Introduction of a drug treatment case management system into the Irish Prison Service

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Thesis submitted in accordance with the regulations as part fulfilment M.Sc. in Drug and Alcohol Policy, Trinity College, Dublin

June 2004

Declaration

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Acknowledgements

I wish to thank all the many people who worked with me on this project, who are too many to name.
It truly was a participative event and was enthusiastically undertaken by all at a time of great stress in Mountjoy Prison. The keen desire of participants to effect organisational change has been inspiring. It has been clearly acknowledged by those who have generously given of their time, expertise and experience that real change will only take place through collective and co-ordinated endeavour. I hope this project will provide the impetus and structure for such a process to succeed, thereby bringing about a real and positive change for all those who work and reside in our prisons.

For Angela

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Invocation

“Each minute may be marvellously – or horribly –profound . . . There are swift hours and very long seconds. Past time is void. There is no chronology of events to mark it; external duration no longer exists”.

Victor Serge in Men in Prison.

“Prisons are forcing houses in which all human life is reduced, concentrated and distorted. You see the full glory of the human spirit up beside the lowest depravity and degradation. You see the brilliance and inspiration of leadership in staff and prisoners, and its instant eclipse by a risk taken too far. You view with alarm and perhaps cynicism the emergence of yet another test designed to prove that prison is something other than the outward sign of an inner failing. You see the struggle of people brought in to the heart of the criminal justice system by the heels who then try to make sense of the indifference and even hatred which the community is prepared to reveal in its handling of those who challenge its stability . . .

Treating people as responsible, or discovering the responsibility in people, is our greatest contribution to the future”.

Stephen Pryor, Prison Governor.

Abstract

This exploratory study describes the piloting of a strengths based case management approach into the prison system. The purpose of such a system is to identify the needs of prisoners with a drug misuse problem, so as to achieve positive sentence management and to facilitate successful reintegration back into the community. The introduction of a networked database formed an essential component of the study, and was designed to limit problems associated with communication, fragmentation and demarcation of service delivery.

In the study, a participative action research methodology was utilised to identify and address the issues involved in this change process. The study identified fundamental issues which would need to be addressed if case management is to succeed, including effective management of resources, appropriate selection of prisoners and the use of verifiable information in order to address care and risk management issues. In order for shared care planning and integrated care pathways to be effective, a resolution of the confidentiality-information sharing issue must be found. In addition, the critical role of the Operations Directorate in facilitating a policy of positive sentence management and co-ordinated temporary release needs to be recognised.

On the basis of the findings of this study, it is envisioned that such a total system approach has the potential to deliver continuity of service along integrated care pathways thereby addressing the gap between prison and community in the provision of transitional care services. The research highlights the need for transparent protocols to enhance multidisciplinary co-operation and co-ordination of drug treatment services in prisons and by so doing improve efficiency, effectiveness and value for money.

Glossary

CAART	Common addictions assessment tool
CARAT	Counselling assessment referral advice throughcare
CJIP	Criminal Justice Interventions Programme
EDR	Earliest date of release
ERHA	Eastern Regional Health Authority
IPS	Irish Prison Service
MMT	Methadone maintenance treatment
OASys	Offender assessment system
OD	Organisational development
POA	Prison Officers Association
PSM	Positive sentence management
PWS	Probation and Welfare Service
SCP	Shared care planning
TR	Temporary release

Introduction

The aim of this study is to pilot an effective system of case management, in vivo, which will identify the needs of prisoners with a drug misuse problem, positively manage their sentence and enable them to successfully reintegrate into the community. The study which will be piloted in Mountjoy Prison, Dublin will herald a system of shared care planning based upon an individualised needs assessment of prisoners. To facilitate this objective, it will set up and test an associated networked relational database on the IPS intranet. The purpose of the project is to improve the co-ordination of drug treatment services in prisons by improving efficiency and effectiveness and by delivering value for money. This objective is congruent within the remit of the Co-ordinator of Drug Treatment Services (Prisons), (Department of Tourism, Sport and Recreation, 2001:58).

The project will explore and develop a process of multidisciplinary working via a participatory action research methodology and will introduce a shared care planning system promoting continuity of service provision (via integrated service delivery) for prisoners between internal prison agencies and community agencies. It is hoped that a more coherent way of working will evolve and that the current lacuna of service provision between prison and the community will be closed.

This research will, via an inductive approach, address the issues involved and suggest a model of best practice which will influence policy and the roll out of this strategy across the prison estate.

The National Drugs Strategy Report states that:
"There was widespread concern that the prison system is failing to realise its potential, not only in addressing the needs of those who are addicted to drugs through the provision of suitable treatment, but also in the provision of the kinds of counselling, education and training which would impact on the offender's behaviour after release" (Department of Tourism, Sport and Recreation, 2001:84).

Furthermore, in its 1999 report relating to the spread of blood borne diseases in prisons, the Department of Community Health and General Practice expressed

serious concerns about the spread of Hepatitis and HIV in prisons and the risks of transmission via the sharing of injecting equipment (Long et al, 2000). One of this report's recommendations was that "An individualised treatment plan should be offered to all prisoners who are addicted to opiates. This should take account of the social, educational, and medical needs of the prisoners and consequently will require multi-disciplinary input. Existing programmes in some prisons will provide a good basis for this. . . . The potential for rehabilitation and quality health care to be provided on a much wider scale than heretofore in the prison system should be realised".

Action Points 21 –24 of the National Drug Strategy have been put into place to attempt to address general issues regarding drug treatment services (Department of Tourism, Sport and Recreation, 2001:114). However, crucial and specific targets have not been set and critical actions are not subject to fixed time lines. There is much that can be achieved via the use of organisational development theory in realising change and the re-organisation of existing resources, particularly at a time when there are restrictions on the provision of new resources.

However, the problematic nature of drug misuse and its complex association with offending behaviour gives rise to treatment and management issues which are compounded by the illicit and clandestine behaviour often associated with this activity. Furthermore, the nature of human systems within prison settings makes effective organisational development problematic (Goffman, 1981).

There is a body of literature which has attempted to address the issues of planning and management of drug addiction in the community, but these issues have not been adequately addressed within the prison setting. The emphasis placed on equivalence of drug treatment service delivery between the community and prison has still not solved the structural difficulties of providing an efficient and effective service to prisoners. Furthermore, capacity problems between the prison and the community have greatly exacerbated the difficulties (World Health Organization, 2001; Department of Health UK, 2002a; IPS, 2000; Audit Commission, 2002).

Attempts have been made to address case management and care planning within UK prison settings via the use of CARAT, CAART and OASys but these models of practice represent parallel managerial approaches to service delivery and from an organisational development perspective are fragmented and therefore unlikely to deliver effective, holistic treatment throughcare for prisoners. They do nevertheless represent a robust attempt to address many of the problems surrounding throughcare such as inter-agency rivalry concerns and demarcation about confidentiality, competing allegiance to particular models of addiction and linkage problems (Burrows, J. et al, 2000; Home Office, 2002; Kothari, et al, 2002; Maguire et al, 1997; Edmunds, et al, 1999).

Within the Irish penal context, efforts have been made to devise an overall drug treatment strategy but the implementation of this has been stalled (IPS, 2003a). This situation has been exacerbated by current resource limitations within the IPS due to high prison officer overtime costs and a requirement to modernise an antiquated system of prison management in the face of significant industrial relations resistance from the Prison Officers Association.

There is an obvious need to introduce a strategic plan capable of addressing the enormous challenge inherent to the problem of drug use in prisons. Such a plan should seek to stabilise drug users and to address issues and needs relevant to successful treatment and rehabilitation. For this to happen it will be necessary to translate the rhetoric of strategy into effective systems of co-ordinated service delivery (Department of Justice, 1994; Department of Justice, Equality and Law Reform, 2001:24; Irish Prison Service, 2001). It is suggested that this can only be achieved if sound commissioning principles are set (Pugh, 2002) and a participatory action research approach is adopted by the organisations charged with service delivery. Reliance on the isolated charismatic manager in the face of fragmentation and divisive disputes over demarcation and models of addiction can only provide a partial solution to change (Burrows et al, 2000). On the other hand, rigid managerial directives and manualisation of procedures can alienate workers and lead to people failing to comply with procedures (Maguire et al, 2000; Home Office, 2002; Baldwin, 2001, Coghlan and McDonagh, 2001; Stringer, 1999).

There is a necessity to examine models of integrated service delivery and multidisciplinary models of practice (Ovretveit, 1993). There is also a need to examine cross cutting issues between different agencies and departments (Boyle, 1999; Whelan et al, 2003). In addition, there is a requirement to address points of conflict such as the dichotomy between care and control, the use of a holistic model rather than a medical model, the issue of confidentiality within a prison setting and the power conflict between healthcare and prison governors in terms of prisoner-care issues.

This research will attempt to introduce, analyse and formulate the introduction of a case management approach by a multidisciplinary team, within the prison setting. It is hoped that the insights gained through such a project might be used to assist in the development of a more cohesive and purposeful approach to the throughcare management of prisoners. Such an approach involves the adoption of an individualised needs based plan for prisoners, from the time of sentence through to the point of their release and beyond. Positive sentence management is a process of assessment, engagement and intervention which is designed to address some of the issues which may have led to imprisonment, such as the misuse of drugs. For such an approach to be successful prisoner co-operation is a vital component and therefore the process will be designed with the assistance of each prisoner involved. The process will involve the assessment of needs, the setting of targets and the establishment of plans. This is outlined in Environmental Factor No: 8 and Planning Assumption No: 8 on positive sentence management (PSM) in the IPS Strategy Statement 2001-2003 (IPS, 2001). This target was to have been achieved by June 2002. In addition positive sentence management will require the co-operation of community agencies in release preparation.

In reviewing the problem of drug misuse within the prison service, it may be more helpful to think in terms of a treatment system rather than a treatment service, given the interaction of each of the aforementioned constituents in the creation of a coherent treatment approach (Coghlan and McAuliffe, 2003). For example, provision of continuity of care is likely to reinforce personal gains made by users in prison. This will impact upon relapse rates, recidivism and the spread of blood borne diseases.

The importance of establishing links between prison and community services is crucial and is supported at a national level (IPS 2000:1, Department of Tourism, Sport and Recreation, 2001) and at an international level (Inciardi, 1993: Leukefeld and Tims, 1990; EMCDDA, 2003; Stover and von Ossietzky, 1998 cited by (Ramsay, 2003:89). The critical elements for treatment include a holistic and ongoing assessment, a comprehensive range of services which are needs-based, a continuum of treatment interventions, case management and integration and continuity of social supports (Murphy, 1999) It is also important that data is collected on the needs of prisoners in order that it can guide future policy and practice (Health Research Board, 2003).

It is anticipated that the Irish Prison Service (IPS), together with the organisations with whom it is involved, will benefit from the development and pilot testing of a model of best practice. In addition, it is hoped that this research will benefit prisoners by introducing a more coherent and less fragmented structure of throughcare. Accordingly this will lead to the creation of a more diversified structure of responsibility for the drug treatment within prison.

Aims

To pilot an effective system of case management which will identify the needs of prisoners (with a drug misuse problem), positively manage their sentence and enable them to successfully reintegrate into the community.

To devise a shared care plan and associated networked relational database in order that all key individuals within the case management process are aware of the shared care plan and release plans.

To explore and develop a process of multidisciplinary working which combines shared care planning and integrated care pathway planning, together with the principles of positive sentence management. This is to be achieved via a participative action research methodology.

To identify the role of the governor as co-ordinator of positive sentence management and to devise a multi-disciplinary structure of care planning in order to achieve accountable and devolved case management.

To make recommendations as to practice and policy development.

To contribute to the corpus of knowledge of action research, prisoner throughcare and multidisciplinary working.

Chapter 1
Literature Review

This section will outline the structures and policies involved in the inter-sectoral relationship between health and justice in the management of drug treatment issues in prison. It will explore the aims of the IPS in relation to equivalence with community treatment providers as well as their quest for efficiency and effectiveness in implementing positive sentence management. The section will address the realities of prison life in theoretical, policy and practical terms. It will collate essential components in order to construct a case management system. Namely, shared care planning, multidisciplinary working and the adoption of a strengths based approach in engaging the prisoner. The merits of UK prison case management systems will be analysed. The current potential of the Irish Probation and Welfare Service will be examined in relation to the roll out of case management.

1.1 Structures

The Irish Prison Service (IPS) was established as an executive agency of the Department of Justice, Equality and Law Reform as a precursor to forming a statutory Prisons Board with operational responsibility for the management of prisons. A Prisons Authority interim board was set-up in 2000 order to be more responsive to the necessary changes in operational and regime planning. However, the Minister still retains many powers. The Minister has also reviewed the Probation and Welfare Service and is considering a number of options including the amalgamation of both the prison service and the Probation and Welfare Service (Irish Prison Service, 2002a).

The Eastern Regional Health Authority (ERHA) was established under statute in 2000 and was tasked to be responsible for the planning, commissioning, monitoring and evaluation of all health and personal social services for the population of Dublin, Kildare and Wicklow (Stationery Office, 1999). The rationale was to address fragmentation and gaps in service delivery and thus provide a better service to

clients. By improving service delivery via planning by care group, commissioning standards can be set. There are three health boards within the ERHA who provide services for this area via 36 directly funded agencies and over 400 indirectly funded organisations. Next year it is proposed to completely restructure health services nationwide and have only 4 area health boards. In addition there will be a primary community and continuing care directorate, a national shared services centre and a national hospitals centre. All will be answerable to a health service executive (Prospectus, 2003).

> "The potential for lack of communication and fragmentisation of services exist in all organisations. By addressing co-ordination, communication and fragmentisation of services existing in all complex organisations. . . , will have a greater appreciation of each other's roles and a greater unity of purpose" (IPS, 2000:2).

Figure 1. The core policy recommendations of the Report of the Steering Group on Prison-Based Drug Treatment Services:

Equivalence of prison treatment with community drug treatment.
Prevention and early intervention for those drug users at risk
Addressing the prevention of viral illnesses
Continuity of care and treatment for those sentenced to imprisonment e.g. MMT Throughcare and aftercare treatment
A range of interventions relevant to prisoner needs
A commitment to explore the possibility of commencing treatments in prison on a similar basis to the community (e.g. joint prison/community waiting lists for MMT).
Providing opportunities to commence Hepatitis C and HIV treatment
Developing and integrating existing rehabilitation programmes
Staff training to build multidisciplinary approaches

1.2 Current situation

Role of the Co-ordinator of Drug Treatment Services (Prisons).

The author fulfils this role which enables him to act as a bridge between the IPS and the health boards in the Eastern Regional Health Authority. These bodies are committed to the equivalence of health care provision between prisons and the community. The co-ordinators role also involves the co-ordination and management of drug treatment and throughcare services in prisons. In addition, the co-ordinator links with ERHA planners and evaluators, as well as service providers, in order to bridge the gap between prison and the community. It is at this junction that chronic problems have to be identified and models of service delivery constructed so as to meet the needs of prisoners.

The co-ordinator on the basis of a commissioning plan (Pugh, 2003) has committed the ERHA to the initiation of a pilot project on multidisciplinary working and case management within Mountjoy Prison in order to introduce the concepts of shared care planning and integrated care pathways to establish continuity of service provision between prisons and the community (ERHA, 2004).

The aims of the IPS are “to operate in a more efficient and effective manner while delivering quality regimes with an emphasis on throughcare and rehabilitation”. To further this end the IPS has been in protracted negotiations with the Prison Officers Association (POA) over new working arrangements in order to cut an annual overtime cost of 60 million euro in respect of 3,300 prison officers (IPS Website, 2004).

During 2002 there were 11,860 committals to the IPS (17 prisons) with an average daily population of 3,165 (IPS, 2003). During 2004 it is intended to close 4 prisons as part of a cost-cutting exercise if prison officers do not agree to new work practices. During 2000, 72 per cent of male prisoners and 83 per cent of female prisoners reported taking drugs (Centre for Health Promotion Studies, 2000). Sixty eight per cent of female prisoners and 38 per cent of male prisoners reported

smoking heroin in the 12 months prior to the date of the research in July 2000. Ninety five percent of heroin users are in the ERHA area, 4,000 are in treatment out of an estimated total of 15,000 users and 2,900 persons are without a home of their own (ERHA, 2004).

Despite the many good services provided in prisons there is a lack of effective co-ordination in relation to treatment, care and rehabilitation. This is at its worst when the prisoner is released into the community. Apart from the 1994 Management of Offenders Report (Department of Justice) and a "Scoping Group on Positive Sentence Management" which was due to report in November, 2003. (Strategy Statement 11. Elaborate positive sentence management (IPS, 2001) no discernible comprehensive throughcare initiative has been established within the prisons. St Patrick's Institution (for young offenders) does have a good but limited case management system but this is a paper-based system which is labour intensive for governors.

The Health Research Board, as representatives of the national focal point for the EMCDDA REITOX group, monitor drug treatment services and activities. They comment that "Sadly, the prison authorities and their health care staff have made large strides to improve access to drug treatment and health care services but there is very little evidence of this because of their failure to use conventional health information systems; this is a missed opportunity" (Health Research Board, 2003). The IPS does have a functioning medical database but information is not being entered into it due to industrial relations reasons. The database was also designed to be a collection point for the National Drug Treatment Reporting System (NDTRS).

1.3 A Theoretical Framework for understanding incarceration

Prison serves to incapacitate a person by removing him from society and as such is the most visible form of punishment. One needs to be careful not to view prison from an isolationist perspective because it is important to consider what led to a person being imprisoned as well as what can be done to prevent this recurring. The initial emphasis of imprisonment is on confinement, security and control with all care considerations being subordinate to those aims. The concept of good order and

discipline is enforced through a hierarchical command structure and rules. Such rules, whilst irksome to prisoners and community workers alike, are necessary for the safety of prisoners in a situation where bullying, rape or even murder can take place.

> "The multi-faceted appeal of the prison and imprisonment, then and now, emphasises that imprisonment, like punishment generally needs to be understood from a variety of angles, as: a technical means to an end; a coercive relationship; an instrument of class domination; a form of power; and an expression of collective moral feeling ritually expressed" (Morgan, 2002:1122).

If change is to be implemented successfully within any organisation or system, it is necessary to understand the social context within which this change must be negotiated. A sociological appreciation of prison organisation which focuses upon the nature of total institutions therefore seems vital. In 1961 Goffman produced his seminal work on the nature of asylums and on the impact of institutional life upon the life of inmates. His insights appear as relevant today, in a 150-year-old chronically overcrowded and physically dilapidated prison such as Mountjoy, as when he wrote this important work.

The admission procedure into institutional life has been defined as a physical and emotional stripping of the individual. It is a form of "civil death" (Goffman, 1961:25). "The inmate often finds that certain roles are lost to him by virtue of the barrier that separates him from the outside world". It takes the form of "mortification" and "contamination" where the inmate has to mould to the administrative needs and dysfunctional dynamics of the institution. The inmate as an individual cannot maintain his separateness from the environment within which he finds himself (Goffman, 1981:32). This has implications for "the information preserve regarding self". Information is collected in a file or database. This information can include negative information about past behaviour. Information can be based on disclosures made by the prisoner. Staff members can make information and interpretation of events and this can be based on current or previous sentences. The memories of staff or word of mouth history can have an important interpretative bias on the construction of the individual' s identity and the way that he might be treated in future. This engenders a sense of personal failure but is translated into injustice,

bitterness towards authority and a view that the received punishment is beyond just deserts (Goffman, 1981:58).

The rejection of those that reject him is an antidote to self-rejection and as such sustains the inmate in ‘a them and us’ world which is characterised by clandestine behaviour, argot and the management of self-image in an unsafe environment. The inmate must adapt to his environment he must manage the tensions between the home world and the institutional world (Goffman, 1981:65). This can be achieved in a number of ways. He can “withdraw” from the situation in which he finds himself. He can adopt an “intransigent mode”. He can take on a “colonisation” perspective to living in another world. Alternatively he can undertake a “conversion” to the values, policies and practices to be found in his new world (Goffman, 1981:61).

These insights of Goffman can enlighten understanding of the manner in which some prisoners respond to their incarceration in Irish prisons today. For example, situation withdrawal is evident in relation to some female prisoners who appear to respond by entering a regressive state with concomitant implications for throughcare.

> “Lifestyles are ' chaotic' and recidivism for minor offences seems high. Personality disorder, repeated self-harm, histories of child abuse and subsequent abuse as adult, and . . . institutional childcare seem to part of people's stories. I have a strong sense that people are as institutionalised in the new system within the prison by virtue of the fact that it as not as structured as the old regime” (NiCholmain, 2003).

This refers to the differences between the current purpose built women’s prison and the old cramped prison. NiCholmain explains this difference in terms of boredom, apathy and increased drug use.

> “The transition then to community living seems to be too big a gap and so people do not seem to be able to negotiate such basic norms as timekeeping, curfews (where they operate) keeping appointments, working to a plan, taking personal responsibility, having a sense of control over one's future. I have seen a similar pattern of 'chaos' when people who have been sleeping rough move into own accommodation. It works it's way out but only when people's sense of confidence and basic skills increases. Motivational interviewing, brief but focused contact and contracts about managing crisis are some of the tools that I have used successfully. It would be interesting for the Dochas research (ERHA sponsored research on needs assessment and care pathways on

> prisoners in Dochas Centre) were to look out for institutionalisation as an experience pre, during and post prison experience and to see if it has been addressed in any of the systems of care" (NiCholmain, 2003).

These observations can also be seen within the categorisation of habitualisation which can incorporate the effects of recidivism and institutional living in a prison or community setting. Individual actions can be reduced to form limited patterns of behaviour which can be displayed with minimum effort. This reduces the need for effort and decision-making and so reduces the quality and range of responses to stimulus. This can lead to individuals being seen as presenting behaviour problems due to the effects of their hostile environments.

> "The paradox is that humans are capable of producing a world that they then experience as something other than a human product. The relationship between person, the producer, and the social world, the product, is and remains a dialectical one. The product acts back upon the producer" (British Library, 2004).

It is axiomatic to state that prisons are places of punishment in which there are significant physical and mental deprivations which contain a fundamental contradiction between what the institution says it does and what actually happens (Goffman, 1981:73). Yet, there is much worthy individual effort which goes on in prison and likewise there is much individual and collective effort amongst staff. This is not always remembered when Mountjoy Prison still has slopping out and has been condemned to closure. Even national strategy documents make serious charges about prisons without being specific about the remedies or noting the deviant clandestine activity of drug users and prisoners.

It is clear that failures associated with adequate care can arise within prison systems because of the stultifying nature of the institution and the complex demands of the drug user. The fragmented and demarcated provision of professional services, which are not subject to vertical or horizontal management integration, exacerbates problems and prevents shared care planning and continuity of service via integrated care management. Such strains can affect their ability to undertake effective shared care planning.

Goffman viewed the difficulties of introducing professional treatment into institutions in terms of incongruence between the goals of the institution and those of the professionals. He observed that professional staff hired to work within institutions had a tendency to become dissatisfied, because their very presence condoned a system in which captives were sanctioned. He suggested the use of indigenous staff to overcome this problem (Goffman, 1981:87).

It could be suggested that professionals should not operate in isolation from other staff and should adopt best practice strategies. There appears to be a tendency among professional staff within prisons, not to want to share information or develop full multidisciplinary working. This is evidenced by the lack of shared care planning and the structures in which this could be undertaken. Another critical element is that professionals do not attend to the small but sometimes crucial tasks which can determine the fate of prisoners within the first couple of days of their release. Evidence of this can be found in the 'Mountjoy Prisoners Information booklet' in the reference to probation officers not performing tasks that the prisoner or his family could manage themselves (IPS, 2003). This could be seen to be encouraging a strengths perspective but it assumes that no breakdown in relationships has occurred. The emphasis of probation services is on producing outputs in the form of group work interventions rather than in concentrating on individual work with prisoners and/or measuring the effectiveness of those outcomes in terms of relapse and recidivism rates. This type of observation has been referred to by others (Comptroller and Auditor General, 2004; Morgan, 2002:1159).

1.4 Prison drug treatment policy and practice

In order to meet the needs of prisoners, it is necessary to examine and to adapt models of integrated service delivery and multidisciplinary models of practice. Other sectors have successfully used this approach (Ovretveit, 1993). It is also necessary to examine cross cutting issues between different agencies and departments (Boyle, 1999). There is a requirement to address points of conflict such as the divide between care and control, the medical versus the holistic model, the issue of client confidentiality within a prison setting and the power conflict between doctors and prison governors in terms of safe care and the management of prisoner issues. The

Irish Prison Drug Treatment Policy (IPS, 2003a) provides a blueprint for the major changes in practice which need to be implemented. This document was delivered to the Minister in December 2002 and no direction has been given about its content or implementation. Similarly other policy documents provide examples of best practice (WHO et al, 2001; Scottish Prison Service, 2002).

O'Mahony (1996; 2000) has been a persistent critic of the Irish penal service and he highlights some of the intrinsic dichotomies within the system. He identifies the opposing forces of the need for care, in terms of treatment and rehabilitation, and the impetus for control in terms of a prohibitionist policy on drugs (O'Mahony, 2002:760). He outlines the nature of the prison as an institution and the pernicious nature of the drug culture which in part acts as an anaesthetic to the effects of the system. Some of the difficulties that O'Mahony identifies in terms of articulating a common and comprehensive philosophy are problematic. Some of these difficulties have also been articulated within the England and Wales UK prison system (Duke, 2000). Her analysis identifies themes which are familiar to the Irish context. It notes the various attempts to conceptualise the nature of the drugs problem, the collusion about whether to admit such a problem exists in prisons and the resistance in accepting a harm-minimisation as a congruent policy with the principals of control and containment. She also refers to the absence of policy as a form of inaction and as such is a policy itself (2003:8).

O'Mahony (2002) dismisses the report of the Steering Group on Prison-Based Drug Treatment Services as flawed because it failed to outline the structure for throughcare and equivalence of treatment with the community. He also commented on the lack of philosophy or explicit policy network. However, the report did provide needs assessment of current prisoner populations and pointed the way to future planning via positive sentence management and throughcare. It crystallised the start of an effective ongoing working relationship between the community health sectors and the agencies working within the IPS both at management and service levels. This relationship, though the fora of several working parties, has produced a drug policy document for the prison service (IPS, 2003a) and the structure in which to develop protocols to address many of the practical problems that exist within prisons. These include issues surrounding confidentiality and information sharing, prison

methadone dispensing and working with the voluntary sector. The report of the Steering Group was subsequently approved by the government and absorbed into the National Drug Treatment Strategy 2001-2008. Financial approval was granted to appoint a wide range of staff to implement the future decisions of the Steering Group although unfortunately this has been beset with recruitment difficulties (Considine, 2001).

The two latter reports bound the IPS and the health agencies into a new formal relationship in which cross cutting and inter-sectoral issues had to be addressed. Some of these issues had often been a bone of contention between them. The ERHA was tasked with recruiting a co-ordinating manager to drive the process. The health sector was keen to be part of this process as it provided an opportunity to further its public health agenda in relation to drug treatment. Furthermore, it brought the IPS to the shared anvil of equivalence and provided an opportunity to address issues of conflict between them. These issues include resolving differences associated with harm minimisation. In particular, the provisions of bleach and needles within prison in order to limit the spread of blood-borne diseases. In this way the personal and public costs associated with blood-borne diseases might be limited and the likelihood of major future litigation avoided. The role of the co-ordinator has been further expanded to address the holistic needs of prisoners in terms of homelessness, co-morbidity issues and the impact of released prisoners upon the provision of community primary care resources. These transitional planning issues for prisoners have traditionally been dumped in the 'gap' between prison and the community. This has been due to service provider's capacity problems and public perception regarding the unworthy status of prisoners upon release. The requirement to provide continuity of methadone maintenance treatment (MMT) for prisoners and the efforts of the National Steering Group on Prison Based Drug Treatment Services has contributed to closing that gap.

1.5 The role of Case Management

Case management is a rather clumsy term which has variously been defined over the years.

> "The most common definitions of case management practice divide its components into a series of analytically discrete yet overlapping set of functions that includes initial client outreach and engagement; assessment and diagnosis of needed services, programmes and resources; developing a service strategy (referred to as a plan of care or the service plan); linking clients to services and community resources identified in the plan; implementation and co-ordination of effort to ensure that the programmes are implemented in logical, stepwise fashion and that they jointly address identified needs, which are 'pooled' in the plan; and monitoring and evaluation to determine the goodness of fit between the client's state of being and current service deliverables" (Raiff and Shore, 1993:4).

Case management has advantages when viewed from a systems perspective. Research in this area has

> "spotlighted the need for strategic planning, more information about the interactive provider-environment relationship, better knowledge of 'best design' features for organisational sponsorship, and greater awareness of barriers and opportunities in service initiation and implementation" (Raiff and Shore, 1993:129).

1.6 Shared care planning (SCP).

It has been suggested that multidisciplinary local prison drug treatment teams should adopt a shared care planning arrangement, with other parties within the prison and with statutory voluntary agencies within the community. This links in with Action 47 of the National Drugs Strategy, which bases plans for treatment services on a continuum of care model.

Shared care models are subject to differing interpretations and there is no one prescribed model of use. The UK Department of Health defines shared care in terms of joint participation of agencies and services in the planned delivery of care for patients with a drug misuse problem using an enhanced form of information exchange (Department of Health UK, 2002a).

Case management addresses some of the issues in terms of the prisoner's 'moral career'. If, as Goffman has suggested, the prisoners feels an injustice or bitterness toward the institution and the society, or the instruments which decided his fate, he may well act in a troublesome way (Clausen and Yarrow, 1958 cited by

Goffman,1981:68). Goffman has previously indicated that staff efforts can reduce psychological stress and stigmatisation. This suggests that a case management system based upon strengths theory might be beneficial. The use of case notes, to which the client would have access, would have implications for the construction of a prisoner's moral career (Goffman, 1981).

The adoption of a case management approach in the IPS could provide for continuity of treatment and a co-ordinated approach via the use of multi-disciplinary working. Inherent in multidisciplinary working is the fact that staff members have different backgrounds in terms of training, experience and models of practice.

A case management approach militates against criticisms levelled at other models of practice which focus on the client as being problematic, damaged, pathological, embracing environmental deficits etc (Rapp, 1998:2; Edelman, 1984). In the case of prisoners the adoption of a strengths based model of case management has to be seen as part of a multidisciplinary perspective. This encourages prisoners to take responsibility for their actions and future efforts and forms part of a 'responsible prisoner' philosophy (HMIP, 2001; Pryor, 2001).

1.7 What works

The concept of the 'what works philosophy' has been met with a growing international acceptance by many treatment workers within the criminal justice systems over many years (McGuire, 1995). This has been evident since the forerunners of the concept, Gendreau and Andrews (1990), challenged the 'nothing works' era inadvertently heralded by Martinson (1974). Case management dovetails into the use of a 'what works' philosophy within prisons because it acts as a common cement between multidisciplinary groups. This shared care planning approach allows for the collection of systematic information which can be utilised to evaluate progress. Indeed if differences of opinion do arise then the database can be used to undertake differential evaluations on the basis of planned interventions.

Prochaska, DiClemente and Norcross (2003) outline a "wheel of change" model which describes the potential movement of people with an addiction problem through

five stages of change. This conceptualisation of the change experience allows the chronic nature of relapse to be seen in a non-blaming model. This is particularly important within a prison setting as recidivism and relapse has often been associated with failure and derogatory comments from staff. The use of motivational interviewing is also recognised as an effective and necessary intervention within a grim prison setting (Miller and Rollinick, 2002). This fits in with a lot of cognitive behavioural treatment interventions which suit the brief periods of treatment which prisoners can avail of. Finally another core treatment approach is that of relapse prevention (Marlatt and Gordon, 1985) which is very necessary and may even be life saving following discharge from prison. Other interventions which can be contained within the case management approach include screening, effective assessments, motivational interviewing, skills training and cognitive behavioural approaches.

The importance of case management initiatives to straddle substance treatment and primary health sectors precipitated a partnership between two US federal agencies who, via 21 projects in 15 states, demonstrated that clients with health and social needs made effective use of "linkage and referral services" particularly when case management with proactive and assertive procedures were utilised (Martin and Inciardi, 1993:89).

Criminal justice system clients, more so than others who are subject to case management, "often face a wider spectrum of problems" which are associated with relapse and recidivism and are often "more complex, problematic and costly for both the individual and society" (Martin and Inciardi, 1993:89).

1.8 The strengths perspective

This approach is congruent with many of the existing models of drug treatment intervention described earlier as well as Zinberg's (1984) ubiquitous drug set and setting (Woods, 2000). Woods calls for a paradigm shift in order to self actualise clients and to enable them to develop outside the "technical rationality, procedures, guidelines and techniques what Gowdy (1994) has described as "participating consciousness". A more critical analysis of the role of the helping professions in diagnosis and treatment can be found elsewhere (Esland, 1976; Friedson, 1970).

This theme is developed in the Usice report and calls for the inclusion of a consumer perspective in the development of drug treatment policy and protocols (Uisce, 2003). The strengths perspective can also provide strength to workers in low threshold agencies who have had to endure decades of derision until the public health impetus of addressing blood borne diseases have accorded them clinical respectability.

The strengths model provides clients with a perception of possibilities rather than problems and encourages them to realise these possibilities through the pursuit of opportunities (Rapp, 1998:24). This suggests a partnership approach in which

> "a case manager works to 'identify secure and sustain' resources that are both external (i.e., social relations, opportunities and resources) and internal (i.e., aspirations, competencies, confidence) rather than a focus on just external resources (brokerage model of care management) or internal (psychotherapy or skills development)" (Rapp, 1998:44).

The strengths model places the emphasis on assessment as opposed to diagnosis and the negative connotation associated with that process. Assessment contributes to a more equal relationship between the client and the worker. This is similar to the process described by Mary Richmond (1917), which comprises of a "study" component, which examines the facts pertaining to the client, and defines the problem within a systems perspective.

Case management is subject to constant development. It can drive service delivery and powerfully influence the systems in which it is located. Furthermore, it can also be used as a way of marshalling restricted resources (Raiff, 1992:12), as cited by Raiff and Shore (1993)). This is a particular problem in prisons. Applehaun and Wilson (1998), as cited by Raiff and Shore (1993), state that these new systems may well impact upon the time allocated to clients (intensity), upon how wide staff are able to scope client problems (breadth) and upon the length of engagement (duration). Furthermore, case management models can be 'client focused' or 'systems focused'.

Robinson and Bergman (1989), as cited by Raiff and Shore (1993) identify four aspects of client-focused models; the expanded broker which links services to

clients, the personal strengths aspect which stresses a more egalitarian approach to sharing with the client, the rehabilitation aspect based on needs identification, goal setting and transitional care planning. Lastly there is the full support version which contains a comprehensive package of support planning and direct provision of treatment and rehabilitation. Different agencies may have different allegiances to one or more of these models. "Competition between alternative models is one of the indicators of the field's vitality, yet it may also create additional confusion for the client's, service providers, third-party players and the public at large who are already struggling with case management as a concept" (Raiff and Shore, 1993:18).

It is worth noting that models are not necessarily fixed in terms of professional dogma or current requirements, they must adapt to changing circumstances and so enable cross-fertilisation of ideas on several levels of engagement. In this way needs assessment is not based solely on the needs of a current population but also takes into account a vision of what they will be and of what they will require in later periods of time (Raiff and Shore, 1993:18).

It is important to differentiate clinical case management from basic or even advanced case management in that the former addresses medical or psychiatric matters which are confidential. Whilst there is a need for clinical case management when such skills are necessary, it is not appropriate or feasible, with available resources, to manage low level communication and case management systems in prisons on such a basis. To do so excludes, disenfranchises or even makes redundant the contribution of other workers. It would also fail to meet the demand for throughcare.

Nonetheless, clinical skills, counselling skills and specialist skills in the management of offending behaviour need to be made available to prisoners. This can be achieved via specialised assessments or by the use of flagging devices which indicates whether a particular intervention is being undertaken. In these cases the content, nature and results of the intervention is confidential to the prisoner and worker involved.

Perhaps clinical case management should be viewed as a method of advanced intervention in high risk or high need situations. In that way "it weaves clinical

understandings throughout the processes of disposition, planning, service referral, advocacy and follow-up" (Raiff, 1992:85). In this way clinical case management "closes a circle by positing a relationship between brokering and clinical functions" Bachrach (1989:884) as cited by Raiff and Shore (1993:86).

1.9 Multi-disciplinary Teams

Multi-disciplinary teams are often constructed to reduce organisational problems when many workers interact with the same client. However such teams can also display negative dynamics associated with inequality of status, vocabulary and discourse differences, territorial issues and a perception of some workers having a lower impact upon the decisions reached by the team (Raiff and Shore,1993:91).

The IPS provides a typical example of an organisation where there is potential for chaos, fragmentisation of service delivery and a lack of planning and a continuity of service provision. Interventions in such scenarios can be perfunctory and subject to different methods of recording intervention which are exclusive to the staff group undertaking the intervention. It is therefore important to consider the different types of multidisciplinary approaches.

A parallel approach ("side by side but separate") can lead to uncoordinated and isolated goals which can be incongruent. They also tend to place the problem of formulating recommendations on the shoulders of the clients or family members (Raiff and Shore, 1993:94). An inter-disciplinary approach is also dependent on the independent assessments of the various workers involved although there is more emphasis on staff training and service planning (Raiff and Shore, 1993:94).

The trans-disciplinary approach contains two critical factors. "Role release refers to the exchange of skills and information across disciplines so that interventions can be integrated, rather than fragmented" (Raiff and Shore, 1993:95). This reflects a cross-fertilisation and sharing of vocabulary and competency based interventions though working with others on the team. The pure form of this model is associated with the provision of early education support services and it involves the families as well as service providers. It also designates one of the team to interface with the

families. However, it begs the question as to the proficiency of one designated team member in addressing the needs and issues outside their own professional training. It does nevertheless provide a working model which could be modified when working with other client groups.

Methods of practice which can enhance multi-disciplinary team working include joint training, networking, developing consensus about working styles, decision making and inclusiveness among team members (Raiff and Shore,1993:98, Ostreveit, 1998).

> "Standards of practice for a truly collaborative multidisciplinary team include shared respect and knowledge of limitations, consensus about preferred work styles for making group decisions, sensitivity to members comfort, with consumer-centeredness, awareness of the importance of group process, and a commitment to lifelong learning through formal and informal exchanges" (Raiff and Shore, 1993:99).

There is controversy as to whether case management should be provided by highly educated and trained staff or whether the tasks can be accomplished by individuals with minimalist skills (Raiff and Shore, 1993:102). This is a major argument not only within case management but in drug treatment where the roles of psychologist, social worker, counsellor, nurse, generic drug worker and prison officer need to be forged on the anvil of practicality and competency based skills. Are these arguments solely concerned with professional demarcation or are there significant issues involving competency? These issues need to be tackled and resolved. Raiff and Shore (1993) argue that experience with a particular client group is often a major consideration when employing staff. So maybe there is a role for everyone. The important point is that all should function on the same track. An inclusive case management system could form that track.

However, in this time of restricted resources within prison, other staffing possibilities need to be considered. The role of the prison officer requires major development and there is great potential to move the role of the officer from turnkey to one that engages prisoners in a fuller interpersonal way (IPS, 2000). Prison officer training could be individualised, experiential, display respect for the ability of the learner to solve problems, and be competency based" Raiff (1990), cited by Raiff and Shore (1993:109). Very importantly staff at all levels require training in core case

management activity which goes beyond an understanding of “front-end assessment/service planning functions” in order not to neglect the necessity for concern with process intervention as well as professional and clinical practice” (Raiff and Shore, 1993:110).
This is akin to an action research model as it allows for caseload review and group problem solving and the possibility of learning and developing creative solutions.

1.10 Managerialism in the context of prison drug treatment

Managerialism has been a developing political philosophy for many years and was a particular feature of Thatcherite governments in the UK. Since 1997 the British Labour Government has developed “a Third Way” through the processes of managerialism and modernisation of public services in order to achieve greater efficiency, effectiveness and value for money. The origin for this policy was originally sketched by Giddens (1994; 1998) cited by McLaughlin and Muncie (2000) and was a departure from the traditional left and right debates which have been a feature of British Labour and Conservative parties. Managerialism is a central plank of this new way which in criminal justice system matters has spawned the slogan “tough on crime and tough on the causes of crime”. In this way “an amalgam of managerialism, communitarian and authoritarian populist ideas have been pulled together under the phrase ‘modernisation’ (McLaughlin and Muncie, 2000:169). Hence the impetus for having an integrated joined up criminal justice system (Carter, 2003, Blunkett, 2004).

“Managerialism – like professionalism – defines a set of expectations, values and beliefs. It is a normative system concerning what counts as valuable knowledge, who knows it, and who is empowered to act in what ways as a consequence” (Clarke, et al, 2000:9). This challenge to professionalism is explicitly stated in OASys prison system of risk and offending behaviour classification and management that is deliberately structured in an actuarial rather than a clinical format because of the superior predictive ability of the former (Home Office, 2002). This mathematical approach is based on the assumption that it is possible to make an objective numerical classification of risk factors (Aye Maung and Hammond, 2000).

This form of managerialism "brings about changes in power, knowledge and calculation within organisations, between organisation and in the organisation of social welfare" (Clarke et al, 2000:9). It has the potential to make the internal workings of social welfare organisations more open and subject to public debate and to allow politicians a greater degree of overall social control. The question is whether such a policy thrust is more concerned with issues of social control or whether it is concerned with issues of social inclusion? This depends on the nature and purpose of the instruments used to audit these structures. It can also "create dilemmas for and conflicts within organisations over defining objectives, choosing indicators, the attribution of causality and how to make comparisons" (Clarke et al, 2000:24). These dilemmas are even more complex when one considers the issues from a health and/or justice perspective.

There is a need to address the inefficient and the uncoordinated use of resources within prison, between prison and the community and within the community. This appreciation of system service management should also include the judiciary who do not have a responsibility for resource use or the means to determine sentencing guidelines (Carter, 2003; Law Reform Commission, 1996).

It may well be that as a result of closer official monitoring, the individual client will become subject to a greater degree of social control. This may in turn lead to the development of protocols which define values and explicitly state the limits of unacceptable behaviour or the definition of legitimate need. This repressive intent can be found within the criminal justice system concepts of net widening and up-tarrifing which relate to the inappropriate inclusion of offenders in a form of punishment level based on social diagnosis, which is higher than the one they would be allocated to were it not for the bureaucratic features of the decision making structure.

1.11 Prison case management in Great Britain

Holt views case management from a probation perspective and sees it through a prism of 'effective practice' and 'what works philosophy' (Holt, 2002). This is the current probation and prison practice philosophy of Home Office which is exemplified

in their major guides which includes the ‘Criminal Justice Interventions Programme’ (Chapman and Hough, 1998). Case management is seen not simply as a number of interconnecting parts comprising of assessment, planning, linking etc. but as a whole integrated system (Holt, 2002:263; Carter, 2003). Whilst the virtues of case management are extolled they are firmly located within a social control context to achieve client compliance and supervision completion targets (Holt, 2002:261). “Case managers . . . represent the probation service to the individual. They may also be ‘the point of stability’ of contact with multiple service providers” (Chapman and Hough, 1998). This perception of case management is quite ‘assertive’ and more akin to a brokerage model as opposed to a client’s strengths based model. Perhaps there is little wonder that there has been almost no progress in developing or enforcing a national model within the UK (Home Office, 1999). Accordingly, service practicioners implement these standards according to various local practices. UK Government thinking now suggests that probation officer interventions at reducing re-offending are “naïve” (Blunkett, 2004:10). The new way forward will involve the creation of a National Offender Management Service which will “separate case management of offenders from the provision of prison places, treatment services or community programmes” (Carter, 2003; Blunkett, 2004).

Attempts have been made to address case management and care planning within UK prison settings via the use of CARAT, CAART and OASys case management systems but these models of practice represent a partial managerial approach to service delivery and as such are not likely to deliver effective, holistic treatment and throughcare for prisoners (Burrows, J. et al, 2000, Home Office, 2002, Kothari, et al, 2002 and Maguire et al, 1997). In particular these systems separate out clinical, risk management, offending behaviour and drug treatment interventions into parallel systems with their own data collection instruments. This may be seen as understandable in terms of managing confidentiality issues but it can promote fragmentisation and demarcation of working practices.

Sentence planning in UK has been referred to as a paper exercise powered by the managerial imperative of achieving key tasks within certain time periods. The process often does not directly involve the prisoner and when it does it matches

prisoners to the availability of services rather than on the basis of need (Social Exclusion Unit, 2002).

When prisoners are transferred within the prison estate, the lack of IT systems associated with these paper case management systems renders communication problematic and oftentimes impossible. Some local IT systems have been put in place and although they can track basic movement and referral documentation, they are mainly geared to the production of management data associated with key performance indicators (Syddal, 2001). The successful introduction of an IT system is dependent upon co-ordinating and integrating complex organizational processes (human and electronic) rather than allowing them to be isolated and fragmented (McDonagh and Coghlan, 2001:6).

Despite the emphasis on achieving targets, 90% of prisons state that the transfer of paper sentence plans occurs within 7 days. However, only 60% of prisons state that they receive such plans within that period (Social Exclusion Unit, 2002). One reason for this disparity is a lack of personal staff accountability for completion of plans. In addition, the process is unable to deal with remand prisoners or those sentenced to less than 12 months because of short time lines, thus denying individuals the opportunity to link into treatment and rehabilitation systems. Failure to classify prisoners in terms of risk or need for drug treatment may also lead to some prisoners receiving interventions they may not require or indeed might be harmed by (Social Exclusion Unit, 2002).

NACRO (National Association for the Care and Resettlement of Offenders) comment that, as an organisation managing several CARAT programmes "it is often not possible to offer prisoners . . . the help they need leading to the danger of a tick box mentality " with too much attention to process at the expense of outcomes." (Roberts, 2003:73). The stated objective of NACRO is to get prisoners to stop using drugs and to reduce recidivism. They do not enter into any of the specific policy debates which involve the public health model or substitution treatment within prisons.

According to Lowthian, (2002:171) cited in Carlen, (2002) "the bankruptcy" of the

programme (CARAT) lies in its inability to deliver quality work because it is not part of the service provider contract which is set in terms of targets and outputs. In other words it does not address all the resettlement needs of a prisoner and only requires that an appointment is made and kept with a community drug treatment agency. Concern over this failure of the CARAT service to work in consultation or partnership with outside community agencies working in parallel drug treatment schemes has been expressed by SCODA (Select Committee on Home Affairs, 1999). In Scotland the similar CAART system does use community agencies under contract, to fill this gap. However, neither system uses databases to comprehensively capture the identified qualitative needs of prisoners and to overcome the problems of transfers within the prison estate. "A third of prisons were unlikely to continue treatment following inter-prison transfers" National Audit Office, (2002), as cited by Social Exclusion Unit (2002). The same source also indicates that only 7% of prisoners, who entered the CARAT system, had contacted their CARAT worker following release.

There are many reasons why the gap between prison and community service provision exists and these do not rest with the well-intentioned attempts of OASys or CARAT teams because they were not designed to fulfil the task. "SEU discovered that there was no clear responsibility for linking prisoners with the community as CARAT teams were only charged with producing care plans and that the demand for these in the prison was extremely high, Home Office, Criminality Survey: drugs follow-up, (2001) cited by Social Exclusion Unit (2002). This has led to a vernacular expression of prisoners experiencing 'death by assessment'.

The solution lies in the effective management of existing resources through multidisciplinary working, information sharing and a partnership approach which is innovative and participative in the institution of change.
Individually constructed care plans should enable prisoners to identify and connect with agencies upon discharge and worker's tasks and responsibilities should be made explicit both within prison and within the community.

In June 2000, the Scottish Prison Service launched its revised drugs strategy in the form of drug teams and a case management system (HMPS, 2000).

"The aim of the throughcare model is to facilitate access to pre-existing community services particularly in relation to housing, benefits and finance, health (general and specific, education, training and employment". (Aberdeen City Council, 18/11/03). Whilst the Scots believe their system is superior to CARAT, particularly in relation to employing agencies under contract to follow through on aftercare, problems do exist (Scottish Prison Service, 2002a). Some of these have been highlighted by a recent prison inspector's report which stated that on transfer to another prison the assessment phase was commenced again with no reference to the work undertaken previously. (Her Majesty's Inspectorate of Prisons, 2003:3.64).

There are significant fall-out rates in retention as prisoners' progress through the Scottish prison system. It can be seen that 6.6% of those offered an assessment in 2001/2002 attended a throughcare appointment.

Table 1. Fall-out rates, in prisoner retention, for drug treatment in Scottish Prisons.

Number of cases (6)	2000/01	2000/02
Total recorded prison receptions (1)	23,472	25,101
Total addictions presentations (2)	14,300	16,867
Offered assessment	9,800	9,289
Undertook assessment (3)	7,600	6,110
Started treatment options (4)	5,400	4,452
Throughcare appointment made	600	1,210
Attended throughcare appointment (5)	175	615

1. Strategy monitoring process established early during 2000/01, and does not include all cases for that year.
2. Prisoners identified as having an issue with substance misuse.
3. Clinical addictions assessments not included for 2001/02
4. Individuals who began working on the first item in their individualised car-plan
5. Individual client confirmed by community agency as having attended first post-release appointment
6. Drop-out rate includes those released from custody.
(Aberdeen City Council, 2003).

1.12 Probation and Welfare Service provision in Irish Prisons

The necessity to undertake an evaluation of the effectiveness of probation work has been expressed in a number of reports (Council of Europe, 1990; Expert Group on the Probation and Welfare Service, 1999).

The “Value for Money Report on the Probation and Welfare Service” pointed out the lack of management information systems in the service and its inability to produce quantitative and qualitative data on the effectiveness of service delivery (Comptroller and Auditor General, 2004). “It describes quite accurately the areas of inefficiency in the delivery of the service, e.g. . . . to the low level of evaluation of the various operations of the service and the fact that, as a result it cannot demonstrate the effectiveness of its interventions” (Lowry, 2004).

“The service gathers very little data in relation to the work it carries out with offenders in custody. There is no count of the number of offenders with which the service is dealing at a point in time, or of the number of cases commenced or completed within a time period. As a result, the service is unaware even of the proportion of offenders in custody who make formal contact with its officers or who seek to engage with the service” (Comptroller and Auditor General, 2004:26). Arguably similar observations could be made in relation to other agencies and staff providing interventions in respect of prisoners.

This report notes the change in the type of interventions undertaken in prison over recent years, which has involved a reduction in one to one (prison) welfare sessions in favour of structured group work addressing offending behaviour. Such intervention aims to effectively utilise the time offenders spend in custody (Comptroller and Auditor General, 2004:10). Whilst there have been some isolated efforts to record effectiveness of such programmes research as to re-offending rates, prisoner engagement and personal change has so far been seriously lacking (Pugh, 1995; Pugh and Comiskey, 2004; Connell and Sheehan, 2004). Evidence does exist for the need to prioritise throughcare in order not to lose the benefit of Probation and Welfare Service group work interventions:

" . . . analysis of the efficacy of the prison-based drug treatment programme would suggest that it has value, given the statistically significant changes brought about in three of the five dependent variables (general attitude to offending, anticipation of re-offending and perception of current life problems). Most importantly the results indicate a lack of continuity of post-programme treatment in prison and in the community. Effective case management based on the principles of shared care planning and integrated service delivery can remedy this" (Pugh and Comiskey, 2004).

Supervised temporary release is only a fraction of the Probation and Welfare Services' work and as such highlights the extent of the gap, or discontinuity of service provision between prison and the community. In July 2003, 126 persons were on supervised TR and half of this group were released under licence following a life sentence. These figures may well include a rollover of lifers from the previous year? Currently an additional 10% of the prison population of 3,200 individuals (in 2002) were subject to ordinary temporary release arrangements at any one time. This contrasts with the extent to which the service is able "to facilitate throughcare and resettlement of prisoners on discharge from custody" (IPS, 2002a). Furthermore, the ratio of offenders under community supervision by the courts in comparison with the number of prisoners in custody reflects a ratio of 1.3. When this is compared with the ratios between the years 1995 to 2002 the ratio fluctuated between 1.25 and 1.4. This indicates that the courts have not heeded the recommendations of various commentators to use more community-based sanctions (Report of the Committee of Inquiry into the Penal System (Whitaker Report), 1985; Expert Group on the Probation, 1999). The mentioned reports also refer to the service pursuing the aim of resettlement of prisoners

There would also appear to be an incongruity between current service provision for prisoners and stated policy objectives. The role of the service as portrayed in "The Management of Offenders" (Department of Justice, 1994) and endorsed by the aforementioned Expert Group on Probation (1999) refers to the service pursuing the aim of resettlement of prisoners but it does not specifically refer to the management of prisoners with a drug misuse problem. This schism is also evident in IPS policy planning which separates drug treatment issues from offending behaviour. Yet, in Mountjoy at least 80% of the current population (494) are drug users and despite a

large increase in staffing, the number of individual prison counselling sessions has decreased by 20% between 1998 and 2000 in favour of group work interventions. A decrease in counselling interviews by one third was also noted in relation to the actual number of prison places (Comptroller and Auditor General, 2004:25). Whilst appearing stark, these figures were compiled during a time period when there were difficulty-filling posts. However, given problems of continuity of service provision, the question arises as to whether individual work is sufficiently prioritised. It could be argued that the reduction in time allocated to individualise casework by the Probation and Welfare Service has implications for the depth and breadth of effective case management. This gap could be filled by SCP and an expansion of the prison officer role.

There are no data collection instruments to measure any aspect of effective worker interventions or outcomes within the prison system. This is remarkable given that the total expenditure of Probation and Welfare Service was 40.7 million euro in 2003 and that 8% of this was spent in relation to prisons. In 2001 a rough calculation of total Probation and Welfare Service costs, based on the total population of prisoners, amounted to 750 euro per prisoner which is less than 1% of the annual cost of a prison place per annum (Comptroller and Auditor General, 2004:34).

The Comptroller and Auditor General acts as an independent constitutional officer with responsibility for the audit of public funds (Comptroller and Auditor General, 2004). In the latest report (2004:60) there is a call for a " greater co-ordination of agencies to achieve a rational, cost-effective and efficient criminal justice system". The report does not take account of the methodological difficulties associated with criminological monitoring and evaluation although it curiously suggests that early committal interviews be undertaken as soon as possible in order to rehabilitate offenders

It seems clear that analysis of the criminal justice system is a complex task which needs to take account of the sizeable methodological difficulties in proving effectiveness, which difficulties are further hampered by the lack of consistency in data collection systems of the various agencies involved (National Economic and Social Council, 1984). "This state of affairs renders analysis complex, conclusions

tentative and reform difficult". (O'Donnell, Irish Times 3/2/04). It would appear therefore that addressing the needs of prisoners, and providing managed continuity of service provision during the course of imprisonment and release back into the community, is more problematic than the simplicity of the concept would suggest.

Action Intervention

Anchored by the findings of this literature review, this thesis will examine the implementation of a participative, bottom-up approach to addressing and implementing change within the prison system. It will examine the actual functioning of the system. It will delineate the impact of a bureaucratic system upon the manner in which the rules, roles and routines that define prisoner and prison management interconnect with and interact with one other. It will explore these interactions or micro-processes and note their capacity to accommodate to the introduction of a case management system.

Chapter 2
Methodology

2.1 Research Design Rationale

The realisation of an effective case management system within the prison has required the initiation of a pilot developmental project that could test out a particular model of case management so as to ascertain its viability. The ideal model refers to a vision of case management in which each prison wing organises weekly meetings with a multidisciplinary group of staff. The aim of such meetings is to adopt a shared care planning and positive sentence management approach and to utilise integrated care pathways so as to ensure continuity of service provision for prisoners, both whilst in prison and upon discharge back into the community. The model includes the establishment of a stronger link with the Operations Directorate in IPS HQ in order to advance these aims in a practical and developmental way. Furthermore, the use of regular prisoner review meetings and a shared care planning database to which all relevant staff have access, enables the development of clear communication channels between key participants. This includes a release planning channel between governors and the Operations Directorate and a system of medical flags attached to particular cases, denoting the need to inform surgeries prior to release. The composition of the weekly wing case management meeting includes the governor, chief prison officer or assistant chief prison officer, a designated prison officer, probation officer, nurse or medical orderly and chaplain. Depending on the particular case, the meeting may include the psychologist, teacher or any other relevant worker within the prison. In the 'ideal model' an initial wing meeting would consider the merits of including a prisoner into the shared care planning system based on resources and particular selection criteria.

2.2 Participants

The participants in this study were drawn from a range of multidisciplinary staff from Mountjoy Prison. These included governors (in charge of a particular prison wing),

chief prison officers (second in charge of a particular wing), class/prison officer (in charge of a particular wing landing), probation officer, teacher and nurse. Four prisoners were invited to participate on the basis of informed consent and awareness of the contents of the SCP on an imaginary prisoner in Appendix 2.

2.3 Inclusion Criteria

Those included in the study were those considered to be key participants in the implementation of a case management approach to prisoner care. The participating prisoners were selected on the basis of their involvement with a particular counsellor from a particular health board clinic. In this way the research could track the known transitional care pathway that each prisoner would undertake. This also had the advantage of improving the original ethical safeguard for each prisoner in terms of continuity of service provision within prison and between the prison and the community.

2.4 Ethical considerations

Approval for the study was obtained from Irish Prison Service Ethics Committee. Appendix 1 and Appendix 2 contains documentation which formed part of their deliberations.

2.5 Research Design and Procedure

This research piloted the use of a developmental model of case management as a strategic first step in the process of establishing an ideal case management model within the prison system. The process consisted of the setting up of a wing meeting and a prison review meeting in order to test out the case management proforma and database. The purpose was to elicit actual decision making pathways and dynamics which might facilitate or impede the introduction of the ideal model. In order to reach a position to test the ideal model. The following methodology and sequence of tasks were undertaken:

Figure 2. Research Implementation Tasks

Submit research proposal to the IPS Ethics Committee for approval.
Construct a paper case management proforma and outline model of case management.
Use focus groups with prisoners to elicit their views on the proposed system.
Observe a current prison review meeting which is attended by a member of IPS Operations staff.
Approach all key staff within the system to persuade them of the benefits of the proposed system and to obtain their co-operation.
Design and commission an electronic shared care planning database and link it in with the main IPS PRIS database.
Select 4 prisoners to assist in testing the system of shared care planning and allocate 4 key workers to perform an initial assessment using a proforma.
Hold a prison wing meeting to discuss 4prisoners and elicit the issues in progressing the venture.
Hold a prison review meeting which includes a member of IPS Operations staff, members of the multidisciplinary prison wing team and a representative of a health board clinic.

2.51 Construction of a paper case management proforma and outline model of case management.

Appendicies 1 and 2 contains a copy of the information leaflet and proforma completed in respect of an imaginary prisoner. Both forms were used to clearly explain the nature of the project to both prisoners and staff. The literature review provides the basis of the strengths based model of casework on which the proforma was based and on which the manualised procedures for the 'ideal system', for phase 2 of the project will be based, i.e. the stage after this piece of research is completed. The details of the strengths based model were articulated to the participants in general terms. A presentation of the shared care-planning database was made, using as a subject, an imaginary prisoner; so all participants were familiarised with the concepts, processes and nature of the system and also of the research element of the project.

An action research model was utilised. This participative form of research included the researcher and the multidisciplinary team in open cyclical discussions utilising 'wing' and 'review meeting' structures. The meetings were audio-recorded and the discussions subject to ongoing cyclical analysis via diagnosing, planning, action and evaluation stages. An edited version of the transcript of Meeting 1 was made available to all participants in order to prepare them for the next meeting. A shared care plan was utilised in conjunction with participating prisoners and staff. This proforma is a partial composite and development of existing Scottish and English case management systems (CARAT, CAART and OASys). A projected electronic version of the proforma, in database form, relating to each prisoner was used during the meetings. A member of the Operations Directorate was also involved in the process. This person is an official within the executive, and as such represents the Minister of Justice. He is responsible for decisions relating to temporary release and positive sentence management. Prisoners were individually informed of the procedures and implications involved and they had the right to decide if any staff member should not view their care plan (Appendix 2). The prisoners were contributors to the plan and were able to decide with which outside agencies the plan might be shared.
A governor chaired the prison wing meeting (Meeting 1).

2.5.2 Selection of 4 prisoners to populate share care planning process.

The author undertook an initial interview with the prisoners. Their agreement was greatly influenced by their knowledge that their community counsellor supported the project and this reflected the quality of their relationship with him. In the 'ideal model' an initial wing meeting would consider the merits of including a prisoner into the shared care planning system based on resources and particular selection criteria. In view of time constraints the author directly allocated a key worker to each of the prisoners in order to complete the first three pages of the paper proforma. This data was then fed into the database on the author's laptop computer. The author was readily available to the prisoners, individual key workers and other prison staff when necessary.

2.5.3 Analysis

The systems processes and concepts discussed at this meeting were analysed in terms of the action research model and in relation to evidence based best practice models from the health and criminal justice systems. The use of the action research cycle included the following components: diagnosing, planning action, taking action and evaluating action. A second parallel cycle involved the researcher in a reflexive mode, which is an action research cycle about the action research cycle (learning about learning – meta-learning). This latter process considers content reflection, process reflection and premise reflection. Efforts will be made to triangulate data collection and to refine the proforma by using focus groups with selected individuals.

Chapter 3
Findings

3.1 Step 1. Preparatory Discussions with key Participants

Meetings took place with a number of key participants within the prison in order to explain the benefits of the proposed system change and to obtain their co-operation. The purpose was to diffuse anxiety regarding the proposal and to institute a major multidisciplinary change process. Most of those seen expressed support for what is regarded as a necessary system change. The process involved an enormous amount of undocumented effort and in some part was reliant upon the author's knowledge of key players and informal insider knowledge of the system.

3.2 Step 2. Observation of a prison review meeting

Prison review meetings are held generally on a 6 weekly basis. They are attended by a representative of the Operations Directorate who holds a series of meetings covering each prison wing in turn. The wing governor, chief prison officer, probation officer, chaplaincy attended the meetings. This particular meeting was unrepresentative of usual meetings in that a large turnover of senior prison staff had occurred 2 weeks previously. This resulted in staff not being fully aware of each prisoner's circumstances. No records had been made in respect of previous meetings and few individual records were kept by the staff attending these meetings. The Operations Directorate representative maintained a proforma in respect of each prisoner. This noted details concerning the offence, Garda report, PSM decisions and release decisions. Frequently the Operations Directorate representative asked for information regarding "the line out" (PSM and transitional care planning). Frequently this information was not forthcoming. In all, a large number of prisoners were briefly reviewed.

3.3 Step 3. Prisoner focus group

A focus group was undertaken with twelve prisoners from the Connect Project. This project is a life skills and employment training programme which is operated by 2 trained prison officers under the direction of National Training and Development Institute (NTDI). This project, which had been in operation for 5 years, was recently closed due to the current industrial relations situation. The purpose of the focus group was firstly to examine prisoners' views about accommodation issues and to gather views about the case management paper proforma, which was completed on an imaginary prisoner and which the author had projected onto a screen. Prisoner response to the proposed plan was generally positive.

Two of the prisoners had served sentences in England and praised the CARAT system. They praised the drug free wings in English prisons and noted the good interpersonal relationships engendered as a consequence. They expressed disappointment that such systems were not in operation in Ireland and stated their view of the Irish system as lacking a similar sense of organisation. The group recognised that a certain amount of information sharing within the prison system is necessary. They did not object to the disclosure of such information so long as it was restricted to a limited number of known staff and "did not include information about their sexuality or HIV status". It was observed that the shared care plan proforma would not work well for prisoners on short sentences and its use for prisoners on long sentences was also queried. It was suggested that some prisoners would make a minimal effort to engage in the system. The author pointed out that if prisoners were released to attend outside agencies and failed to do so, this would be reported back to the prison governor. This statement did not provoke any comment. Many prisoners expressed the view that the proposed system was a positive endeavour though they expressed the view that it would probably take years to put in place.
"If we make an effort will this effort will be recognised"?
"It will oblige staff to make commitments and we will know where we stand".
"It will mean everyone knows who is doing what, to whom and when".

3.4 Step 4. Design and commissioning of a shared care-planning database

On the basis of findings from the aforementioned steps, the author was better placed to design a non-partisan database which crystallised the aims of the project in an inclusive multidisciplinary way.

The analysis of Scottish and English prison case management systems highlighted the need for a single electronic system in order to facilitate multi-user access to a database in order to cope with the transfers across the prison estate (without initiating a fresh assessment) and to provide some form of continuity of service knowledge with the community upon release and in relation to re-admission. A Lotus Approach database was developed as a trial effort to test the original design (Pugh and Nolan, 2003). After testing the embryonic database IPS IT Section were approached and a project was initiated to develop a specification for an integrated share care plan database using a Lotus Notes application connected to "PRIS" the main prisoner information database. This database was formulated on the basis of a work flow chart (See Appendix 2) and detailed specification in terms of design, software development and project management (Pugh, McCarthy and Merrick, 2004) respectively. The networked database in this study was designed, developed and linked into the current prison database PRIS on time (8 weeks), in full working order (tested with 4 prisoners), exactly on cost and above the original specification.

3.5 Step 5. Wing review meeting- Meeting 1

Meetings based on shared care planning principles require staff to physically meet and exchange verbal and paper based information on selected prisoners. It was originally planned that 4 prisoners selected for the pilot study would come from the same wing. However, the actual selection of prisoners, who were all former clients of a particular counsellor, resulted in prisoners being selected from 2 different wings. It would therefore have been anticipated that all necessary staff from both wings would attend the meeting. However, in view of staffing shortages, rostering arrangements and leave arrangements, this did not occur. The author's attempts to

contact key workers during the week preceding the meeting also met with similar difficulties.

Meeting 1 was attended by 3 prison wing governors, two chief prison officers, a governor in charge of training, probation officer (key worker) and a nurse (key worker). Absentees included (relevant governor), prison officer/class officer, medical orderly, teacher (key worker), Connect Project prison officer (key worker) and the community counsellor. The aim of the first part of the case management meeting was to utilise a shared care planning process to examine the needs of each individual prisoner and to formulate specific plans to address those needs in terms of positive sentence management and transitional care planning.

The aim of the second part of the meeting was to collectively address the issues raised in the context and purpose of case management in each of the individual prisoner cases. Such issues are shared by many prisoners and relate to common processes in terms of PSM. It is not appropriate to give a vignette of each case for ethical reasons but it is possible to reconstruct the transcript in terms of the issues, processes and premises on which the former are based.

The meeting was transcribed verbatim (version a), it was then edited in terms of the issues, processes and premises identified (version b) and then edited in the form of notes by way of informing participants prior to the next prison review meeting (version c).

The author introduced the meetings by explaining their purpose “which is to better link people together within the prison and to link in with outside agencies”.
Action research methodology uses a method of array identification in order to summarise information in terms of premises, issues and processes (Coghlan and Brannick, 2001:76). This approach was adopted in order to address the complexity of issues and processes that surfaced during the course of wing meeting 1. These are summarised as follows:

Figure 3. Array Identification

Issues
1. Different disciplines completing proforma or acting as the key worker. Different perspectives are based on different levels of ability or expertise.
• 2. Absence of staff who are part of the prisoner's plan.
3. Implications of missing dates and contacts on the proforma in terms of verifiable and accurate information
• 4. Is there insufficient knowledge of the offence?
5. Should this system also contain negative or hearsay which may not be correct?
• 6. What are the implications if a prisoner lies as opposed to just getting it wrong?
7. Resource issues in implementing a shared care planning system.
Processes
8. No PWS aftercare what does this mean for TR and continuity of service?
9. What should we do for prisoners who do not engage with activities that are available?
10. Advantages of access to other known information sources.
• 11. Implications of interaction with parallel information systems e.g. Clinical system, Connect Project and Parole Board.
• 12. Implications of referring to and identifying 'release windows.
13. How is the allocation of tasks and identification of key workers going to be undertaken?
14. How do we sequence tasks in relation to positive sentence management?
• 15. How do meetings address the issue of MMT status in relation to medical confidentiality and information sharing?
16. Will the system involve a lot of paperwork and bureaucratic processes?
17. The criteria for prisoner selection a major issue in terms of drug use, high-risk activity and nature of offence. Ultimately you want them all in the system.
18. Is there potential of prisoners abusing the system to get out of prison more quickly?
19. How does on facilitate staff to attend meetings or to perform tasks defined in the plan?
20. How does one institute new ways of doing things?
Premises
21. Presence or absence of key workers from community agencies at the meeting.
22. How do prisoners perceive the value and function of the various workers?
• 23. How does one sequence confidential medical issues in relation to positive sentence management?
• 24. Important point about not giving wrong or unrealistic impression about release dates or movement in the system as this could disturb the prisoner as well as the process of managing information in the system.

- These points will be examined in the text to follow.

3.6 Narrative of Wing Review Meeting (Meeting 1).

Meeting 1 contained a case discussion of each prisoner followed by a discussion of the points raised. The material discussed has been generalised to avoid mentioning information which could breach confidentiality. Whilst the issues that were raised in terms of individual prisoners are likely to have applicability to many prisoners, this research is focused on the processes involved rather than the idiosyncratic qualities of each prisoner's circumstances.

The following issues and processes have been selected from the array identification for further analysis.

1. Absence of staff, who are part of the prisoner's plan and the construction of a model to cope with that contingency.

If key participants are absent from SCP meetings, there are implications in terms of information sharing and communication. Such difficulties are identifiable in the following narrative. Prison staff are required to attend meetings to discuss shared care planning and to make decisions. Given the failure of this to occur in this planned meeting, the question was raised as to how attendance at such meetings could be facilitated so that tasks defined in the shared care plan could be performed. Such difficulties were crystallised by the following comment.
"I have another issue. If the key worker (prison officer) is on a post, how do you relieve him to do all of this? The other issue is the POA. We just don't have the staff".

In the discussion of Case A, the key worker was absent. As no other person had sufficient knowledge of the prisoner, the author gave a synopsis of the case utilising knowledge gained from the proforma and the key worker. The prison officer/class officer who had daily knowledge of the prisoner was on leave but had conveyed his comments to the author by telephone. On the basis of the synopsis of Case A, other staff commented on the prisoner's situation and suggested options in relation to positive sentence management (PSM). A discussion followed which reviewed the

possibility of the prisoner realistically pursuing one particular option in view of his circumstances and family responsibilities.

The meeting began to formulate a plan or structure in relation to Prisoner A which had the potential for being a template for others. " We need to look at the nature of his drug problem first and if necessary, more specialised assessments should be undertaken on the basis of the first assessment".

Prisoner B's key worker was absent so another synopsis had to be given by the author on the basis of received information. Multiple options were identified in view of the prisoner considering detoxification from methadone prior to or following release. These required feedback to key worker, community counsellor and discussion with the prisoner. This verbal feedback would be via the chief prison officer as no minutes were taken at this meeting.
"Though unless we have some degree of information sharing with some issues we are going nowhere in terms of a process of continuity of service provision for prisoners. If the prisoner has nominated certain people then that is fair enough in allowing information sharing".
"It might involve a lot of time and paperwork".
"The system is electronic, so it wouldn't involve much paper but there are very real resource issues here.
" If you have a wing you have to decide how many prisoners you put into such a system" and the criteria for inclusion.
The benefits of the electronic database were noted as was the possibility of resolving issues by the construction and live testing of the model.

There was a discussion about the proposed change from "an old system to a new system", the changes in work practices that might be necessary, the keenness of prison officers to contribute to multidisciplinary working and the need to construct an Irish model as opposed to models utilised in other countries. It was recognised that efforts should be made to ensure continuity of service between the community and the prison at committal and release stages and that this required addressing problems concerning information sharing.

“It will be alright on a small scale but if we have to do it on a large scale we are going to have to have a whole new set of work practices” Chief Officer.

“There is a key worker for each case. It may well be that we look at all the items you mentioned and that we split them up and allocate them to other people. Obviously if there are areas more suitable for probation, then X will approach them, particularly with regards to offending behaviour.
“I don’t doubt the commitment of the people that are here (premise). I just want to make sure that everybody knows what their task is”.
“When can I go back to the prisoner and say we are going to get these problems sorted out “?

2. “Is there insufficient knowledge of the offence”.

If there is insufficient knowledge as to the nature or seriousness of an offence, this will impact upon risk assessment and will in term have implications for SCP. This point is a feature in the consideration of all cases and relates to the importance of having adequate and accurate information and an appreciation of the prisoner’s attitude towards the offence, the likelihood of repeat offending, the need to address the possibility of re-offending and to assess this in terms of criminogenic needs and risk management. The following narrative highlights these issues.

“Does anybody know about the offence? It looks serious enough”.

“There are however, offending behaviour matters which need to be addressed. They certainly will be weighed at the next meeting”. “This case involved a . . . Was he open in court about the offending behaviour and the nature of the offence”?

“Is it relevant here or is it relevant in dealing with risk”?

“Are there future consequences in terms of the victim’s relative? Are these the thoughts of a probation officer as well as the Operations Directorate”? These points refer to the suggestion that the representative from the Operations Directorate would be able to enlighten the next meeting.

"Do we need better protocols regarding this"?
At this meeting, there was no file available, no information about nature of offence and no information about whether anybody was injured or whether a weapon was used.

3. Veracity of information. What are the implications if a prisoner lies as opposed to just getting it wrong?

The veracity of information supplied by prisoners has implications for the workings of the SCP process, because accurate and verifiable information is essential, particularly where health or release related decisions are involved. Generally prisoners are poor historians when remembering dates and contacts with helping agencies, and some prisoners may also tend to minimise the nature of their culpability in relation to the offence for which they have been sentenced. This theme is reflected in some of the comments related below, which form part of the narrative.

"He is up for . . . Maybe we need to look at that. Is he trying to avoid addressing that?"
"If he is thrown out of the system or has a black mark against him, is he therefore suspect in terms of future planning".
"I think he only gave you the information that he wanted you to know".
"That is one of the benefits of shared care planning".

X says "prisoner said he was not on methadone" Significant pause here.
"Is he lying, is he just not using illicit drugs? What does this say about probation officer/prisoner/key worker relationship?".

X said "They did not know him particularly well and he said he was not on methadone".
Y said "He was on methadone".
Z said "He looks pretty well at the moment".

"Did you feel he wanted to play ball with us?".
" Well he said all the right things to that point". "I am happy to see him again".

“They usually say the right things because they want me to go back to the system”.
“Sometimes when they say they are clean, they mean (illicit) drugs generally and don’t class MMT as an (illicit) drug”.
“We need to be honest about this”.
“We have to go back and challenge him about the veracity of his position”.

4. Task allocation and the implications of interaction with parallel information systems e.g. clinical system, Connect Project and the Parole Board.

If SCP is to operate successfully, the needs of prisoners must be identified and tasks to address those needs must be allocated to the relevant staff.
This requires an integrated and holistic approach to planning. However, this raises the ethical issue of confidentiality, especially in relation to the sharing of confidential medical or psychosocial information. Yet, failure to share such information has implications for SCP, relapse prevention and ability not to re-offend whilst on TR.
The following narrative draws attention to these dilemmas.

“I discussed this with X and got the impression there are other medical issues here which may need a nurse to tactfully enquire about with him and maybe address”.
“It would have been good to have access to the probation file and Circuit Court report”.

“Drugs main problem . . . we also need to address employment and support networks”.
“If you do not link prisoners with the outside they will have nothing.
“How do we construct these links? How do we create some modus operandi here”?
“Who is going to contact these agencies? . . . “.

Concern was expressed about the cessation and possible demise of the Connect Project, which had a care plan, and the fact that there was no follow through in relation to the plans of individual prisoners.

In relation to SCP, concern was expressed about who is going to perform the tasks and the need to be clear about how the system will actually operate.

“I want to be clear that something is being done”.
“There is a key worker for each case. It may well be that we look at all the items you mentioned and that we split them up and allocate them to other people. Obviously if there are areas more suitable for probation, then X will approach them (probation), particularly with regards to offending behaviour”.

5. Implications of referring to and identifying prisoner ‘release windows.

Prisoners are required to serve the sentence imposed by a judge. Once this sentence commences it is the responsibility of the executive to manage that sentence. The executive, as a separate power of the state, will determine that most prisoners will have one quarter of their actual sentence deducted and be allocated an EDR (earliest release date). The executive also have the power to release prisoners earlier than their EDR subject to certain conditions under Temporary Release (TR) Rules. It is feasible for prisoners to be released a lot earlier if they are seen to be making good progress. The interventions of staff in relation to this process are important. The executive makes decisions about the prisoner in relation to his progress (PSM), transitional care arrangements, risk management and the requirement to fulfil the element of incarceration (as punishment), which is intrinsic in the sentence of the court. This process is based on making graduated decisions in relation to the prisoner’s progress. This will eventually involve increasing periods of short-term release. The author has named this conceptual and decision making structure as a ’prisoner release window’. The following comments reflect the factors which determine such windows.

6. Comments reflecting a view that prisoners might abuse the system

“Prisoners might have unrealistic expectations as to what they wish to achieve and that those working in prisons need to bare this in mind. I may wish to be an airline pilot but at my age this is not going to be the case”.

“Excellent prisoner in terms of inside prison behaviour”.
“Need to find out what resources are available”.
“Get likely release window from . . . “ (Operations Directorate).

“So this is a release date issue. Was he open in court about the offending behaviour and the nature of the offence? Is it relevant here? Or is it relevant in terms of dealing with risk? Are there future consequences in terms of the victim’s relative?”.

“We don’t want to wind the prisoner up because he has quite a long way to go. This relates to the point made earlier about trying to find the release window from Operations Directorate”.
“He still has a long way to go. They are going to think, ‘good’, I have got into this system and I will be out next year. So it has got to be realistic and we can’t wind him up.
“It might be the case that there is no rush in this case but the next case might be and we need to have procedures in place so that we know where we are all going”.
“So most importantly, so the prisoner knows where he is going and importantly where he is not going”.

“You identified issues about resources if you have every prisoner on this (SCP) there are going to be huge resource implications. If they see the light at the end of the tunnel with this then they are all going to want to be on the bandwagon.
“So do you pick the heavy duty (high risk) offenders or the high need offenders? You don’t pick the ones that don’t have a drug problem”?
“You say the light at the end of the tunnel. In some cases there is no light on when you are staying in prison”.

“No, he will think that getting to (a particular prison) is the way out”.
A way to get out of prison earlier.
“No, if you get another prisoner, for the same offence, it is a totally different crime. He has latched on to this system because he thinks that it is a way out”.

“It may very well be that the key worker goes down to him and says to him, in 2004, that realistically there won’t be any changes like you moving to another prison until 2006”.

7. How do meetings address the issue of methadone maintenance treatment (MMT) status in relation to medical confidentiality and information sharing?

The Healthcare Directorate of the IPS regards the MMT status of prisoners as confidential and have instructed surgeries not to provide lists of these prisoners to governors. This has implications for SCP and the transfer of prisoners to other prisons where MMT is not available. In reality, the MMT status of all prisoners is known because those prisoners who do receive treatment in prison do so in full view of prison staff. The following comments reflect the reality that information which is viewed as confidential, by some individuals, is in fact not so.

The prison officer/class officer said that prisoner A worked well on the wing, that he got out on TR recently and returned satisfactorily. The only negative is that he is part of a group who are
" . . . too eager to get their methadone in the morning".
"What does that mean – he is too aggressive"?

" Was he on MMT on the outside and for how long? The forms did not have any dates on them so we could not tell. Someone mentioned that there were drugs in the family (Chief's knowledge of the family).
"The other thing is that . . . (one of his visitors) is barred for bringing in drugs".

"I know the family history because of my previous involvement with his father who was also in prison".
"Drugs are his main problem".

"He did well. He wants to get drug free before he gets out. We will have to find out from . . . (Operations Directorate) when the release window will be open. This would be important in terms of planning any MMT reduction".

"What can we do to help him get drug free? What form of counselling", (Governor).

"Maybe it is a matter of finding out what contacts he had in the past. Maybe we can get a counsellor from his area to come in"?

The possibility of a number of treatment or positive sentence management options was raised in relation to the prisoners. Prisoners had discussed these with staff. Some of these options were based upon the stated desire of prisoners to become abstinent or to reduce their MMT whilst in prison. Such options are significant in terms of SCP. In addition, where the prisoner is motivated to become drug free, staff will generally support that objective.

“He wants to get drug free so lets look at what he wants, not giving him something that he does not want”.
“It is a matter of different courses for different horses. Maybe this time around the cycle of change he is ready for it or wants it. How to we organise this?”.
“How do we construct these links How do we create a modus operandi here?”.

“What I am trying to do is to establish a pattern for this group to get things done”
“It is not up to us to decide which route”
“There are other options too”.

A more detailed discussion ensued about other transitional care arrangements for particular prisoners. Three options regarding MMT reduction were elicited in respect of one prisoner.

It was noted that positive sentence management issues were particularly complicated when planning for prisoners with long sentences as they may require continuity of SCP when individuals are transferred to another prison.

“At the moment, to a certain extent, we are making it up (protocols) as we go along. But then again we have had review meetings a bit like these for years so it is a familiar thing. But in terms of getting the sequencing right we need to give that some thought”.

“We also addressed the MMT issue so we have covered that. Again we touched on the issue of confidentiality and information sharing. We have to recognise that there has to be medical confidentiality. Though unless we have some degree of

information sharing with some issues we are going nowhere in terms of continuity of service provision to prisoners".
"If the prisoner has nominated certain people then that is fair enough in allowing information sharing".

The meeting considered the negative consequences for the prisoner if information sharing did not take place and if knowledge and discussion about MMT was not part of that process.

"But if we can get it down to just the relevant details. We don't need to know all about Joe Bloggs. But we need to know relevant stuff. What is wrong is that everybody is looking after their own little patch. There are identifiable little issues and we are going to have a lot of fights as we go along. But, if we don't start to have some type of plan these fellows are going to keep coming back into prison. The other issues we can work out. They won't be easy to work out. But we will work them out if we work at it".
"I think if we take baby steps with the system and then we can identify the problems as they arise".
"I think it is a very good idea".

"If at the end of the day policies need to be made, resources need to be found then if you want it to work you have to put in the investment into it. You have to talk to people".

3.7 Step 6 Prison Review Meeting - Meeting 2

Preamble
A significant number of staff were absent. The meeting had to be condensed into 37 minutes instead of the planned for 60 minutes. This limitation required the author to firmly structure and manage the meeting whilst obtaining the views of the staff without undue influence. No prison governors were present as they were either on leave or still taking parade (talking to all prisoners who had requested an interview with the governor). The probation officer had been replaced by her senior. Two staff who attended the previous meeting, were present, a chief officer and a nurse,

although the latter was unavoidably late. A teacher and the community counsellor attended the meeting for the first time. Most importantly, the representative of the Operations Directorate attended the meeting. In ordinary circumstances the review meeting would be divided into time slots for each wing. The efforts of the author to hold a meeting in the morning did not facilitate all governors attending together.

All staff had been informed of the previous meeting via the edited transcript of Meeting 1. Meeting 2 discussed only two prisoners because one had been released and the Operations Directorate file on the other had been left in headquarters.

It was necessary for the author to give a synopsis in respect of the two prisoners discussed because one of the key workers was absent and the other arrived late. Without the intervention a limited amount of information would have been available. Again the personal details of each prisoner cannot be revealed. The synopsis did contain a consensus about the issues relating to each prisoner and the issues which required consideration by the representative of the Operations Directorate

The second cycle of the action research methodology builds upon some of the issues identified within wing meeting 1, which issues are reflected in the key themes emerging in the prison review meeting. These are summarised under three main headings.

1. The identification of factors that would influence the location and opening of release windows.

The issue of release window identification was referred to in the narrative of Meeting 1. At the meeting, staff discussed when these windows might become available to particular prisoners.

This prison review meeting was attended by the representative of the Operations Directorate, who on behalf of the executive, determines when these release windows are opened. The following narrative demonstrates the interaction which took place and which addressed this issue.

“He has a year left so would it be too early from your point of view”?
(Question to representative from Operations Directorate).
“No. As regards TR, what do you have in mind for him”?

“If you are saying that it isn’t too early to consider this guy and consider what we can put together for him then, well that is a good enough indication for us to start motoring at a higher level with him”.
“Is Agency A an option again for him “. Reference to a community programme which the prisoner successfully completed some years ago.
“It depends at what stage of the programme he was breached. I will go back and check that”.

A series of discussions took place about a prisoner’s re-admission to a particular community agency and how PSM could promote this goal. This related to the re-admission criteria of the agency. It was decided that there might be a possibility of repeating the last module in order to address the client’s lack of structure which might best be addressed by that agency.
“So . . . would Agency A be an early possibility for him again?”.

“The fact that he did complete it speaks well for him” Representative from Operations Directorate commenting on the positive fact that the prisoner had successfully completed Agency A’s programme.

“ . . . if they had him on the programme they might consider him for supervised TR given that he had completed the programme. I can go back and see. That is probably the best option”.
“If they aren’t prepared to take him back what are our other options”?

The meeting was informed that the prisoner was not keen on post-release supervision although this might relate to Circuit Court type supervision when breach arrangements would lead to re-incarceration.
“But then again what sort of level of self- awareness does he have around the issues which led to him being revoked in the first place and how much movement has there been with those issues? I am not familiar with that”.

2. The veracity of prisoner's comments as they affect shared care planning and positive sentence management.

The implications for the workings of the SCP process and the availability of accurate and verifiable information has already been noted. This theme was further explored in the prison review meeting.

In relation to Prisoner A, the following comments were made.

"The other issue is to do with the veracity of his comments. He was asked whether he was on any drugs. He gave the impression that he wasn't on anything, even on MMT when in fact he is on MMT. Was it a case of somebody saying he was not on drugs when they don't count MMT as being on drugs? It would seem foolish to say one is not on MMT when it is easy for most people to know if one is on MMT". Long pause.

In relation to Prisoner B, it was noted that "He obviously has a long way to go and the nature of the offence is not as clear cut as one would imagine". "The offence was about . . . ".

"Was it? So there are a few interpretations about the offence".

(Definitive version of offence given by representative from Operations Directorate).

"I wonder where that other version came from?".

The question of verifiability of information was also emphasised.

"The other issue is the whole question of verification of information".

"How important is that for you and what sort of difficulties do we have in verifying the information we put into a shared care planning system like this"? "Is it accurate, and how important is that, if you are going to make decisions on it"?

"The accuracy is very important", (Representative from Operations Directorate).

"There is also the issue of full information as well. Do we have full knowledge of information?".

"Such as urinalysis information to see if he is topping up as well".

"Do we have anything back from psychiatry to say if he has any contacts from that side? There is a bigger picture of information that we as staff should be able to access centrally. I know that there's this medical records and confidentiality issue

but we should be able to identify key issues centrally somewhere and I think that is the problem".
"That is a problem. Yes, (Representative from Operations Directorate).

3. Perceptions of confidentiality regarding MMT affecting shared care planning and sentence planning.

This is a recurring theme identified in Meeting 1 which impacts upon the possibilities for information sharing within the SCP process. Extracts from the following dialogue between prison staff and the Operations Directorate reflect these dilemmas, as does the last paragraph of the previous section.

"There is a bigger picture of information that we as staff should be able to access centrally. I know that there's this medical records and confidentiality issue but we should be able to identify key issues centrally somewhere and I think that is the problem".
"That is a problem. Yes".

"All we have on this database is a medical flag to identify issues generally. In the case of the last guy there is a medical issue which we did not discuss. I don't think it is a serious issue but it could become one possibly. But, it is something that we cannot take into account. On the other hand if information was given on a need to know basis and the prisoner was in agreement we could take that into account today".
"If those two guys were on some anti-psychotic medication would we know about it?"
"Well this is it".
"That is the weakness of the system".

The meeting was informed that some efforts were being made to address confidentiality and information sharing issues but little progress had been achieved.

"It is about the non-inclusion of governors regarding issues to do with confidential clinical information which leaves the rest of us in a difficult and almost farcical position in trying to plan essential services for prisoners".

“Can we get the prisoner to sign a sheet to say that they give agreement for certain people to be aware of their medical details?”

“Is that real consent?”.
“It is a very grey area”.

“I would say that it would be of benefit to Department of Justice and the prison system, the health board and more importantly the prisoner concerned to have open and honest information sharing so you can have the best care plan possible and have a review process so you can look at him again”.

“It’s like taking your car to the garage and saying its not going well, and asking them what’s wrong with it, and they say I can’t tell you. It’s not going well. It is a bit like that”.

“The other thing is that if you put all the information on the table you are trusting all the people at the table that they don’t bring it elsewhere and there have been cases where some of that information has left the table”.

Summary

The two meetings identified key issues which impact upon the ability of the IPS to implement PSM. They exposed communication and continuity of service planning problems. These involve difficulties in managing effective multidisciplinary meetings due to an absence of staff and the lack of protocols. They also highlighted difficulties associated with confidentiality and information sharing, such as the veracity of information and the inclusion of MMT status, in order to realise the objective of shared care planning and positive sentence management.

Chapter 4
Discussion

This research forms part of an ongoing project to introduce a case management system into the IPS and as such it is subject to the project management requirements of that task and the realities of ongoing prison life. During May 2004, both the prison officers and the prison doctors were engaged in industrial action, the latter having actually withdrawn their service. This reality has impacted upon the ability of the author to persuade prison staff to engage in non-essential duties and as such has had implications for the implementation and outcome of this research. Indeed, the influence of specific contextual characteristics reflective of prison environment must be acknowledged in terms of their impact upon the processes and outcome of this research. However, the privileged role of the author as an insider within the organisation has been of assistance in achieving the level of cooperation and open and honest discussion which is evidenced in the narrative described above.

The choice of the action research model utilised in the current study was based on the epistemological assumption that academic endeavours should not only describe and analyse the world but should seek to effectively change it (Coghlan and Brannick, 2001:9). The usefulness and effectiveness of such a model has been well recognised as having the potential to form an integral part of effective organisational development and change (Coghlan and Brannick, 2001; Stringer, 1999; Reason, 2001).

The discussion which follows will focus upon the themes which have emerged in this pilot project as integral and essential elements likely to influence and effect the implementation of the SCP process. Where tentative interpretations are put forward, these can be seen as attempts to make sense of the narrative and to ground it in the theories outlined in the literature review.
Where necessary, further theory may be introduced in order to make sense of emerging findings.

4.1 Key issues

4.1.1 Confidentiality and Information Sharing

A core issue emerging from the findings of this study was the impact of confidentiality upon effective SCP. The concerns expressed by participants highlight some of the inherent difficulties of providing a unified, holistic approach to SCP by a multidisciplinary team of workers consisting of both clinical and non-clinical personnel. The backdrop to the discussion relates to concern expressed by the health care directorate in relation to the attendance at clinical meetings by non-clinical personnel and at the access afforded to such personnel to confidential information including the MMT status of prisoners. This has led to the suggestion that prison governors should not be entitled to attend clinical meetings. In reality clinical meetings are few and far between but new arrangements, which relate to the extra staffing of drug workers in prison, may precipitate the development of a new model of working. During 2003, a consultant in ethical matters intervened with prison governors to address this issue but it has yet to be resolved. A sub-committee of the National Steering Group for Prison-Based Drug Treatment is also examining the issue. Tensions surrounding confidentiality issues also occur in other jurisdictions. Sometimes this has involved clinical personnel excluding themselves from non-clinical sentence planning. In some circumstances protocols are devised to manage working relationships. In many jurisdictions nursing and medical functions are assigned to community health providers and this overcomes some of the clinical and line manager role strain which the Irish prison officer/nurse encounters. Against a backdrop of conflicting concerns and differing attitudes to this issue, it is important to state the reality that Mountjoy Male Prison has a total population of 494 and a cohort of 136 who are in receipt of MMT (31/5/04). At least 80% of prisoners are believed to experience problem drug use with a concomitant risk of associated blood-borne diseases. Drug use, its effects and the implications of being in receipt of MMT in relation to positive sentence management are therefore key elements in prisoner management. Despite this, governors and the Operations Directorate do not receive official lists of prisoners who are in receipt of MMT, and

this impacts upon sentence planning, release and transfer arrangements with other prisons who do not have MMT facilities.

During the meetings described in the findings, this matter received some considerable comment because of the manner in which rules of confidentiality limit information sharing and thereby effect the ability of the staff to address issues. The author had given particular assurances to the IPS Ethics Committee about the safe storage of information, the continuity of prisoner interventions and respect for the confidential nature of medical information. These promises were delivered. Indeed, by storing information on a database and by utilising a particular counsellor and clinic to ensure continuity of service with the community, ethical safeguards have in effect been improved.

In reality what has emerged in this study is that despite existent confidentiality protocols, it was evident that non-clinical staff attending the meetings were aware of those prisoners who were in receipt of MMT and of those who were not. Indeed, many prisoners themselves make a distinction between “being on drugs” and receiving MMT and do not regard MMT as being in the same category. The transcripts indicate that MMT status is an important consideration in sentence planning, sequencing of tasks and transitional care planning. This potential impasse with some clinical staff (IPS healthcare management, doctors, medical orderlies/prison officers and nurse/prison officers) has implications for shared care planning and multi-disciplinary working. The unarticulated assumption may be that governors and uniformed staff have not been trained in ethical matters and might use such information as a form of coercion or control. It may be that there is a perception that clinical teams should operate in a manner that is exclusive from the prison milieu. The natural tendency within any organisations is for demarcations between the disciplines to occur. Such demarcations support sectional interests and any threat to these can lead to anxiety and strains within an organisation ((Burrows, J. et al, 2000; Home Office, 2002; Kothari, et al, 2002). This does not explain the inclusion of general assistants in the community clinical teams or the planned inclusion of specialised prison officers in local prison multidisciplinary teams. In the absence of compromise or the development of protocols this will become more of a corrosive issue.

4.1.2 Attitudes towards the exclusion of MMT status from official information sharing channels.

The confidentiality surrounding the MMT status of prisoners has emerged as a potential obstacle in the development of an effective communication channel which is an essential component in the establishment of a SCP system. The ethical concerns raised in the previous section provide the rationale for such limitation in terms of information sharing.

In the UK prison system there is guidance to assist staff in addressing the problems associated with confidentiality and information sharing. Such an approach can facilitate the development of protocols to ensure that information sharing is effective (Department of Health UK, 2002b). The key issue of real consent is also addressed. "Consent implies both choice and understanding," and is not to be associated with duress or coercion or inadequacy of information concerning the purpose for which the information is to be used. Within a prison environment where the first consideration is security and control of the environment then individual confidentiality may have to take second place. "The key principle to follow is that information provided in confidence should, in normal circumstances, only be disclosed with the consent of the individual concerned" (Department of Health UK, 2002b:5). A new Irish framework is also emerging (Midland Health Board, 2004).

Rule 51 of the "Draft Prison Rules" imposes a requirement on prison officers and governors not to "disclose intimate or sensitive information about prisoners unless it is necessary for the proper performance of their duties or in the interests of justice" (IPS, 2002). This definition is open to various interpretations and is a long way from the development of multi-agency protocols. On the other hand Draft Rule 103 states that "an officer shall communicate freely and openly with his or her superior officer on all matters relating to the prison when required (IPS, 2002).

In the narrative reported upon within the findings, the following comment relating to a prisoner was noted:

"too eager to get their methadone in the morning".

"What does that mean – he is too aggressive?"

This raises the question of whether such information sharing should occur in an open forum such as a wing meeting? In reality, this type of information will be shared because of its implications for the control function of prisons. Such function must prioritise the safety and security of the prison population, both inmates and staff. In prison a separation exists between treatment and control issues. In HMP Swansea "the prison governor ensured full management support and the maintenance of what came to be called the 'Chinese Wall', separating the prison's 'caring' and 'control' functions. The key to our strategy was this understanding of a prison's dual functions – to care for prisoners and to control their environment" (Heyes and King, 1996).

The dilemma concerning information sharing is an ongoing challenge highlighting the complexity of managing these dual functions. The confidentiality protocols relating to MMT can give rise to other difficulties, such as when a prisoner communicates to non-clinical personnel a wish to commence reducing his MMT. Such information is likely to impact upon the opening of their release window. How can such communication between doctor and non-clinical staff be channelled and managed and what if divergent views exist between the concerned parties? Indeed, how can such information be discussed given the limitations imposed by the confidentiality protocols? Further medical issues may also need to be addressed in relation to the sequencing of psychosocial interventions relating to MMT reduction and abstinence, such interventions form part of positive sentence management. Equivalence of prison healthcare requires dialogue and effective communication structures between clinical, psychosocial and positive sentence management systems**.** If this is to be achieved, it may be that the confidentiality rule which limits information sharing regarding MMT should be reviewed, thereby creating the possibility for more realistic and effective planning. This comment is made in the light of the finding that in fact MMT status is already an open secret within the prison system.

4.1.3 Veracity of prisoner comments

The issue of information veracity has also emerged in the findings as an essential to the process of decision-making.

"What are the implications if a prisoner lies as opposed to just getting it wrong? Is he thrown out of the system or has a black mark against him and is he therefore suspect in terms of future planning?" Staff indicate that they are prepared to address these matters and to work with prisoners in the knowledge that there may be occasions when the veracity of his comments are suspect. Social control and veracity issues are also relevant in the community clinical setting as they relate to safe management of MMT. Social control aspects also figure in the relationship between community clinics, the Probation and Welfare Service and the courts. The Irish Drug Court is a specific example where there is an emphasis on therapeutic jurisprudence as a form of treatment and social control (Pugh, 2003).

The veracity of information upon which decisions are made has implications for worker credibility with colleagues and also with the Operations Directorate. Indeed, prisoners also expect staff to be honest in their dealings with them, which can sometimes be difficult if prisoners want to speculate about their release possibilities. It can also be challenging for staff if a prisoner has chosen to discuss confidential matters with them. Such difficult and sensitive areas are important where the demand for the protection of personal ('non-confidential') information and the desire of the system to monitor a prisoners functioning in terms of self-control, risk management and sentence planning can conflict. In the community, offenders are subject to supervision with urinalysis requirements and reporting lines to judges. In prison the Minister is considering mandatory drug testing. There is also, on occasions, the facility for prisoners to provide voluntary urinalysis. Are these diverse demands from care and control perspectives reconcilable? Where issues concerning veracity of information are raised, how do these impinge upon clinical and/or sentence planning?

4.1.4 The creation of an effective case management system.

The findings of this study have highlighted the manner in which prison organisation can impact upon a SCP system. The absence of essential staff was a feature of both meetings. This is likely to be a permanent feature and raises major issues concerning the potential pitfalls inherent to a system which depends upon the contribution of a number of essential participants. To compensate for the inevitability

of this occurrence, the SCP database was created. This will facilitate staff access to essential information and will allow for the timely sequencing of interventions.

Prisoner selection has been identified in the literature review as a major issue in terms of drug use, risk management and the nature of offence. The danger that SCP might be abused by some prisoners was alluded to in the findings. The resource issues in rolling out a case management system were also forcefully mentioned in Meeting 1.
"It will be alright on a small scale but if we do it on a large scale it we are going to have a whole new set of work practices". Some participants viewed the difficulties as enormous at this juncture whilst others thought we should proceed by "baby steps . . . then we can identify the problems as they arise". Whilst one might want to include as many prisoners as possible within a case management system, because of the potential for change which such a system promises, limited resources and the desire to achieve effective outcomes could dictate otherwise. The CAART and CARAT systems bear witness to the dangers of system overload.

Weekes (2003) emphasises the importance of client/treatment matching and the development of a differentiated treatment plan according to problem severity and risk. This has a cost benefit impact upon service delivery and client outcomes which could result in more effectively focusing limited resources and in reducing treatment programme durations (Weekes, 2003).

The management of offending behaviour, risk assessments and the influence of these upon release dates and conditions of release and community safety are all factors which are involved in PSM although they might be considered outside the remit of shared care planning. They are essential components of prison and probation functioning and ones which have to be accommodated. A clinical perspective may view them as unnecessary contaminants but the medicalisation of a social problem (drug use) also creates dilemmas. The question arises as to whether one should separate health, from PSM by way of parallel information systems (as in the UK) or whether one should combine them into a holistic model with necessary safeguards for the protection of confidential health information? At present toxicology screening is separated into information required for MMT, which is placed

on the medical file, and into information that which is required by the courts and the governor for social control purposes (IPS, 2003c).

4.1.5 The case for an organisational development approach.

The potential difficulties in organising major change on a piecemeal basis without a strategic plan or organisational development assistance are axiomatic. Organisational development (OD) is "a system wide application of behavioural science knowledge to the planned development, improvement, and reinforcement of the strategies, structures and processes that lead to organizational effectiveness"(Cummings and Worley, 2001:1).

> "In the OD process, three main criteria define an effective intervention 1) the extent to which it fits the needs of the organisation;(2) the degree to which it is based on causal knowledge of intended outcomes; and (3) the extent to which it transfers change-management competence to organisation members" (Cummings and Worley, 2001:142).

> "Effective intervention "requires paying careful attention to the needs and dynamics of the change situation and crafting a change programme which is highly dependent on the skills and knowledge of the change agent . . . and to some extent on the expertise of the practitioner . . . and those related to the target of change" (Cummings and Worley, 2001:143).

This particular model of shared care planning is based on the identification and prioritisation of needs, defining objectives (which are specific, measurable, achievable, realistic and time-bound) and translating them into a care plan (positive sentence management) and transitional care plan (release plan). Whilst participants in this study were aware of the model, via the paper proforma and the database, no specific SCP protocols have yet been developed as this is a phase 2 action. Meeting 1 did identify the need to develop such protocols, particularly in relation to task allocation "and the need to be clear about how the system will actually operate". Staff absence at meetings can make this even more of an imperative because whilst an electronic system can hold and facilitate shared information and task allocations, it will also require commitment and co-ordination to ensure that the prisoner receives continuity of service delivery.

The IPS values and fosters working relationships with a wide variety of agencies in order to attend to the many needs of its prisoners. This requires the maintenance of a complicated network of integrated services at both local prison level and between the community services from voluntary and statutory providers. The management of such complexity requires an OD approach which can accommodate interactions between different organisational levels (Coghlan and McAuliffe, 2003:1; Rashford and Coghlan, 1994). An argument can be made for a "total system perspective" which examines each issue, the inter-connectivity of issues and the impact of changes in a system upon other parts of the system (Coghlan and McAuliffe, 2003:1). There is therefore a requirement to obtain horizontal as well as vertical integration. There is also a requirement for inter-sector communication (Butler, 2002). It is for this reason that an action research approach was utilised as it identifies relevant actors as participants in the cyclical process of diagnosing, eliciting ideas, planning, taking action and evaluating action. Such an approach is congruent with current health strategy as it involves a participative approach, integration of services based on need, e-health delivery systems and addresses cross-sectoral issues (Department of Health and Children, 2001; Department of Health and Children, 2003:27; Prospectus, 2003).

A total system perspective also addresses the risk of failure associated with the introduction of major change processes, particularly when such processes involve IT. The risk of failure is commonly associated with a defective theory of change and it is suggested that is more effective to actually put workers into a new organisational situation and to tease out the new roles, responsibilities and relationships which that new situation creates (Beer et al, 1990, as cited by Coghlan and McAuliffe, 2003:115). This can be achieved in four steps according Beckhard, one of the leading OD theorists, and requires; determining the need for change, stating a vision of that change, determining the change components between the current and desired future and managing the transition process (Coghlan and McAuliffe, 2003:121).

4.1.6 Case management is a developing feature of criminal justice system interventions

Expanding the operation of shared care planning can be seen as a major issue in terms of changing work practices and extra resources. However, at this juncture it is not necessarily an extra resource issue in view of the lack of co-ordination and fragmentation of services associated with the current system. It is arguable that it is better to develop a best practice model in order to identify real needs and protocols before expanding a service without direction. The meetings indicated that staff appreciated what changes would be involved and that it was possible to make those changes if prison officers were involved. Currently they are not involved in the process. This has implications for working with the POA or individual officers as well as implications for progressing that work within the new work practices that are currently subject to industrial relations. All these proposals have to be viewed in relation to the current problems within the system. A system which does not address the continuity of PSM and transitional care planning in a consistent and effective way is likely to fail.

Case management is a developing feature in the provision of community probation services in England and Wales (Grapes, 2004) and within the prison system (OASys, CARAT and CJIP). However, its development appears to be concerned with the measurement of key performance tasks and reduction in offending rates. There appears to be less concentration on establishing meaningful relationship with clients although references are made to their needs. "The research found that most offenders did not understand the concept of case management or, case managers. Most had difficulty articulating what type of order they had received, the length of the order or when it commenced" (Partridge, 2004:47). These perceptions are based on a small sample and may well reflect the bureaucracy surrounding the community sanction rather than the client relationships with the workers or the ability of management to flexibly allocate resources, prioritise and plan service delivery. This pilot study has indicated that both prisoners and staff have understood the concepts of SCP and were impressed by the simplicity of the forms and database. It is yet to be seen whether the issue of task separation causes confusion. However, such

difficulty, if it emerges, could be overcome by providing prisoners with a paper copy of their plan.

Within Ireland there is also a growth in the development of case management systems in the areas of homelessness and primary care initiatives (ERHA, 2004; Homeless Agency, 2004). Action 1.2 of the "Action Plan on Homelessness" requires the prevention of unplanned discharge from institutions, including IPS and PWS, by ensuring that a throughcare policy is in place. The report builds upon the continuum of care approach mentioned in it's previous report "Shaping the Future" (Homeless Agency, 2000) and makes the distinction between sectoral care management, which includes "the co-ordination of case management, and its monitoring and evaluation" with that of case management. It seems vital therefore for effective discharge planning that community and prison SCP operate congruent systems. There is also a need to have congruent information and IT systems with the Probation and Welfare Service.

4.1.7 Role of Operations Directorate

A key feature in the successful operation of any SCP system is the pivotal role of the Operations Directorate in the organisation of PSM and risk management. The Operations Directorate manages the responsibilities of the executive as they relate to length of sentence served, conditions of release and risk management. A decade ago, sentence planning and release planning were firmly decided in terms of length of sentence remaining and a graduated release mechanism. Prisoners were examined in a way analogous to stored wine. Bottles would be inspected and returned to their case without any immediate consideration to future planning. It was observed that the judiciary appear to have been unimpressed with the role of the executive in terms of sentence planning, a role which they undertook for a period of time when they usurped the executive function of managing sentences (Pugh and Comiskey, 2004).

For a period of time the Circuit Criminal Court undertook reviews of sentences.

> "The review structure is a process by which a judge is able to individualise a sentence for the particular convicted sentence. It is a tool by which the judge may include in a sentence the appropriate element of punishment (retribution and deterrence) and yet also include an element of rehabilitation. For example, it may be relevant to a young person or a person who has an addiction or behavioural problem and at least some motivation to overcome that problem, it may well be appropriate as part of a rehabilitation aspect of the sentence to provide for a programme or treatment within the sentence as a whole and then to provide for a review of the process at a determinate time" (Court of Criminal Appeal, The People at the suit of the Director of Public Prosecutions .v. Philip Sheedy (unreported: judgment delivered 15th October 1999).

> "This innovative practice, which had been in existence for over 100 years and put on a statutory basis by other jurisdictions, was effectively ended because it had no statutory basis and that it eroded the powers of the executive (D.P.P. v. Finn, 2000). Arguably this practice, met the challenges of current social problems (55 and 63) by stimulating offender motivation and promoting rehabilitation in a prison system with few treatment facilities. The practice also addressed "the revolving door syndrome" of prisoner management by ensuring minimum periods of incarceration. The judgement also referred to "the rather haphazard" (63) executive process of remission because it did "not meet the penological requirement of reasonable certainty" (D.P.P. v. Finn, 2000). No reference was made to the "general approach by the Irish Prison Service to drug treatment in custody" by way of positive sentence management (Department of Justice, 1994) or the aims of providing, multidisciplinary service provision and "measures to promote prisoner integration into the community (IPS, 2000). It would appear that both the judiciary and the executive were taking into account the individual needs and plans for prisoners; and both with the principal assistance of the Probation and Welfare Service" (Pugh and Comiskey, 2004).

The findings of this study suggest that the prisoner with a drug free status is regarded by the Operations Directorate as having an advantage in such a system. Indeed, meeting 2 at which the operations directorate was present, placed a particular value on prisoners becoming drug free. Such status may be viewed as a currency within prison, which could provide certain advantages such as admission to drug free wings and earlier release. Another perspective might be that those in prison who receive MMT are likely to receive better treatment if they continue MMT as this may provide a safeguard against relapse and the risk of acquiring blood-borne diseases. Creating a reward system for being drug free might be seen as contradicting a public health model which appreciates the chronic relapsing nature of drug addition. In other words, it could be argued that there is a greater probability and safety in effecting MMT reduction in a community environment rather than in

prison. Perhaps this dichotomy has to be determined in terms of the individual needs and wishes of each prisoner.

Both meetings raised the issue of the unknown factors associated with the construction of the release window paradigm. Are there consistent components in the construction of the release windows and can they be seen as positive or negative influences? There would appear to be great potential in exploring and mapping this area in order to clarify decision-making and the development of protocols. This would also have a great influence on sentence planning and the identification of positive aspects of a prisoner's behaviour in relation to that process. This could well impact upon regime planning and the development of a reward system associated with a 'responsible prisoner' philosophy. Clarification and transparency in this area would save staff and prisoners engaging in meta perspective speculations concerning the representative of the Operations Directorate. This is an important area "about not giving the wrong or unrealistic impression about release dates or movement in the system as this could disturb the prisoner as well as the system".

4.1.8 Summary

In summary, the pilot study has identified fundamental issues which need to be addressed in order that a successful SCP system can be established within the prison. This must include a resolution of the confidentiality-information sharing issue. It must also recognise the essential elements of effective case management, including management of resources, appropriate selection of prisoners and the use of verifiable information in order to address care and risk management issues. There needs to be a recognition of the critical role of the Operations Directorate in facilitating this process. This can be achieved through a policy of positive sentence management and co-ordinated temporary release. In this way, continuity of service delivery along integrated care pathways can be achieved.

4.2 Self-reflection and learning of the action researcher

This section summarises some of the author's observations arising out of this action research project. The meetings were designed to test and develop a particular model of case management and as such were well planned. However, although understood as reflective of the vagaries and reality of prison life, they were nevertheless a source of some anxiety and frustration due to staff absences and the problems associated with the establishment of effective communication. The author was required to meet and make best use of the situations in which he found himself. This can be a curse, a methodological excuse or a reflection of reality. In retrospect, such difficulties inhibited the task allocation which is an essential feature of multidisciplinary working. The author found this frustrating although he was pleased to note the positive efforts made by participants to determining task allocation. Although there was an expressed awareness that difficulties associated with inter-agency relationships would have to be overcome, it was gratifying to note the lack of partisan criticisms of the system. The commitment and goodwill of the staff in progressing the project was impressive, especially in the light of current stress factors in the system. This enthusiasm in relation to SCP has placed more responsibility on the author whose job it is to progress and co-ordinate the system.

Other commentators might have expected the author to have analysed the social control role of governors and the Operations Directorate representative more fully as they don't appear to reflect common stereotypes. This was evidenced in the narrative by the caring and concerned attitudes adopted to the prisoners. These roles are generally seen in terms of coercion and as not being conducive to the primary care interests of the prisoner. In fact, from experience of working as an insider within the prison system over a number of years, such findings did not surprise the author, who has noted the capacity of prison staff to use "the Chinese wall" device by separating out care and control issues. The author was intrigued about the possibility of exploring decision-making and sentence planning with the Operations Directorate. This could well have an enormous impact upon the motivation of prisoners if the system were to positively reward effort. It would also have safety implications for the community by providing a greater degree of

supervision to people subject to temporary release conditions. Such an approach is also more likely to encourage abstinence and drug-free prisons.

The author was surprised that some of the individual case discussions became quite detailed and complex in terms of treatment options and sentence planning. The plans had not envisaged such in-depth work for a low level system. The author was also concerned that the focus on release windows might have negative connotations in that it mirrored the prisoner's primary aim to get out as soon as possible. Staff could be challenged as to whether they had 'gone native' if this concern was a primary factor in their decision-making. The author could then be challenged as to whether he had designed a system which instead of encapsulating treatment and rehabilitation sought to make it solely a multidisciplinary structure which embraced the elements of risk assessment and social control. On the other hand by adopting a total systems perspective with built in confidentiality safeguards, positive sentence planning can become streamlined and effective.

The confidentiality/ information sharing issue is a source of concern to the author who believes that it has to be addressed via the development of protocols, before it becomes an even more corrosive issue. In some ways it was a distraction for the research.

Chapter 5
Future directions

Prison meetings in the form of case conferences and review meetings with the Operations Directorate have existed for some considerable time. Meetings 1 and 2 are a developmental precursor to the construction of an 'ideal model' of shared care planning which will take the form of a wing meeting format. This allows for an appreciation to be made of the 'dynamic complexity' of the organisation, Senge, (1990), cited by Coghlan and Brannick (2001). In this way circuitry, patterns, meanings, covert rules and time dimensions can be explored with a view to establishing an 'ideal model'.(McCaughran and Palmer, 1994). This "involves building and managing the collaborative arrangement within the organisation to work on the project (Coghlan and Brannick, 2001:106).

"One of the fictions of modern management is scientific planning procedure which may be used to describe objectives, activities and outcomes in precise detail, a continuing source of frustration for those who work in large organisations . . . " (Stringer, 1999:193). The OASys (actuarial) case management system might be considered as such an example. Stringer argues that these processes lead to increased worker contacts, stress due to scientific calculation and prescriptive plans that don't allow for adaptation. There is therefore a need to examine the use of scientific rationality for it's own sake because there is no objective reality, particularly in relation to the social construction of drug misuse and criminology. That is not to say that managerial efforts and standardised systems are not useful. Focault, (1972) cited by Stringer (1999), in his analysis of modern institutional life views the arrangement of social activities in the form of discourses which require flexibility in order to promote diversity. This is congruent with team building and the development of a process approach to organisational problem solving and efficiency. Stringer develops his argument (Derrida, 1976, Fish, 1980, Focault, and Leyotard, 1984 all cited by Stringer, 1999) by referring to "interpretive communities" which relate to social controllers and the controlled, prison being the starkest domain where such interactions take place.

Stringer (1999) would argue that it is the participants who attended Meeting 1 and Meeting 2, "who control the rules and procedures" and have much latitude in the exercise of power. However, this is a perspective within a much wider debate. Those who attend prison meetings are also those who define and assess the values of prisoner effort and behaviour. These are then articulated within a case conference format and constructed within a SCP database. The possibility of reward is given to those who co-operate and those who are seen to be making an effort to achieve a responsible and gainful lifestyle.

This research has, through the participative development of a shared care and integrative care planning, allowed participants to visualise and work towards developing an ideal model. This process of democratic participative planning is the essence of action research and effective organisational change. How far that process can be developed within a structure designed for punishment will be measured in relation to the care - control continuum and human effort.

This research has adopted a micro-system approach to change which is also congruent with wider government strategy as outlined by "Delivering Better Government" (1996) which had a particular concern regarding crosscutting issues. The research was an attempt to address the silo mentality which reflects sectoral and functional interests. Unfortunately this silos attitude exists today in terms of agencies and the occupational interests of the workers involved in inter-sectoral working.

Whelan et al (2003:32) refer to the extent to which technology is driving changes in society in order to achieve competitiveness and notes consequent effect upon policy makers. The demands for effectiveness and efficiency both in personal human terms and in the local environment of prisoners can equate with a win-win situation, as both are dependent upon each other. This form of rationalism need not be based on pure social control ideology but upon one that recognises the importance of regime factors in addressing some of the reasons why people end up in prison. Assuming an expanding economy the impetus is likely to be focused on increasing the human potential within prisons. This will necessitate that the executive considers

adventurous policies such as reducing the time of sentences served on the basis that they offer reward for drug free status. This will require particular attention to the integration of planning and service provision in order to address crosscutting issues effectively (Whelan et al, 2003:41and 66). This vista can be realised on the basis of:

> "Clarity and coherence of roles and objectives
> capacity to allocate financial resources and mobilise supporting facilities according to new priorities
> capacity to build the necessary delivery competencies, capabilities and skills to adapt organisational culture to new needs
> capacity to adapt structures as necessary
> the need for accountability and evaluation methodologies"
> Whelan et al, 2003:66).

Extra resources for such an approach can be accessed via the PSMA 1997 which provides authority to allocate finance for crosscutting projects (Public Service Management Act, 1997; Whelan et al, 2003:32) This money is needed in terms of prison drug treatment and can be attached to achieving objectives such as incentive payments associated with the number of prisoners in the database. Prisoners could be allocated a theoretical sum of money upon release to purchase aftercare from private, public or voluntary aftercare providers. This process could be enhanced by management information systems which provide evidence about needs, locations, services and effective outcomes.

Chapter 6
Endnote

Case management in prisons is problematic due to the nature of institutions, fragmented and demarcated services and the complex nature of the problems of addiction. This thesis has suggested organisational development steps to address these issues and to provide a framework in which individual prisoners can address the issues which have prevented them from leading a life free of crime and drugs.

Whilst there can be difficulties in utilising a managerial approach to the provision of services for drug users and prisoners, an organisational development approach is necessary to achieve efficiency and effectiveness. In this way, the vertical and horizontal layers of prison and community related interactions can be managed in a crosscutting way.

There would appear to be a dynamic interaction between social control and social care initiatives. This needs to be explored further so that a participative total system approach to prisoner management can be achieved which reflects a holistic rather than partisan approach. Planning should be directed by client needs rather than by availability of services. Such planning in relation to prisoners needs to be undertaken at a local prison level. This has implications for the use of a strengths model (care) within the justice (control) system. This can be achieved by forwarding an agenda based on shared care planning and integrated multidisciplinary working.

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Appendix 1 Letter to Irish Prison Service Ethics Committee.

FROM
Julian Pugh, Co-ordinator Drug Treatment Services (Prisons), Directorate of Planning, Commissioning and Change, Eastern Regional Health Authority, Mill Lane, Palmerstown, Dublin 20

TO
Mr Mark Curley,
Secretary,
Research Ethics Committee,
Irish Prison Service,
Monastery Road,
Clondalkin,
Dublin 22 Your Ref: RP10/03

Dear Mr Curley,
Re: "An examination of multidisciplinary interaction using action research and the introduction of a case management model into a prison setting".

Further to a meeting between myself and members of a sub-committee of the of the Research Ethics Committee on the 26 September 2003 I have redrafted my letter sent to you on the 24 May 2003. In order to facilitate comparison with that letter I have put all alterations in bold, italic and underlined type. I have also enclosed revisions to the Client Assessment Form and the Crime Pics 2 instrument which is a statistically validated instrument which measures change in relation to attitudes towards offending behaviour and self-perception of problems.

Following the submission of my research application to the last meeting of the Research Ethics Committee and your letter dated 7 May I wish to respond to the following issues that were raised in relation to the proposal:

"The committee had difficulty in understanding the proposal and considered that, in view of the target audience, the terminology used should be simplified.

The committee considered that the consent form should be simplified, with particular regard to literacy and other attributes of the research population.

The committee has concerns regarding the issue of confidentiality and sought clarification in relation to what information would be shared, how the information would be managed, who would have access to information and what interaction with other disciplines would be involved in relation to confidential information".
Reply
The planned research will assess the introduction by a multidisciplinary team, of a case management approach to the care of prisoners. Such an approach involves the adoption of an individualised needs based plan for the management of prisoners, from the time of sentence through to the point of their release. Positive sentence management is a process of assessment, engagement and treatment which is designed to address some of the issues which may have led to imprisonment, such as the misuse of drugs. For such an approach to be

successful, prisoner co-operation is a vital component and therefore the process will be designed with the assistance of each prisoner involved. This will involve the assessment of needs, the setting of targets and the establishment of plans. In addition the approach requires the co-operation of community agencies in release preparation.

Fragmented service delivery and ineffective linking with community agencies are factors contributing to the failure of the present management of prisoners upon release which often results in recidivism. A case management approach will require an agreed management plan for prisoners with arrangements for review, re-assessment and information exchange. At a multidisciplinary level it demands the allocation of roles and responsibilities, and the identification of a key worker (care co-ordinator). The purpose of this research to introduce such a system and to explore the manner in which the multidisciplinary team interacts in this process. ***This form of process evaluation, which involves staff in analysing what they are doing, is known as action research.***

In response to the concerns expressed by your committee concerning the proposed consent form, I have endeavoured to make the subject of shared care planning an easier concept to understand.

I have simplified the consent form and have included details of an imaginary prisoner in the case management form itself. This will be used as a backup to the consent form. It is my intention as researcher of this project, to read the consent form to each prisoner involved so as to ensure that it is understood.

I have undertaken a couple of focus groups with prisoners, including a lively one-hour session with the current Connect Project participants. I have also piloted the procedure with two prisoners and am happy to report that they were able to understand the consent form and to identify with the process involved. ***These prisoners stated that it would be important to them to be able to be involved, in selecting which prison officer, was to be part of their case management plan.*** These prisoners also wanted to be reassured that sensitive information would not be recorded on the form unless they agreed to this.

Prior to the planned research, all staff will be instructed regarding confidentiality and will be asked to agree not to disclose matters outside the multidisciplinary team, nor to include sensitive information on the proforma. In order to safeguard confidentiality I intend to use a flagging device. This flag, which maintains confidentiality regarding clinical matters, might involve the arranging of an outpatient appointment or relate to something of a more sensitive nature. An example of this device can be found on the treatment care plan and release plan pages of the case management pro forma.

In short, all staff within the multidisciplinary team will be expected to maintain the rule of confidentiality. The case management form will be stored in a locked cabinet within the Medical Unit surgery and be accessed by the nursing staff***. Only the nurses and members of the multidisciplinary team will have rights of access to the form***. All recordings will be completed within the surgery, and will then be returned to the locked cabinet. The governor in attendance will also be given the right to inspect and record on the file during multidisciplinary meetings. Prisoners will also have the right to view the file if they contact a member of the multidisciplinary team. The research project will only be concerned with prisoners whilst they are in the Medical Unit. Once they are transferred from the Medical Unit or when released, the file will be attached to their ***confidential*** Probation and Welfare

Service file so as ***to ensure continuity of care planning*** and facilitate release arrangements. ***(A sentence was deleted here) Prisoners will be able to be involved, with the governor, in selecting the prison officer who will be involved with the case management plan and this process will take into account the working relationships between prison staff and individual prisoners. (Sentence deleted here as it repeats information in 3rd next sentence) This process will involve the prisoner being informed of his options and he will be assisted in making decisions based on his needs and situation.*** The prisoner will have the right to terminate his involvement in the process and to have his file destroyed. ***No agency or individual will have access to prisoner information contained in the case management plan, unless they are nurses, members of the multidisciplinary team or are persons or members of agencies who are involved in the Transitional (Release Plan).***

It is proposed to utilise a named multidisciplinary team in the Medical Unit, Mountjoy Prison:
Governor of the Medical Unit
Chief Officer of the Medical Unit
Prison Officer
Nurse –
Teacher -
Probation and Welfare Officer allocated to the Unit
Operations Directorate.
Julian Pugh – Researcher
I hope that this letter adequately addresses your concerns in relation to the proposal. I am available to any member of the committee should they wish to contact me***. I appreciate the time, interaction and very useful advice given to me by the members of the sub-committee.***

Yours sincerely,
Julian Pugh
Co-ordinator Drug Treatment Services (Prisons)
26 September 2003

INFORMATION SHEET
CASE MANAGEMENT PROJECT
MEDICAL UNIT MOUNTJOY PRISON

You are being ***invited*** to improve the planning of services for prisoners both while they are inside prison and following release. You do not have to take part in this unless you want to and if you decide not to take part, this won't work against you.

Often when somebody ends up in prison it is because they have particular problems such as being addicted to alcohol or drugs or having no money or job. If they do not get help with their problems while in prison or do not plan for their release, they can end up coming back inside.

We want to change this by planning a new system but we need your ***support.*** What we want to do is to make a plan especially for you while you are in prison and to plan support services for when you are released. This plan will involve talking to you about the difficulties that may have led to your imprisonment. Once we know what your needs are, we can begin to plan how to deal with them while you are inside prison. This could involve activities such as education and counselling.
One of the benefits of having a plan will be that any efforts you make while in prison will help you. The plan will also be shared with the person in prison service headquarters who makes decisions about release. Another benefit will be that before you leave prison, we will try to link you in with support services in the community.

We want to improve things for you in prison and we hope you agree to be part of this planning. Once you agree to your plan, it will be written down and kept in a private file to which only you***, the nurse and the multidisciplinary team of staff that have been approved of by you name can have the right of access.***

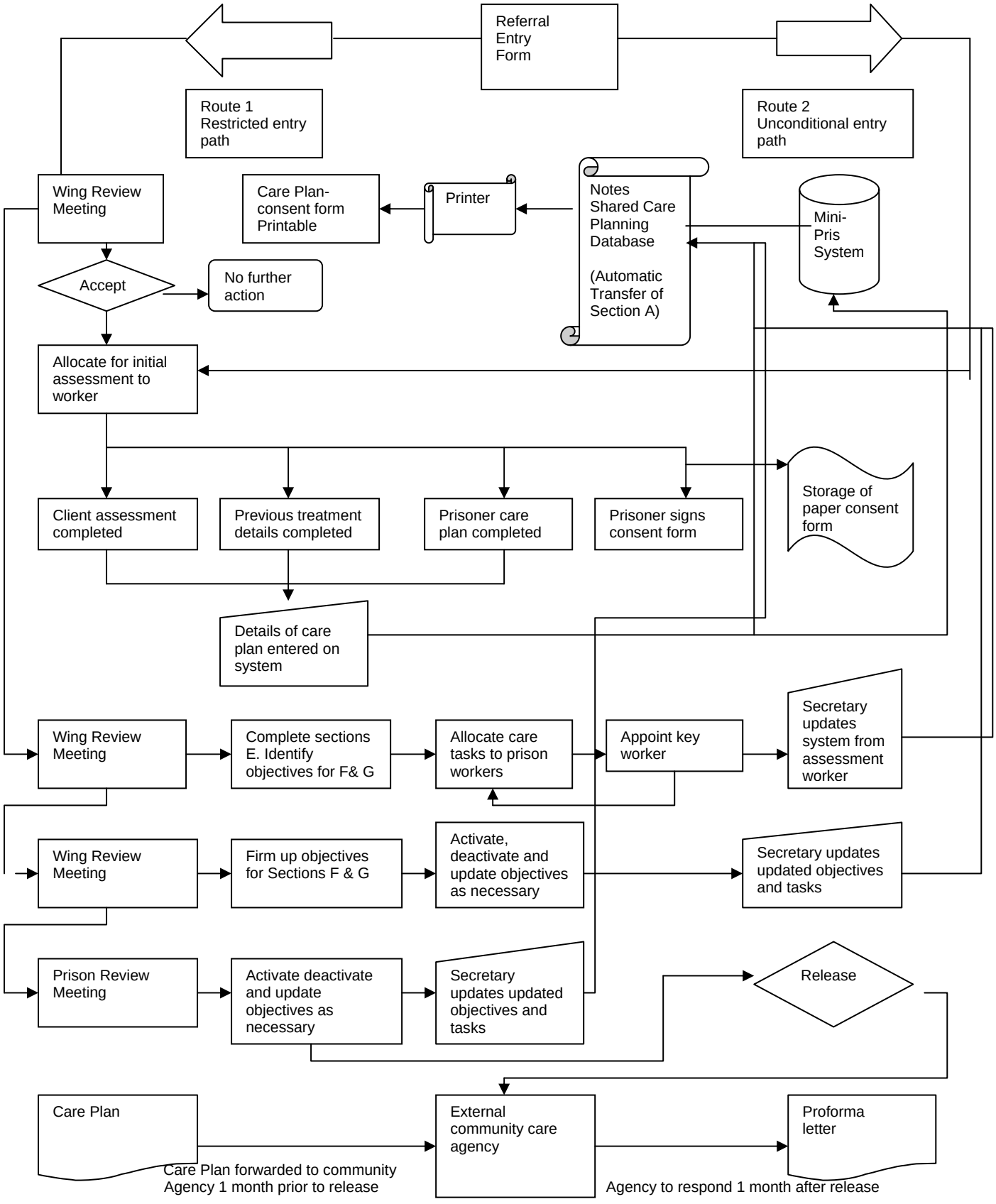
If you do agree to be part of this project, you can decide to leave it at any time and have your file destroyed. If you want any more information before deciding to join, or while you are in the project, you will have the right to ask. Before you agree, I will show you an example of an imaginary file that will show you the type of information that might be kept in your file.

I have been given a copy of this form and understand and agree to be part of the project to help plan better services for ***myself and other prisoners.***

Signed …….. Witness ……..

Date: ……..

Appendix 2. Algorithm of IT design, Shared Care Plan Proforma and Case Management Model.



SHARED CARE PLAN

SECTION A: PERSONAL DETAILS

Forename	**Surname**	**Other Names**	**D.O.B.**
Smyth	John		17/6/82

Gender	**PRIS No.**	**Committal Date**	**Remission Date**	**Expiration Date**
Male	4361	1/1/04	30/4/05	31/12/04

Nationality	**Remand/Sentence**	**In Custody**	**Most Serious Offence**
Irish	Sentenced	Yes	Burglary

Sentence length	**Wing**	**Database ID**	**Generic ID**
2 years	D2	48913	JS17061982

Address			County/Post Code
4 Boghall Road	Crumlin	Dublin	12

Reason for Referral:
Drug misuse problem, wants to quit, wants to develop employment skills.

SUPPORT ACCEPTED
I have read the information sheet and have been given a copy to keep. I have had a chance to ask questions about the information which is collected and kept about me, why it is kept and how it is used or disclosed. I understand that the information is held on computer and/or paper. I consent to the purposes for which the information is being collected, kept and disclosed. I have specified the individuals and agencies to whom the information may be disclosed and to whom it may not be disclosed.

Client Signature	Staff Signature	Date

SUPPORT DECLINED
I do not require support from staff at this time. The support services have been explained to me. I take full responsibility for this decision. I understand that I will be offered such support at a later date.

Client Signature	Staff Signature	Date

Date of Referral	Date of Assessment	Date of Shared Care Plan	Date of Transitional Plan
10/1/04	20/1/04	10/2/04	4/5/04

SECTION B: CLIENT ASSESSMENT

Name: John Smyth Date 20/1/04

PROBLEM CHECKLIST

LP Large Problem **P** Problem **SP** Small Problem **NONE** **Linked** (to crime or drugs)

✓ **DO YOU HAVE A PROBLEM WITH:**

	LP	**P**	**SP**	**NONE**	**LINKED**
1. Reading, writing, numbers or education	.	.	.	.	.
2. Getting a job or getting the job you want	.	.	.	.	.
3. Thinking and decision making	.	.	.	.	.
4. Getting angry and controlling your temper	.	.	.	.	.
5. Getting bored	.	.	.	.	.
6. Having to feel a buzz in your life	.	.	.	.	.
7. Depression	.	.	.	.	.
8. Something that a counsellor could help with	.	.	.	.	.
9. Lack of confidence or ability to cope	.	.	.	.	.
10. Feeling good about yourself	.	.	.	.	.
11. Family issues	.	.	.	.	.
12. Relationships with other people	.	.	.	.	.
13. Worrying about things	.	.	.	.	.
14. Gambling	.	.	.	.	.
15. Alcohol	.	.	.	.	.
16. Drugs	.	.	.	.	.
17. Physical health and fitness	.	.	.	.	.
18. Getting accommodation after release	.	.	.	.	.
19. Getting the accommodation you really want	.	.	.	.	.
20. Managing your money	.	.	.	.	.

SCORES

	Date	Flat	Classed
Date 1			
Date 2			
Date 3			

SECTION C: PREVIOUS TREATMENT OR SUPPORT

Provider	Name of provider	Code	When 1st Contact (d/m/y)	Length of Contact months)	Type of support	Code	Outcome(inc.attendance, compliance&effectiveness
GP or other prescriber	No doctor				Lost contact		GP retired wants new one
Hospital							
Needle Exchange	Merchant 's Quay		11/1/02	3 months	Counsel-or, needle exchange		Useful stopped attending
Mental Health							
Counsellin g							
Probation	Crumlin PWS		12/2/01	12 months	Probation Order		Breached for non-attendance. Warrant issued
SocialWork							
Community Agency	Bob Kelly CWO				On and off		Found him very helpful
Residential Rehab							
Previous sentence	Mountjoy 6 months		12/3/02		Cleaner		No real release planning
Peer support	Gym in Mountjoy		12/3/02				Mixed with positive prisoners
Self help							
Help line							
Other (Specify)							

Client wishes to continue contact with service providers: In prison **Y**/N On release **Y**/N

D: PRIORITY OF IDENTIFIED NEED

	code		code
Need identified		**Action agreed with client**	
Problem drug use		Willing to attend 1:1 counselling and group work	
Worries about health and drug use		Willing to see nurse	
Wants reading, writing and vocational assistance		Wants to attend school or skill based workshops	

SECTION F: SHARED CARE PLAN

Date Object-ive set	Objective and Timescale	Code	How will progress be measured	Work to be done to achieve objective	Code	Referred to	Code	Name of prison worker	Outcome	Code	Comment: Reasons achieved or not
10/2/04	Reduce level of drug use (2 months)		Self-report Attend Drug awaren-ess course	1:1 with probation officer Attend next drug awareness course		Probation Officer		John Bloggs	✓ Attending 1:1 Completed drug awareness course 12//6/04 Applied for F5 programme in Medical Unit		
10/2/04	Improve level of reading and writing		Self-report Teacher-report Prison Officer-report	Attend literacy classes and library		Teacher with help from prison officer		Maggie Smyth and Kevin O'Toole	Improvement. Can read newspaper. Applying for Junior Cert in English ✓		
10/2/04	Improve thinking about health matters		Self-report and nurse	Attend 1:1 with nurse. Attend health education course.		Nurse		Pat Murphy	Attended 1:1 sessions. Received leaflets ✓		No health education course as yet. ❖ Medical Flag Contact surgery prior to release

Objectives should be SMART (Specific, Measurable, Achievable, Realistic and Time bound)

Name of Client	John Smyth	Signature	Date
Name of Key Worker	John Bloggs	Signature	Date
Name of Governor	Martin Mullen	Signature	Date

SECTION G: TRANSITIONAL CARE PLAN

Date Object-ive set	Objective and Timescale	Code	How will progress be measured	Work to be done to achieve objective	Code	Referred to	Code	Name of prison worker	Outcome	Code	Comment: Reasons achieved or not
4/5/04	Obtain medical card, GP and link with CWO		Confirmation from CWO	Completion of relevant forms. Obtain Ps number		Sam Smullen CWO, Parnell Road, Dublin 12		Kevin O'Toole Prison Officer	✓ Medical card ✓ GP Dr Reade ✓ Email link to CWO		All achieved
4/5/04	Obtain a prison visit and waiting list place at Addiction Response Crumlin		Waiting list place Prison visit Verification when top of the list	Referral to ARC ARC assessment ARC acceptance		Susan Collins ARC		Fay Dodd Probation Officer	✓ ARC assessment 20th on waiting list on 1/5/04		Estimated 7 week wait to top of the list. Tri-weekly accupuncure available in the interim
4/5/04	Employ-ment/ Training Assessmen-t		Obtain interview first week of release	Letter to Anne Smyth outlining progress to date		Anne Smyth Employment Officer Crumlin		Magggie Smyth Teacher	✓ First progress report with basic cv sent to Anne 1/5/04		Confirmation letter received ❖ Medical Flag Contact surgery prior to release

Objectives should be SMART (Specific, Measurable, Achievable, Realistic and Time bound)
(Tick objective when it has been thoroughly verified for Operations Directorate)

Name of Client John Smyth Signature Date 10/5/04

Name of Key Worker John Bloggs Signature Date 10/5/04

Name of Governor Martin Mullen Signature Date 10/2/04

A PSYCHO – BIO - SOCIAL - CULTURAL DRUG TREATMENT CASE MANAGEMENT SYSTEM