



MAKING THE NET WORK INSIDE/OUT

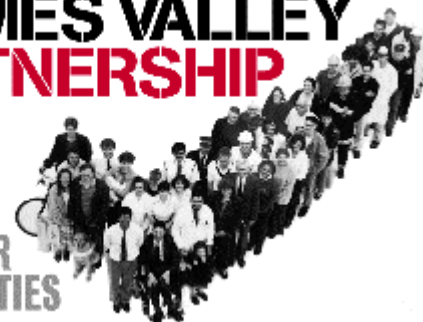
**A seminar for Community
and Prison Service
Practitioners and Managers
who work with Mentally
Disordered Offenders**

**Report of a seminar held at
Her Majesty's Prison Bullingdon
on 10th December 2001**

By the Thames Valley Partnership

**THAMES VALLEY
PARTNERSHIP**

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“Making the Net Work Inside/Out”

An Introduction

*Elizabeth Wincott, Chair “Making the Net Work Inside/Out”
and Trustee of the Thames Valley Partnership*

“*Making the Net Work Inside/Out*” grew out of the Thames Valley Partnership’s research and publication “*Diversions and Networks*” which recognised the importance of collaboration across the whole sector of organisations offering services to mentally disordered offenders. This was the second event the Thames Valley Partnership has hosted - the first (“*Making the Net Work*”) was held earlier in the year in a community setting. At that seminar the importance of sharing areas of common interest with the prison service was underlined – hence this event.

Recent surveys have shown that 90% of people entering prison have mental health and/or substance misuse problems. This has huge implications for the prison staff and not just those involved in health care. There are many challenges, one being for example, the finding of appropriate hospital places for those whom it is considered appropriate to transfer out of the prison.

There are particular challenges resettling offenders with mental health problems. There are sometimes real difficulties linking people into support networks in the community on release. There are particular difficulties in supporting prisoners to resettle who have both mental health problems and multiple needs including substance abuse ones, whose problems may exclude them from many existing services.

Prisoners with mental health problems and multiple needs, will probably need help with finding appropriate accommodation on release. This group of prisoners, on entering prison, already have high levels of poor accommodation with 29% in insecure tenancies and 15% with no fixed abode. During a prison sentence the situation deteriorates further and a person with mental health problems entering prison with a secure tenancy has a 40% chance of having lost that tenancy by time of release. There is a severe lack of housing stock available for this group. (*Where Do They Go? – Mental Health, Housing and Leaving Prison’ - Revolving Doors Agency Jan 2002*).

It is acknowledged that many prisoners have a personality disorder – and some are now defined as having a “Dangerous and Severe Personality Disorder”. We watch with interest the development of “pilot” sites in Prison and Health settings for assessment and treatment of people in this category, and future legislative changes.

The changes in health provision within the prison service make it even more important to share good practice and information. There is an increasing awareness too, of the need to train all prison staff, not just those involved in health care, in mental health issues.

But there is already a lot of knowledge and experience within the prison service which is worth broadcasting, both within the prison service itself and also out to colleagues and agencies in the community. Sharing good practice as well as areas of mutual concern was one of the aims of the event.

It is fitting that this event was held on Human Rights Day.

Elizabeth Wincott

Chair of “Making the Net Work Inside/Out” and Trustee of the Thames Valley Partnership

Acknowledgements

“Making the Net Work Inside/Out” was run in conjunction with the Prison Service Health Task force and we are grateful to David Sheehan from the Task Force and the staff and Governor at Her Majesty’s Prison Bullingdon for providing the venue. Speakers and delegates were present from a wide range of organisations offering services to mentally disordered offenders both in prison establishments and in the community.

Discussion – How Can People With Mental Health Problems be Helped and Harmed While in Prison?

The event started by discussing in small groups the above questions. These are some of the conclusions:

“How can people with mental health problems be helped while in prison?”

- Possible diagnosis and assessment
- Management of medication
- Mental health promotion
- Focused services
- Links and involvement with the NHS which they can build on
- Observation – behaviour
- Structure e.g. regular meals
- Family links
- Action plan for release
- Plan for detention
- Stop drug misuse
- Time out to think, improve
- Spot changing needs
- In-reach work
- On-going assessment
- Links to other agencies
- Individual empowered to take responsibility

“How can people with mental health problems be harmed while in prison?”

- Getting ignored because their mental health problems are not sufficiently obvious
- Huge turnover and lack of resources
- The prison cannot deal with long-term or entrenched problems
- Double stigma when they come out as ex-prisoner and someone with a mental health problem
- Start or continue drug misuse
- No assessment
- Isolation from supportive networks
- Bullying, violence
- Break in other treatment
- Criminal record – affect rest of life
- Develop a Mental Health problem in prison
- Access to skilled help limited
- Assessed by no intervention – raises expectations
- Ineffective help
- Staff shortages = stress for prisoners too
- Passive prisoners
- Sharing information across/within departments prisons
- Lack of continuity of staff
- Deportation

“Bringing About Change – A Critical Analysis of the New Mental Health Strategy in Prisons”

David Sheehan, Prison Service Health Task Force

We need to Change the outlook of mental health services in prisons

- Promoting mental health issues in prisons – recognised as a place where stress can increase illness
- The importance of Primary Care through Care Management Plans needs to be elevated, including access to specialist treatment for psychosis and chronic disease. Reception screening is very important in this respect
- Developing wing-based services with Care Management Plans – HMYOI Moorland have a “crisis card” that prisoners can use with staff when they are in difficulty to get help
- Improving Day Care services
- In-patient services – the need should be much less when strategy restructures the service
- Throughcare plans are critical, linking with evidence based practice in the community
- Juveniles and young prisoners need to have particular programmes developed– 95% morbidity including MH, substance misuse and personality disorders
- Responding also to ethnic minority needs will be a challenge
- The issue of dual diagnosis will be central because of the multi-faceted damage of many inside

50% of the £90million spent on prison health services is currently focused on mental health

Contentious issues

- There is an over reliance on expensive reports by psychiatrists etc
- Health Needs assessments have not been very effectively carried out yet
- Through-care plans need development, including the needs of the prisoner, continuation of medication, maintenance after release, sharing information with medics outside

- Transfer of prisoners into NHS services – delays mean a need for advice on how to manage prisoners
- Access to effective treatment – evidence based treatments, access to information about treatment beyond the medical model usually seen
- Suicide prevention – most suicides happen in early stages of detention
- Some prisoners have special needs, e.g. learning difficulties, sexual orientation etc which we need to learn how to address
- Dual diagnosis

Challenges

- Finding staff when the health sector is already short of trained staff
- There will be issues of integration and culture difference
- Funding will continue to be a concern
- Information – transfer, sharing, access to knowledge, keeping up to date

Questions/Comments to David Sheehan

- What about the involvement of service users? They can be involved in listening services. The new services need a much wider range of people to be involved and to draw on lots of disciplines etc
- Don't forget the involvement of approved social workers and the community mental health teams
- Resources – the new money is going into the areas of highest risk. The rest of the resources will need to come from a reconfiguration of existing services

Preparing and Supporting Staff who Manage Prisoners who Persistently Self-Harm

Jim Begley and Cathy Searl, HMYOI Aylesbury

Changing the culture from one of self-harm to one of safety

Issues in Aylesbury

- Fear of suicide – there had been four hangings in a short time
- Governors and Principal Officers were admitting prisoners into the Health Care Centre
- Prisoners wanting a safe environment away from the wings would commit self-harm to get admitted and stay in
- Health Care Centre was full all the time with little outreach work possible from its staff
- 50% shortage of staff available through stress etc

Action Taken

- Moved prisoners out of HCC and reduced frequency of occupation
- Started outreach team for the wings
- Stopped Governors and Principal Officers admitting into the HCC – started an assessment process
- Challenged bad behaviour and staff refusal to take on the problems. Self-harmers were supported to clean their own wounds for instance.
- Work was done with prison discipline staff, the first line of support for prisoners
- Helped people not to fear self harm – those involved need support and help
- Support from the Maudsley Hospital for further learning to challenge self-harmers
- Challenge the use of medication, psychotropes particularly were reduced saving £400 a month off the bills!
- Team recognised as having a wider involvement in the whole prison with probation, prison and instructors having a role.

Questions/Comments to staff from HMYOI Aylesbury

- Need to make links locally on release, to community mental health teams
- The importance of housing on release – and the difficulty of getting appointments etc
- The need to support staff who are supporting self-harming prisoners – stress and burnout

“Managing Offenders with Dual Diagnosis”

*Trevor Laverick, Health Care Officer, Bullingdon,
Fiona Hudson, Prison Service Area Detox Sister,
Heather Palmer, Manager Counselling, Assessment, Referral,
Advice and Treatment Services (CARATS) team*

- There are huge substance misuse issues in prisons and the introduction of CARATS has enabled much more expertise to be available in prisons
- There are significant definitional issues, not least distinguishing in mental health terms between cause and effect in relation to mental health and drugs, and this makes good assessment crucial
- In Bullingdon there may be the option of inpatient or outpatient working
- Liaison and sharing of information between CARAT Team/Health workers and other prison staff is crucial and the input of Wing staff is very important, particularly in respect of stress levels/depression and anxiety and the problems of “first-timers”. Wing staff also need to be aware of the dangerous problem of “smiling depression”. Prison conditions may well increase symptoms
- Prison does offer some good opportunities to liase and pull different perspectives together
- The role of Reception staff in prison is extremely important in early identification of need
- In Bullingdon the CARATS team had prioritised remand and short sentence prisoners given issues of their faster turnover, frequent crises and tendency to be marginalised
- Recent needs analysis between May and June 2001 revealed that 75% of remanded prisoners reported histories of alcohol abuse and mental health problems in some form. High numbers were also of No Fixed Abode. 48% of drug users reported serious housing problems or were NFA. The presenters commented on the need for better Throughcare and the need for more housing options than presently exist
- The presenters spoke of the difficulty in making and maintaining good working links with Community Mental Health Teams
- Similarly there was reluctance by outside drugs agencies to pick up and work with dual diagnosis cases. Rehabilitation options for dual diagnosis cases were also limited

Working Together

Giles Hobbs, Revolving Doors Agency and John Steele, Governor, HMP Woodhill

The Revolving Doors Agency was set up to improve services to people with mental health problems who are in contact with the Criminal Justice System. Many of these people have multiple needs and complex problems. They have tended in the past to be labelled “personality disordered”. The Revolving Doors Link Worker Schemes in London and Thames Valley identified a need to develop new work in prisons.

Why?

- Prisoners were serving short sentences (less than 12 months) or on remand
- Sub Clinical Client group (client group that is not sufficiently ‘mentally ill’ to receive clinical input from Community Mental Health Team and Hospital).
- Released without access to support
- Deteriorating in community life

Preparation

- Shared vision and goals
- Careful early joint planning
- Continued involvement (Local Advisory Group consisting of local partner agencies such as housing, police, etc who meet at three monthly intervals)
- Information sharing agreements

Woodhill Prison is a local prison in Milton Keynes. Despite having a health care centre, it was previously only giving a service to those with the most severe mental health problems. There continued to be recruitment problems. Previously there was nothing for short stay prisoners, a lack of information and a tendency to lose those with mental health problems within the general population.

A new health care manager and a nurse post were set up alongside the work of the Revolving Doors Agency which gives support on the wing, training to prison officers and has an office on the wing. The aim was to integrate the work of the Revolving Doors Agency with Prison Service staff. They negotiated their way in and have been very much welcomed by prison staff.

What helped?

- Immediate training
- Access to keys (freedom to move around)
- Office space
- Access to the Local Inmate Data System (LIDS)
- Flexibility of prison officers to attend training
- Continued interest in the scheme

Revolving Doors Staff have to be

- Flexible
- Understanding
- Fast learners
- Persistent

Revolving Doors offers practical support. The agency links with the Prison Service database to identify all people from the South Bucks area but they can offer some service to all. The main problem is in trying to follow everybody up and to link them back to services in their own area.

Frustrations

- Mobility of prison population
- Difficulties of planning with remand prisoners
- Continued engagement on release
- Housing procedures

Revolving Doors is committed to assertive outreach but there is a problem with follow-up and it is very difficult to keep in touch particularly over a wide area. A new drop-in centre and links with the Drug Services in Wycombe are positive opportunities and the agency is hoping to link more with Bullingdon Prison in the future.

“Keeping Connected Inside and Out”

*Tania Osborne, Health Care Manager, HM Young Offender Institution
& Remand Centre Reading*

Tania Osborne joined Reading as Healthcare Manager 18 months ago. She came into the job from a general nursing background.

Reading Young Offender Institution and Remand Centre looks after 260 18-21year old men. About 120-140 are received new each month and the establishment is therefore discharging approximately the same number into the community or onto other prisons. About a fifth go to other prisons and about 100 prisoners each month are bailed from court or released on licence. The catchment area of the YOI & RC is over six counties.

A third of the population each week attend court as remand prisoners, and all of these need mental health assessments.

At the moment there is healthcare cover in the establishment from 7.30 am until 9pm and there is an on call GP services.

Of all these prisoners about 90% have used drugs. It is estimated 80% used recreational drugs before coming in.

Luckily only approximately six to eight prisoners per year come in requiring sectioning under the mental health act for either treatment or assessment

There are currently about ten prisoners currently prescribed with psychotropic or mood altering drugs to maintain stability.

The prison detoxes approximately 200 a year.

What is wanted?

A complete and effective multidisciplinary approach to the care of mentally disordered offenders in line with the national service framework.

Today's Situation

- Good networking within the prison
- Approved Social Worker visits regularly
- Good links with Reading's "Divert" scheme
- Care Planning Approach for those who require it
- A need for two psychiatrists identified – which will hopefully be met in the new year
- A good skill mix of staff
- Research project
- A good Governor!

Summary

Health Care staff have surprised themselves with the treasures to be found within the prison particularly through linking in with established routes of contact i.e. Sentence Planning and Release on Temporary Licence boards.

Reading has struggled with Community Psychiatric Nurse visits because of the distance but found phone calls are effective. There is also an excellent forensic social worker who provides community contacts and assessment.

There are good links with DIVERT and the establishment regularly gets background information on prisoners and continuing contact when required.

Health Care staff do implement the Care Planning Approach for those who are ill and are expected to be released. But GP involvement remains limited at times.

How did the prison get there?

- A concise needs assessment – which was clear about the specifics needed. It is important to focus on the needs not the restrictions of the environment
- A driver – an excellent projects manager. “Frequently I felt that this was a beautiful car with an excellent driver but that we were going to struggle to find enough petrol”
- Accountability – making people accountable both inside and out for this agreement so that if timescales are not met or the services not provided, someone either has to resume the service or be billed
- Recruitment – effective recruitment within the prison service and outside. This could link in with nursing service managers in the hospitals and trusts to consider recruiting more laterally
- Utilising existing services

Further Work

- More communication with the police – there is a police liaison officer but communication still needs improving
- Further involvement with the overall planning – Healthcare Staff need to fine tune their involvement in discharge planning
- Voluntary and community facilities – Healthcare Staff would like to make better contacts with the community voluntary services
- Implement recommendations from current research findings

Lessons Learnt

- Link in with other good practices as they develop
- Don't get bogged down with financial issues – it will all come out in the wash! Start small if resources are scarce
- Be patient/ be positive – be patient after the third or fourth rearrangement of the community services has happened. Be positive – believe that things will improve and the people around you will be motivated and want to be part of it sometimes – that is enough to get things started

“The Future Management and Treatment of People with Serious Personality Disorder”

Dr Mark Morris, Director of Therapy, HMP Grendon

The Historical Context

- The review of the Mental Health Act
- Problems with the Special Hospital Personality Disorder Units
- The Personality Disorder Treatment “lottery”

1996 – 98: Scoping of possible changes to existing arrangements

- Increasing public concern about safety
- The Stone case
- J Straw’s public admonishment of psychiatry

1999: White paper proposing a “third service”

- 2200 people identified using Office of National Statistics and risk profiles based on Hare factors
- 200 in the community, others in institutions
- Options of remaining within existing structure or a new independent service
- Need for primary legislation – part 2 of the Mental Health Act

2000: Distinguishing Between Assessment and Treatment

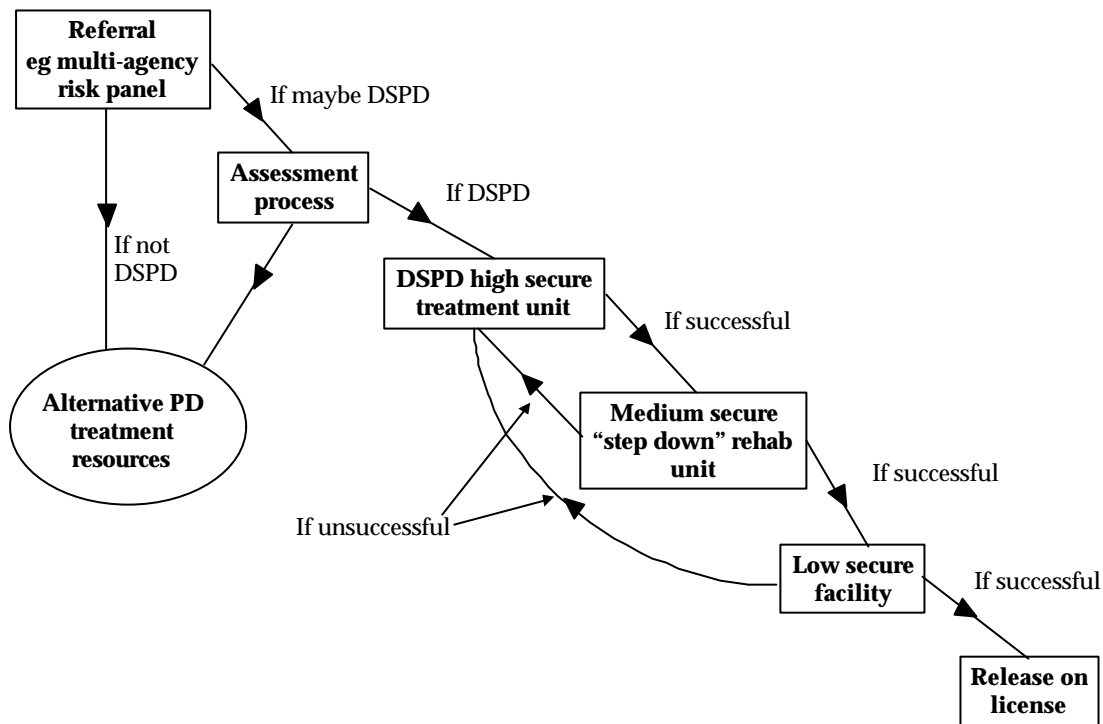
- Development of assessment tools by Thornton, Coid et al
- Development of a definition of Dangerous and Serious Personality Disorder (DSPD)
- Identification of Dialectical Behaviour Therapy (DBT) as possible treatment option
- Pressing need for legitimate treatment option because of the European Court of Human Rights (ECHR)

2001: Development of “pilot” sites in Prison and Health settings, leaving question posed in white paper till later

- Whitemoor “red spur” assessment pilot ran for 6 months
- Whitemoor treatment pilot due to open this month – both based on volunteers
- Rampton assessment and treatment site being built
- Frankland and Broadmoor identified as second set of pilot sites, now in preparation

The Legislation

- Proposed civil detention under new mental health act
- Detention decided by tribunal and progress of treatment decided in the same way
- Patients (sic) will have the same appeal rights as other detained mental health patients
- Crucial aspect of detention for treatment
- Question of whether treatment can take place in prison settings



The Pilots

- Current patients are volunteers – those who want treatment
- Likely to be more borderline
- Post legislation DSPD will be more refractory
- Evidence base for DBT is dubious. Some evidence it is effective with suicidal American women
- Health as a base

Definitions and Controversies

Defining DSPD

Need to have

1. **High Risk** – identified by a battery of actuarial psychological tests including Hare Psychopathy checklist and violent risk assessment guide
2. An antisocial or psychopathic personality; or other combination of **personality disorders** – also empirically determined

3. A **link between the two**, the personality disorder and the risk will be the subject of clinical conjecture, and the adversarial issue for the barristers

This solves the civil liberties riddle of incarceration without an offending history

Questions to Dr Morris

Question: Staffing – what kinds of staff do we envisage working in the pilots?

Response: multi-disciplinary. There is a real problem within health about recruitment and retention however. 10% Consultant Psychiatrist posts are vacant now. They are looking to site pilots where there is a lot of existing enthusiasm

Comment: What happens at the end of the Assessment period if “treatment is not available”?

Response: It is not legitimate to force treatment on people who do not want it. There may be a division between those who want treatment and those who are “parked” in a service.

It is arguable that being in prison for a chaotic cocaine addiction for example, is a form of treatment i.e. the prevention of deterioration. A number of people have challenged being held under the Mental Health Act on the grounds that they are not being treated but have not won their cases.

Comment: There are serious issues for prisoners being released to normal prison accommodation from assessment (and treatment) in special wings. If they return without careful preparation to wings where staff do not have the same time to listen and talk to them their frustration can lead to violence.

Question: Will there be Compulsory Reviews?

Response: Yes, they will be sectioned under the Mental Health Act which has a built in review process

Comment: Will there be a knock-on effect on the lower end? There is no consistency now in the way CMHTs work with people with personality disorders.

Response: In the mid 90s psychiatrists were not allowed to work with personality disorder. Their involvement was to remove them from the CMHTs workload! The National Service Framework for Mental Health does not have much about Personality Disorder. There is not a lot of existing expertise. There is due to be an annex to the National Service Framework on Personality Disorder coming out. I think work on PD will become Mainstream.

My understanding is that the phenomenon of exclusion of personality disorder from psychiatry on the basis of “untreatability” is relatively modern, within the last 50 years. Psychosis and depression a few years ago were “untreatable”. When psychotropic medications were invented in the 1950s and 1960s suddenly psychosis as a medical discipline came about. Personality disorder does not fit into that definition. Treatment for PD does exist however, but it is costly.

Comment: If we don't define an illness as pathological other “treatment” can be brought in i.e. education. One of the critical arguments that could be made about the cognitive programmes is that it narrows the approach down and you close more “holistic” treatments like work, education etc. There is a range of treatments that can help.

Comment: This turns on its head the “treatability” label and can be help when thinking about those with multiple problems

Comment: People may become less honest - if you get this diagnosis you have it for life. People are already reluctant to seek help for mental health problems. Also there is a risk that everything wrong with someone can be put down to their “personality disorder”. GPs need to be part of the understanding.

Themes/Messages From The Day

- Early intervention is vital – beginning with children
- Information needs to follow or accompany the prisoner so they don't have to keep having to repeat it to everyone they meet
- There is lots of experience of good practice in working with offenders with mental health problems and some good experience of staff inside and outside prisons working together
- There is still an enormous problem with staff recruitment both inside and outside prisons
- It is vital staff are supported in the work they do
- There is a demand among prison officers for training in the management of prisoners with mental disorders
- Prison officers need to be encouraged to put their personality into their work, but there is a reluctance still by many to be seen as “Care Bears”
- Health care in prisons is being boosted by a good many RMNs now in post and a willingness of staff to learn
- People in different agencies need to know what is going on elsewhere. There are often low expectations about what others can achieve
- There is recognition that prison can be a very damaging experience yet prison can also be a life saver
- Enough resources need to be present in the community to keep people out of custody wherever possible
- We should seize the opportunity to help people in prisons with mental health problems
- There need to be good links between community services and the prisons. Prisoners otherwise get lost when they leave
- The Probation Service is no longer a general means of support for short-term prisoners on release, who don't receive statutory aftercare
- Recent research on about 1 million users of mental health services (Reading University) shows there is a core group of 2000 who go round and round services

- Lots of families of people with mental health problems need help and respite but their needs are often ignored
- We need a more holistic approach which is a challenge as broadening the approach may lead to a reduction in funding streams
- There are many people with learning disabilities who get in trouble with the law but who may just miss the official definition of having a LD because they have an IQ of over 69
- Services are often service led – not needs led
- Services that exist are very diverse. When we commission services that are not joined up complex cases will not necessarily fit. “We make life very difficult for ourselves”
- “Making the Net Work (Inside/Out)” was described by a delegate as an “uplifting” day. It would not have been so, it was suggested, if it had happened 18 months ago. People have been talking for a long time about lack of resources, but it is clear now that people are grabbing at resources where they exist and being imaginative where they don’t.

Making The Network Inside/Out Delegates List

Mr Ken Adams, Berkshire Divert Scheme, Reading

Ms Brenda Ball, Resettlement Manager, Aylesbury Young Offenders Institution, Aylesbury

Mr Andrew Bates, Principal Forensic Psychologist, National Probation Service: Thames Valley Area, Didcot

Ms Sarah Beech, Revolving Doors Agency

Mr Jim Begley, Health Care Manager, HMYOI Aylesbury

Ms Emma Bradley, Area Health Care Co-ordinator, HM Prison Service – Thames Valley, Hampshire & IOW, Aylesbury

Mr David Cooper, Slough Community Mental Health Team, Slough

Ms Naomi Evans, Support Worker, The Elmore Team, Oxford

Mr Charles Fitzpatrick, Forensic ASW, Slough Community Mental Health Team, Slough

Mrs Sam Gee, Secretary, Thames Valley Partnership

Mr Norrie Greer, Assistant Manager, Newbury Community Mental Health Team, Newbury

Mr John Hedge, Senior Probation Officer, National Probation Service: Thames Valley Area, Oxford

Ms Rajay Herkanaidu, Forensic CPN, Slough Community Mental Health Team, Slough

Mr Giles Hobbes, Revolving Doors Agency

Ms Jean Hodgson, Social Worker/ASW Trainee, Reading Community Mental Health Team, Reading

Inspector Mark Hogarth, Custody at Oxford, Thames Valley Police, Oxford

Ms Kay Howard, Divert Scheme Co-ordinator, Berkshire Divert Scheme, Reading

Ms Fiona Hudson, Area Detox Sister, HM Prison Service, Aylesbury

Ms Kay Isaacs, Liaison Mental Health Nurse, Buckinghamshire Mental Health NHS Trust, High Wycombe

Mr Iain Jamieson, CARAT Manager, Cranstoun Drug Services, Wantage

Ms Jan Keene, Prof. Primary Care, University of Reading, Reading

Ms Beate Kubitz, Head of Training & Communications, Mental Health Media, London

Mr Trevor Laverick, HCO, HMP Bullingdon, Bicester

Ms Lisa Maclean, Nurse Consultant, HMP Woodhill, Milton Keynes

Ms Diane Maguire, CPN Alternative to Admission - Oxford Mental Health Trust, Oxford

Ms Siri Moorby, Community Safety Director, Thames Valley Partnership

Dr Mark Morris, Director of Therapy, HMP Grendon/Springhill, Aylesbury

Mr Tim Newell, Restorative Justice in Prisons Project, Thames Valley Partnership

Mr Jon Olsen, Social Worker, West Berkshire Social Services, Newbury

Ms Tania Osbourne, Health Care Centre, Reading YOI & Remand Centre, Reading

Ms Anne Packman, ASW/Senior Practitioner, Social Services, Headington

Ms Heather Palmer, CARATS Manager, HMP Bullingdon, Bicester

Dr Sam Ragheb, Health Care Centre, HMP Bullingdon, Bicester

Ms Sue Raikes, Chief Executive, Thames Valley Partnership

Ms Fiona Reed, Social Worker – ASW, Newbury Community Mental Health Team, Newbury

Ms Trudy Robertson, Community Forensic Liaison Nurse, Marlborough House RSU Buckinghamshire NHS Mental Health Trust, Milton Keynes

Ms Ethel Samkrange, Revolving Doors Agency

Ms Cathy Searl, HMYOI Aylesbury

Mr Luke Serjeant, Governor, HMP Bullingdon, Bicester

Ms Rosemary Shaylor, Service Development Manager – Mental Health, Berkshire Health Authority, Reading

Mr David Sheehan, Prison Health Development Manager, NHS Executive, South East

Mr Richard Shircore, Community Safety Director (Health), Thames Valley Partnership

Ms Jayne Sparrow, CPN Alternative to Admission, Oxford Mental Health Trust, Oxford

Ms Patricia Taylor, Student Psychiatric Nurse, University of Luton, Stratton Audley

Ms Fiona Titcomb, Trainee Probation Officer, Jonathan Rowlands National Probation Service – Thames Valley, Bracknell

Ms Barbara Treen, Community Safety Director, Thames Valley Partnership

Ms Elizabeth Wincott, Oxford

