisations that work with offenders and their families

Question (63) Are there any core principles or requirements that local authorities should always place on contractors when delegating care and support functions?

As outlined earlier, the ability to engage with hard to reach groups such as offenders and ex-offenders is a particular strength of the voluntary sector, making it essential that local authorities work in partnership with the voluntary sector both operationally and strategically. This partnership allows health services go to where offenders and ex-offenders are already engaged with these organisations. They can then deliver accessible services through outreach or by using the voluntary sector as a gateway.

As previously highlighted, it is also essential that local authorities engage service users in the whole commissioning process, including the assessment of bids.

Author and contact details:

Nicola Drinkwater | Policy Officer | 0207 248 3538 | nicola.drinkwater@clinks.org

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Contact Us www.clinks.org | info@clinks.org | 0207 248 3538

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