REPORT FROM THE FORENSIC & CHALLENGING BEHAVIOUR PRODUCT REVIEW SUB GROUP

September 2011

Executive summary

This report has been produced by the Forensic PRG Sub Group for the National MH Produce Review Group (PRG) and PbR Project Board. The group was challenged with making recommendations for a currency model for Forensic services that is fit for purpose and as far as possible links and builds onto the existing model for Working Aged Adults and Older Peoples services.

Key considerations for the group were to ensure the model had practitioner and service user face validity and utility, encouraged the correct incentives and outcomes whilst supporting ease of transition with other key areas of service provision.

The initial work undertaken has utilised two key streams of work and has produced a set of recommendations that the group believe are both achievable and appropriate in order to establish a currency model that will enhance commissioning, improve transparency and enhance quality and outcomes.

The group is especially grateful for the work of Dr Adrian Berry in the production of this report.

Ged McCann and Carole Green
Joint Chairs

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1.0 Introduction

This report summarises the work undertaken by the Forensic and Challenging Behaviour Product Review Sub Group over the past twelve months. It builds upon two strands of work previously undertaken, the first being the development of a clinically derived set of descriptors piloted by a group of London Medium Secure Units and the second being a modification of the Mental Health Clustering Tool (MHCT) and the 21 Clusters mandated for use in Working Aged Adult and Older Peoples services, piloted by two Trusts in the North East of England.

2.0 Method

The two approaches both aim to assess individuals within forensic services and allocate them to distinct groups which relate both to clinical needs and likely resource requirements. The theoretical underpinning of the two methods is however quite different. The MHCT has been developed within general psychiatry settings and used a clinical assessment tool to assign patients to one of 20 clusters based principally on current symptoms and psychosocial functioning. This tool and the clusters have been amended to reflect the forensic population considered within this initial project work.

A multi-disciplinary group of forensic practitioners used the MHCT and 20 clusters as their starting point, as recommended by the Product Review Group (PRG). They observed that the existing model had gaps or omissions in relation to risk profiles and personality disorders and that the existing clusters did not fully represent all of the presentations seen in forensic settings. To respond to this they produced some additional items for the assessment tool using the same 5 point scale and in a similar way provided descriptions of two additional clusters. The revised tool and clusters were then tested within the two services involved in this pilot work

The approach, developed by a group of London forensic services, is based on both clinical presentation, which is reflected in HoNOS clinical scales, and a range of non clinical factors which are specifically relevant to forensic in patient treatment. Factors of crucial importance relate to the predicted risks which together with clinical care needs influence resource requirements. The first factor relates to the seriousness of recent offending. The second factor examines historical risk factors which are the most evidence based predictor of future violence. This is currently captured by the HCR 20 standardised risk assessment tool which is widely used in forensic services and mandated nationally by the current contract. The Mental Health Act status particularly with reference to Ministry of Justice restrictions forms the third significant non clinical factor. Full details of the clinical descriptors and rationale for the inclusion of the factors are included in Appendix 3.

2.1 Phase 1

The first phase of the current project took place in the autumn of 2010 and involved two separate stands. Both of these involved the assessment of a cross-section of patients within forensic care settings.

The first project involved the use of the London model to assign 200 inpatients in three geographically diverse Medium Secure Services to one of the five clinically derived

pathway groups. Details of this project are included in Appendix 6. Simultaneously two Trusts in the North East of England allocated over 250 patients in the Forensic Service to one of the clusters derived from a modified Mental Health Clustering Tool. This tool had additional clinical indicators and two new clusters in order to try to more accurately reflect the forensic patient population. The sample in this project included patients in medium and low security plus a number of community patients. Details of the study are included in Appendix 5. The sites in the North East included service users in low secure and Learning Disability settings but those using the London clinical descriptor model did not.

Both studies yielded information with regard to the ease of use of the two assessment methods together with a clinical perception of how relevant the allocation process was and the "goodness of fit" of the chosen allocation group. Both studies also collected data to examine differences between the allocated groups.

The first study used results from the HCR20 risk assessment and HoNOS secure together with information regarding offending history, Mental Health Act status and a number of other factors. The second project used results from the modified MHCT and also examined use of medication and psychological treatments within the groups and length of time that patients were in contact with services. Both projects then examined the distribution of allocated groups within the sample populations. The results of both projects were presented to the sub group on 27 January 2011. Both projects described that the process of assessment and allocation had been relatively straight forward with a very high level of successful allocation. It was noted that in the modified MHCT model this high level of allocation was only possible in patients suffering from mental illness or personality disorder and did not allow high rates of allocation within the learning disability group, though it is acknowledged that this may be addressed when the non-forensic learning disability clusters are developed. Both projects also reported some evidence supporting the validity of the cluster groups but it was accepted that the overall numbers in the study were insufficient to allow robust, statistical validation.

Further information was also presented in terms of length of stay analysis from two medium secure units, one using a cross-sectional inpatient survey and the other a discharge cohort which suggested that the lengths of stay of five clinically derived descriptors from the original London based project were in keeping with the differences between the groups which would be predicted.

Following a review of the evidence presented it was agreed that both models had potential benefits and may be mutually supportive taking into account their different constructs. It was therefore agreed that a further pilot project would be undertaken which would include the use of both approaches on a new cohort of patients across multiple sites. For the sake of clarity it was also agreed that the term cluster would be used solely to describe allocation within the modified MHCT and that Five Forensic Pathways (5FP), annotated with roman numerals, would describe the allocation to the clinically based descriptor model.

2.2 Phase 2

Seven sites were chosen, all assessing patients within conditions of medium security and excluding patients suffering from predominantly learning disability. Five of the sites had previously used the 5FP Model and the other two sites had used the modified

MHCT. The project involved the allocation of approximately 15 patients in each service to both a MHCT cluster and a forensic pathway. There were three specific areas of interest within this project which were to be examined:

    i. The first related to the resources needed to undertake each approach and the ease and speed of allocation.

   ii. The second area related to the "goodness of fit" from a clinical perspective and in particular areas of difficulty or disagreement in assigning cases was noted.

  iii. The third area of interest was the correlation between the results of each allocation method.

The principal evaluation criteria used were:

1. Percentage of patients within the sample group who were allocated to a cluster and pathway and the relative ease of use of each approach.

2. The view of clinical teams as to the consistency with which patients fitted the cluster descriptions and whether there were specific discrepancies or the need for "forced allocation".

3. The patterns of association between the results of the two models.

3.0 Results

The qualitative feedback from the seven sites was relatively consistent and showed that both allocation methods were generally quick and easy to use. It was noted that the MHCT approach required more initial training and the assessment and allocation process took slightly longer than that for the 5FP Model. However, it was noted that the 5FP Model required a clinician or clinical team to have a thorough and detailed knowledge of the case prior to allocation.

Although the vast majority of cases were relatively easily assigned to a particular group there were specific areas of difficulty with each approach. It was noted that within the MHCT model the issue of comorbidity, that is the presence of more than one significant mental health issue, was hard to reflect and also that there was no account taken of specific risk factors which may have been unrelated to symptoms of mental disorder. Within the 5FP Model it was noted that the clinical descriptors were at times either too prescriptive or unclear, particularly to allow considered allocations between the two different treatment resistant groups.

The data collected from the seven sites included 117 cases. Allocation within the MHCT model was 100% and allocation to the Five Forensic Pathway was 95%. It was noted that the majority of unallocated cases occurred from one particular site with allocation rates across the remaining six sites of 98%. There were a number of concerns raised with regard to the "goodness of fit". Overall it was thought that 90% of cases were allocated without difficulty. The distribution of allocated cases by both MHCT and 5FP is shown in diagrams 1 and 2.
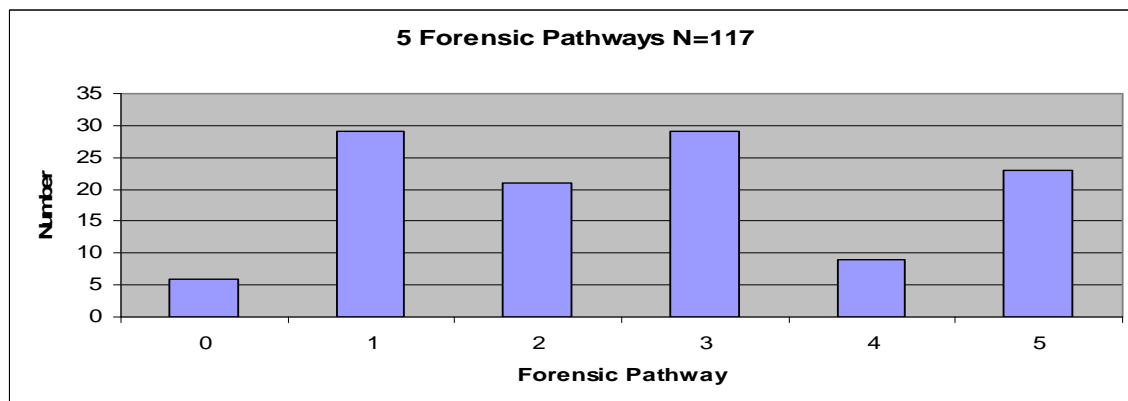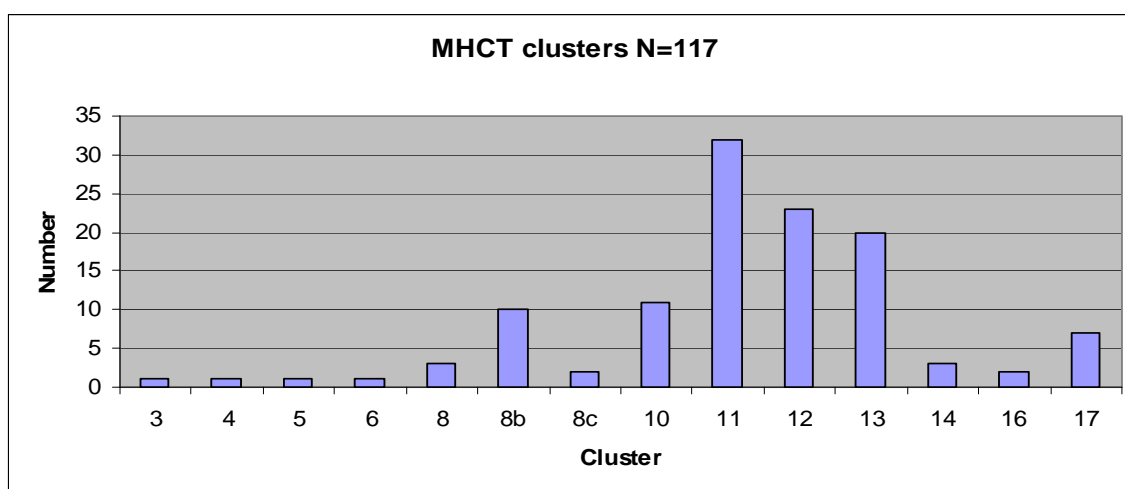
Diagram 1

5 Forensic Pathways N=117

A bar chart with vertical axis labelled "Number" ranging from 0 to 35, and horizontal axis labelled "Forensic Pathway" with categories 0 to 5.

- 0: 6
- 1: 29
- 2: 21
- 3: 29
- 4: 9
- 5: 23

Diagram 2

MHCT clusters N=117

A bar chart with vertical axis labelled "Number" ranging from 0 to 35, and horizontal axis labelled "Cluster" with categories 3, 4, 5, 6, 8, 8b, 8c, 10, 11, 12, 13, 14, 16, 17.

- 3: 1
- 4: 1
- 5: 1
- 6: 1
- 8: 3
- 8b: 10
- 8c: 2
- 10: 11
- 11: 32
- 12: 23
- 13: 20
- 14: 3
- 16: 2
- 17: 7

The distribution of allocated pathways and clusters was compared with the data previously collected and it was evident that, as expected, there were differences between the cross sectional survey of service users, as was the case in the two first phase projects, and the admission cohort examined in the current study. In particular cases expected to have short term admissions were more common in the admission cohort and cases anticipated to have a longer length of stay were over-represented in the cross-sectional study.

Examination of the association between cluster and pathway allocation was limited due to the relatively low sample size but was nonetheless informative. Cases allocated to Pathway I, which is typified by patients who have a treatment sensitive and responsive mental illness showed that as anticipated the vast majority (75%) were allocated to a cluster describing first onset psychosis or ongoing recurrent psychosis with low symptoms (MHCT clusters 10 and 11).

By significant contrast Pathway II, which is typified by treatment resistant mental illness associated predominantly with challenging behaviour in a health care setting showed the significant majority (80%) were allocated to clusters describing ongoing and recurrent psychosis of moderate to high symptom severity or to the difficult to engage psychotic cluster (clusters 12, 13 and 17).

Pathway III which is typified by patients suffering from treatment resistant psychotic illness associated with a significant offending history showed the great majority (76%) allocated to clusters 12, 13 and 17.

Forensic Pathway IV is typified by patients suffering from Personality Disorder who presents in crisis and are generally expected to have a short length of stay once the initial crisis is managed. Cluster allocations within this group were far more diverse with significant representations from both low symptom psychotic groups (cluster 10 and 11) as well as deriving from the Personality Disorder clusters (cluster 8 and 8b).

Forensic Pathway V which is typified by patients with predominantly personality disorder who are admitted for long term treatment, also showed a spread of cluster allocations with roughly half being allocated to specific personality disorder (clusters 8, 8b and 8c) and the remainder having a range of other clusters (clusters 3, 6, 10, 11 and 17).

Because of the relatively low numbers of cases within many of the MHCT clusters there was a limited extent that these could be examined. There were however some striking comparisons. MHCT cluster 10 which describes first onset psychotic illness was predominantly allocated to forensic cluster I, those being the patients with treatment sensitive mental illness. MHCT clusters 12 and 13 which describe moderate and high symptom severity ongoing illness were predominantly allocated to pathways II and III which relate to patients with treatment resistant illnesses. MHCT cluster 8b, which was the most common personality disorder identified within the group, were allocated entirely to pathways IV and V in a ratio of 20-80% respectively.

The associations between MHCT clusters 10, 12, 13 and 8b and the respective Forensic Pathways are entirely consistent with what would be expected. The situation was very different with regard to MHCT cluster 11, this being ongoing recurrent psychotic illness with low symptom severity. This is of particular importance since this was by far the most common MHCT cluster allocated within this group (32 of the 117 allocated patients). Only half of this cluster were allocated to the treatment sensitive pathway (5FPI) with 40% of the cases being allocated to the predominantly personality disordered pathways (5FP IV and V).

4.0 Conclusions

The two allocation processes were undertaken with an admission cohort of 117 patients across seven different sites. Feedback from the sites was that both methods were relatively easy to use and there were generally few concerns with regard to the "goodness of fit". After initial training and familiarisation with the two models allocation was rapid and straight forward in the vast majority of cases but it was noted that further work with regard to the wording of the clinical descriptors in the 5FP Model would improve allocation. Early indicators suggest that there is a good relationship between clusters relating to first onset illness and a treatment sensitive pathway and similarly between clusters relating to higher symptom ongoing illness and the treatment resistant pathway. There is a marked disparity between the allocation of cases within the MHCT and pathways relating specifically to personality disorder. This is to be expected given the very varied presentation and high level of comorbidity occurring within patients with predominantly personality disorder.

5.0 Recommendations

1. The Forensic & Challenging Behaviour Sub Group recommends the adoption of the combined use of a MHCT based allocation system together with additional use of the 5 Forensic Pathway model to establish one single model for currency in forensic services.

2. Further work is required to refine and validate the currency model described above. This would include refining of the clinical descriptors in the 5FP model, exploration of the best evidence based measures to capture historical risk and validation of the revised MHCT and clusters.

3. Additional work is required to establish guidance on the content of treatment packages associated with the proposed currency groups. This can build upon work already being developed by the National Specialist Commissioning Group for Forensic services but will need to be fully aligned with the currency model.

4. It is recommended that the work already initiated by the Forensic Currency Sub Group continues to develop local tariffs to support the overall forensic currency model. This will need to link with the national MH PRG Costing sub group and to utilise the national costing standards, reference cost collection and developing methodologies to ensure consistency with tariff development for generic mental health services.

5. It is essential that further service user involvement is utilised in the development of the model and that more appropriate and accessible language is utilised. This will need to be included within the next phase of the project work and may be achieved by using existing groups and networks supporting the treatment package work.

6. As the project progresses it will become increasingly important to extend stakeholder engagement and gain feedback from a wider range of services and service users. A robust communication and engagement plan will need to be included within the next phase of the project work.

7. The key issue of transition will need to be developed to ensure that the developing currency model supports and enhances transition between forensic and other key services. It is recommended that the PRG facilitates linkages with the following PbR development groups with a remit to ensure effective transition:
   CAMH's
   Working Aged Adult
   Older People
   Prison Health Care

8. Linkages with the PRG sub group for Quality and Outcomes are also required to ensure a consistent and appropriate range of quality indicators and outcome measures are built into the currency model, and to ensure ease of collection, analysis and benchmarking.

9. A resourced project plan should be developed that supports delivery of the following key milestones, and an outline of the proposed plan is included in Appendix 2.

- o Production of the currency groups and assessment tool for wider testing - October 2011
- o Scope work required to utilise model in High and Low secure services - December 2011
- o Identify requirements and secure funding to support ongoing project delivery - December 2011
- o Identification of pilot sites to test agreed model - December 2011
- o Pilot sites commence use of tool and data collection - April 2012
- o Data collection and analysis completed - December 2012
- o ISB process for approving new data set commenced - April 2013
- o Service user engagement established - September 2011
- o Establish quality indicators and outcomes measures to support the currency model - April 2012
- o Undertake costing of currency model in line with national costing standards to support development of local tariff - December 2012
- o Establish guidance for the content of care packages for each of the cluster groups - December 2012
- o Formal report and evidence produced to recommend mandating of tools for currency for forensic services - December 2013
- o National implementation of currency model commences - April 2014

The PRG Forensic sub group recommend this report to the Product Review Group and the National MH PbR Project Board for support and endorsement.

Appendix 1 - Glossary

Determining which of the 5 forensic pathways applies to a particular individual is decided at the end of a three month assessment period.

It requires access to two forms of information:
1. Step one: consider the clinical descriptors for the 5 pathways
2. Step two: check the baseline information against the descriptors. These include:
   - HCR-20
   - MHCT
   - Section (MHA)
   - Index offence
   - Ongoing substance misuse

CLINICAL DESCRIPTORS

The pilots suggested that 95% of all patients in mainstream MSU wards could be allocated on the basis of the descriptors. The descriptors refer to the projected pathway for a particular individual.

It is important to cross reference the descriptors against the baseline information. Common mistakes include failing to take significant victim issues into account when planning the discharge of a pathway 1 patient; or believing a patient to be pathway 3 treatment resistant and not addressing significant forensic and personality issues which emerge as the patient's mental state settles.

BASELINE INFORMATION

HCR-20

It is crucial that the forensic pathways balance clinical concerns with risk assessment, as this lies at the core of MSU work. Risk assessment should have some actuarial basis and credibility within the setting; that is, it should have been validated to some extent with mentally disordered offender populations, particularly those with severe mental illness. The HCR-20 was chosen because it is already widely validated, and used within the UK. It contains both static and dynamic variables which increases its utility.

The HCR-20 only has modest predictive ability, and therefore it may be reasonable to consider other tools in specific circumstances (for example, for sex offenders or domestic violence offenders). The criminal justice tool – OGRS – probably has the most robust predictive ability, and may have a role to play in mental health settings in the future.

Items can be rated as absent (0), possibly present (1), or definitely present (2). For ease of use, a total score for the historical and the clinical scales can be computed but it **only** provides a guide.

Note: the risk items were not used for the pathways, as they only acquire relevance nearer to the point of discharge.
Note: the H7 item (psychopathy) can be omitted.

Historical items:

Research suggests that these items are the most robust in predicting future violence having left the institution. Many of the items pertain (albeit indirectly) to personality traits which are associated with impulsivity, emotional liability and antisociality.

We would suggest:
A score of below 10 is probably low
A score of 15 or above is probably high

Clinical items

The five clinical items of the HCR-20 are dynamic variables and pick up on treatability, behaviour and attitudes. A moderately elevated score could therefore either reflect a patient who is treatment resistant and unwell; or a patient who is mentally well but oppositional and hostile. Research would suggest that the clinical items are more likely to predict violence within the institution than future violence in the community. It is likely to be related to the level of nursing care and supervision needed at a point in time.

The clinical items almost certainly overlap with the MHCT 1-12 clinical items; longer term evaluation will determine their relative utility.

We would suggest that
A score of below 5 is fairly low
A score of above 5 is fairly high

MHCT 1-12 clinical items

It is not yet entirely clear how these items relate to the 5 forensic pathways. It is anticipated that scores will be high for an individual who is awaiting transfer to the MSU from prison, and for individuals in their first few weeks of admission. Following the three month assessment period, it is likely that scores will be fairly low (below 20 out of 48), and will reduce only slowly.

Section (MHA)

This item refers to the section used post-assessment. There are broadly four categories:

Section 37/41 and transferred lifers (requiring a Parole Board to be released)
This section is associated with longer lengths of stay, and progress which is subject to Ministry of Justice scrutiny.

Section 48 or 47/49

Transferred prisoners tend to have much shorter lengths of stay, because they can be returned to prison as soon as their mental health improves or their behaviour becomes disruptive. Their diagnosis may be uncertain.

Civil sections
These patients are less likely to have a significant history of violence and are more likely to be placed on challenging behaviour wards. They are not subject to Ministry of Justice controls.

Index offence

The seriousness of the index offence has two implications. First, there is evidence that the most serious offences of patients in an MSU are associated with individuals who were the most mentally ill at the time and who are the most treatable when admitted (pathway 1). Second, and conversely, the more serious the index offence, the more likely it is to raise public and victim concerns.

We would suggest that you consider:

No offence
Admitted under civil section.

Serious offences
Murder, attempted murder, grievous bodily harm, rape, attempted rape.
Include any offence which was reported in the national media or attracted notoriety.

Moderate offences
All other index convictions.

Ongoing substance misuse

A history of problematic substance misuse is contained within the historical items of the HCR-20. This item relates to continued misuse of substances in the months following admission to the MSU. It suggests a drive to use substances which is problematic as it overrides everyday controls and rules. This item is associated with a greatly increased length of stay.

Rate as present if there has been clear signs of intoxication and/or positive tests for substances by six months following admission.

Appendix 2 – Project Plan Outline & Resource Requirements

The following describe the key objectives that need to be achieved in order to deliver a workable currency model for Forensic Mental Health Services for use from April 2014, and an estimate of the resources required to complete this.

	Key Objective	Completed by	Lead person / Group	Resource requirement
1	Production of a clustering booklet for Forensic services that confirms the currency groups needs assessment tool and data set required to be used by participating pilot sites from April 2012.	October 2011	Forensic PRG Sub Group	Project management time to co-ordinate
2	Scope work required to utilise model in High and Low secure services and prepare sites to participate in piloting.	December 2011	Forensic PRG Sub Group	Project management time to co-ordinate
3	Identification and preparation of pilot sites to test agreed model.	December 2011	Forensic PRG Sub Group	Project management time to co-ordinate
4	Pilot sites commence use of tool and data collection.	April 2012	Local pilot sites x 10	Project management training costs
5	Data collection and analysis completed.	December 2012	Forensic Sub Group	IT support and data analysis. Project management
6	ISB process for approving new data set commenced.	April 2013	NHS IC	Existing or additional resource
7	Service user engagement established.	September 2011	Forensic Sub Group	Project management to co-ordinate funds to pay for service user expertise / consultancy
8	Stakeholder and communication plan established.	December 2011	Forensic Sub Group	Project management
9	Guidance produced on content of care/treatment packages.	December 2012	National Specialist Commissioning Group for Forensic Services	

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10	Establish quality indicators and outcomes measures to support the currency model.	April 2012	Q&O PRG Sub Group Forensic Sub Group	Joint work – project management / data analysis
11	Undertake costing to establish local tariffs for use in pilot sites in shadow form.	December 2012	Pilot sites and National Costing PRG Sub Group	DH PbR reference cost team support
12	Formal report and evidence produced to recommend mandating of tools for currency for forensic services.	December 2013	Forensic sub Group	Project management
13	National implementation of currency model commences.	April 2014		

Appendix 3 – Clinical Descriptors

MENTAL HEALTH CURRENCIES FRONT SHEET

Name.. **Date**...

Mental health currency scores:

H-Score: /20	C-Score: /10		MHCT 1-12 score: /48
Section	Seriousness of Offence[1]	Substance misuse	

1. Treatment responsive group		
Admission likely to be precipitated by a serious offence when the patient was floridly psychotic. May be first episode psychosis. Good response to medication. No significant personality disorder or ongoing substance misuse. Reasonable level of daily living skills and social skills.	Probably: • Low H score (historical) • Low C score after 3 months • Low MHCT 1-12 score • Maybe Sec. 37/41 (MHA) • Maybe national/local victim issues	
2. Treatment resistant group – challenging behaviour		
Treatment resistant psychosis, with a history of revolving door admissions. Challenging behaviour towards staff (perhaps some disinhibited sexual behaviour) or self-harm, but no significant forensic history or interpersonal violence in the community (one serious conviction acceptable). Personality is very damaged by the illness but not necessarily antisocial. Ongoing substance misuse is either absent or manageable. Likely to move on slowly, perhaps to a low secure and/or rehabilitation setting.	Probably: • Low H score (historical) • High C score (clinical) • High MHCT 1-12 score • Maybe civil section (MHA) • Victim issues unlikely	
3. Treatment resistant group – continuing care		
Treatment resistant psychosis, with a history of poor compliance with mental health services. Some serious interpersonal violence previously in the community. Antisocial traits present, although may or may not meet criteria for personality disorder. Ongoing substance misuse likely which interferes with progress. Likely to move on slowly (may have come from high security) to forensic rehabilitation and/or forensic hostel.	Probably: • High H score (historical) • High C score (clinical) • High MHCT 1-12 score • Maybe less serious offences • Maybe section 37/41 (MHA) • Ongoing substance misuse	
4. Personality disorder group – prison transfer		
Commonly psychotic crisis in prison, and may or may not have been psychotic at the time of the offence. Symptoms settle quickly, but difficult behaviours emerge (antisocial behaviour, bullying others and/or ongoing substance misuse). Questions may be raised about malingering. Short stay, but may need to return if relapses.	Probably: • High H score (historical) • Low or high C score (clinical) • Low MHCT 1-12 • Definitely transfer direction (MHA) • Maybe ongoing substance misuse	
5. Personality disorder group – co-morbidity		
May or may not have been psychotic at the time of offence, but likely to have received a diagnosis of mental illness at time of sentence (primary PD diagnosis acceptable). When psychotic symptoms settle – reasonably quickly – becomes clearer that there are substantial personality problems. May include ongoing substance misuse, 'subversive' behaviours and/or failed discharges as a result. Likely to require considerable psychological input but may not be responsive to such interventions.	Probably: • High H score (historical) • Low or high C score (clinical) • Low MHCT 1-12 score • Definitely indeterminate (Sec. 37/41 or lifer) • Maybe victim issues	

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[1] *Higher* = Murder/Attempted murder, manslaughter, rape or national notoriety
Lower = other index offences
None = No index offence

Appendix 4 – Forensic & Challenging Behaviour Sub Group Membership

Adrian Berry	South West Yorkshire Partnership NHS FT
Bob Craig	Tees, Esk & Wear Valley NHS
Bohdan Solomka	Norfolk & Waveney MH NHS FT
Carole Green	CPPP – Humber NHS
Carole Hardwick	North West Specialised Commissioning Team
Claire Bainbridge	Tees, Esk & Wear Valley NHS
Dan Dalton	Norfolk Community Health & Care NHS Trust
David Daniel	DH
David McAuley	Plymouth NHS
Elizabeth Allen	East Midlands Strategic Health Authority
Gail McGregor	Northumberland, Tyne & Wear NHS FT
Ged McCann	NHS Barnsley
Gillian Taylor	Tees, Esk & Wear Valley NHS
Helen Causley	DH
Jackie Craissati	Oxleas NHS
Jo O'Sullivan	Norfolk & Waveney MH NHS FT
John Cunningham	Plymouth NHS
Jon Painter	Northumberland, Tyne & Wear NHS FT
Julian Walker	Avon & Wiltshire MH Partnership NHS Trust
Liz Williams	East of England Specialised Commissioning Group
Myles Paterson	Partnerships in Care
Neil Boast	East London NHS
Nick Broughton	West London MH NHS Trust
Oghogho Manuwa	West London MH Trust
Patrick Knowles	Avon & Wiltshire MH Partnership NHS Trust
Patrick Neville	Southwest Specialised Commissioning Group
Pratish Thakkar	Tees, Esk & Wear Valley NHS
Richard Idle	East London NHS
Sheryle Cleave	Northumberland, Tyne & Wear NHS FT
Sue Nowak	DH
Vanessa Fowler	Medway PCT