MONITORING AND DEVELOPING CASE MANAGEMENT

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The following are some suggestions for the monitoring process. They are under two headings, first to do with monitoring individual prisoners/patients, the other to do with monitoring the process of Case Management itself. In a third section, I've made some suggestions about future developments.

INDIVIDUAL CLINICAL PROGRESS

Monitoring of client (prisoner/patient) progress can be considered as requiring attention to two kinds of variables: first, those that are likely to be common to all those who come under Case Management, and second those that will be unique to each individual in turn.

For the first, there are issues such as medication compliance. This might involve urinalysis or blood tests. I am not sure but it might be possible to combine this with drugs testing (i.e. to check if the individual has been using illicit drugs). All such information would of course be recorded on a chart, etc. Stefan is far better qualified than I am to describe the procedures required in this area.

Whether or not someone is taking medication may of course be perfectly clear from observations of the prisoner. This might show whether symptoms have returned, and obvious events such as episodes of self-harm. The dosage of medication might be modified based on this information. I assume this would also involve all of the other associate health checks (for side-effects etc.).

In a residential secure mental health unit or in a prison, staff should interview patients/prisoners routinely to check their well-being, and maintain notes in a clinical file. (We discussed at the meeting in September the question of who has access to those files.)

In other respects, there would usually be monitoring of such factors as:

- day-to-day behaviour, reported moods etc.,
- attendance at education classes, workshops or other activities,
- amounts of interaction with staff and other prisoners, family visitors, etc.
- any incidents such as breaches of discipline, verbal hostility, assaults etc.

For the second, there can be specially designed monitoring tailored to an individual's symptoms, using what are called *idiographic* methods. This might include daily recording of thoughts in a simple diary format; reporting the strength of delusions, ruminations, trauma memories, etc. Less frequently, it might be possible to use semi-structured interviews or self-report scales to plot changes over time. I'm attaching some journal papers that describe the *Experience Sampling Method*, and 24-hour recording of Time Use, that might suggest how this can be done.

Periodically, all the above available information should be reviewed in a multi-disciplinary team meeting. In most residential units in the UK those would be held weekly and there will be a brief discussion of all patients/prisoners. There is a standard framework for organising this in mental health services, known as the *Care Programme Approach* (CPA, now *Enhanced CPA*).

A larger, more in-depth review of each individual's progress will take place perhaps every six or 12 months. These are multi-professional meetings and they might also be attended by an individual's family members, or if he/she is due to be released or transferred, by someone from the community or another prison unit to which the person is going to move.

In due course, when someone is discharged, we would carry out follow-up work to see if they had somewhere decent to live, how much family contact and the nature/quality of it, level of drug use, mental health status, whether he/she had a job, etc. In England and Wales, if the person had served a long prison sentence, he/she would still be on parole for some time afterwards and would be monitored by the probation service. If they were assessed as "high risk" they would be under frequent review by the local *Multi-Agency Public Protection Panel* which includes police, probation, healthcare, and other agencies involved in the offender's management.

IMPLEMENTATION OF CASE MANAGEMENT

Monitoring how the system as a whole is working would depend partly on the above. That is, if patients/prisoners are being managed well, we should be able to examine their case files and see evidence of progress (or at the very least, that Case Management was happening, and services were being provided). This could be done as a form of management audit, perhaps on an annual basis, or more frequently if there are worries that the work is not being done adequately.

In such an audit, all the documentation is reviewed and inspected. That is, the auditors would expect to see evidence of monitoring of the prisoners/patients, with clinical notes being kept regularly, records or notes of meetings, case files completed with good information available,

letters and memos written by staff, evidence that actions that were planned had been taken. This could be supplemented by interviewing a sample of patients/prisoners and staff.

This could be done locally, by the management of each separate prison unit; it might be the responsibility of one member of the management team; or perhaps there would be one senior manager covering a group of prisons in one geographic region. Alternatively it could be done centrally, i.e. by staff from prison service headquarters (perhaps even a specially appointed team) or perhaps by independent inspectors (maybe from the health ministry, or from an NGO given a contract for the purpose. *Perhaps this is a key role for PRI as it has advised on the setting up of Case Management, see below*). A third option is for it to be done on a "peer review" basis, where small groups of staff circulate round other prisons (once per year) and prepare a report on their functioning. (This is similar to the "external examiner" system we have in universities, where our students are examined both by us and by academics appointed from other institutions who visit one each year, examine dissertations, and take part in decisions about the award of degrees). Obviously, all of this involves varying levels of cost.

The prison service here has a process like this for monitoring offending behaviour programmes. Before they can be used, programmes first have to be approved by a group of experts called the *Correctional Services Accreditation Panel*. Then the delivery of a programme at each prison site is monitored annually – a series of documents has to be completed and members of staff make site visits to other prisons and confirm whether or not the work is being done to the standard that is expected.

In a fully operational system of accountability, there would also be an annual report on all these processes, which would be reviewed by the Director-General's office and perhaps even by the office of government ministers. It is a lot of bureaucracy, but unfortunately this is often the only way to make sure services are properly and efficiently delivered. Even then it's not guaranteed!

In the UK there has been a lot of discussion of how to monitor healthcare provision. Even today on the news there is a dispute between two agencies that have reported on the standard of cleanliness in hospitals and they disagree over their findings. As far as prisons are concerned, in addition to the service's own audit procedures, we also have an independent Prison Inspectorate. There is a dispute here too, about whether they should have to inform a prison in advance of their intention to visit (which allows the prison staff time to look good), or whether they can launch "surprise" visits at very short notice.

FUTURE DEVELOPMENT

In the long run, if there are to be better healthcare services for prisoners with mental health problems, there needs to be better joint working between the ministries of justice and health (and perhaps other agencies too, such as those responsible for social welfare). There is wide agreement that prison is a very difficult place to experience mental disorder; that the proportion of prisoners with mental health problems is higher than in the community outside; and that imprisonment itself may precipitate illness, or make it worse.

So if someone is in this position, depending on the severity of the problem he/she should be transferred to hospital. This may mean establishing new kinds of units (we call them forensic mental health units) though I do not know if they already exist in Romania. It might also require changes in the law relating to detention of people with mental health problems who have also committed crimes. This might mean that someone is assessed even before going to prison and transferred to hospital instead.

Thus there are plenty of things that PRI can do working alongside the National Prison Administration:

1) Monitor the implementation and delivery of Case Management (CM) as described above.
2) Develop the case for a national Prison Mental Health Inspectorate or similar agency, propose a consultation exercise on how it would work.
3) As part of this work, or separately, PRI could do “action research” comparing different areas to see which model of CM worked best (we discussed this idea in September I think), and developing the best ideas and materials into a package or a series of guidelines that could then be disseminated nationally (and internationally).
4) All of our discussions suggested to me that there is a need for more resources.
    a. Perhaps PRI can keep forwarding the argument for this and describe how they could be used.
    b. Possibly request funding for a “demonstration project” in one prison (or more, but a small number) to illustrate how well this could work.
    c. Carry out a “cost-benefit” exercise to show that while the provision of better services may seem expensive in the short term, it saves money in the longer term.
5) Put forward evidence and arguments for reducing the size of the prison population, which in Romania is quite above the European average; using the mental health issue as part of that – better care at lower cost can be provided in non-custodial settings, or in healthcare units which may cost more in the short run but produce savings in the long run.
6) Consult on the development of better inter-agency working and provision of services in institutions and in the community.
    a. Cooperation between justice and health departments at national and local level.

    b. Cooperation between institutions and community agencies to support transfers and rehabilitation/reintegration work with prisoners.
7) Become involved in public education to reduce the stigma of mental illness. This could involve:
    a. Public awareness campaigns through the media;
    b. Providing advice to families who have a member with a mental illness, especially where he/she has also broken the law;
    c. Making proposals on self-care education in schools, bullying prevention programmes, and related initiatives.

These are some of the possibilities, I am sure there are many more!