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AN EVALUATION OF NEW SERVICES FOR PERSONALITY-DISORDERED OFFENDERS: STAFF AND SERVICE USER PERSPECTIVES

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ABSTRACT

Background: Little is known about effective treatment for personality-disordered (PD) offenders. We aimed to obtain the perspective of service users and staff on: (a) the experience of receiving treatment; and (b) the experience of delivering treatment, within new forensic services for PD offenders.

Material: Thematic analysis was applied to qualitative interviews with 30 service users and 22 staff.

Discussion: Service users perceived that they were making positive changes in the areas of anger management, communication, self-harm, self-esteem and insight into their difficulties. Undertaking the clinical work was extremely stressful for staff.

Conclusions: Forensic PD services may be having an important impact on the quality of service users' lives. Whether treatment is successful in reducing long-term risk to others remains to be seen, and the cost-effectiveness of these services needs to be examined.

Key words: offenders, personality disorder, qualitative, service user, staff, treatment

INTRODUCTION

Surveys of psychiatric morbidity have repeatedly demonstrated that the prevalence of personality disorder within the criminal justice system is considerably higher than in the community (Singleton *et al.*, 1998). However, it is unclear how many PD offenders have problems that might benefit from psychiatric treatment and little is known about what might constitute effective treatment for such individuals (Warren *et al.*, 2003).

There is a deficiency in health services for PD offenders (NIMHE, 2003). In the UK, this has been addressed by the Dangerous and Severe Personality Disorder (DSPD) programme (Home Office, 2005), established by the Ministry of Justice and Department of Health. Three new medium-secure forensic services have also been established to provide treatments to reduce the risk of reoffending, address mental health needs and improve social functioning. These services were systematically evaluated by an independent research team; in this paper we report the qualitative findings that emerged from this study.

METHODS

Aims

We used qualitative methods in order to describe the experiences of staff working within the services and of service users receiving treatment.

Sample and setting

To retain confidentiality, we refer to these services as Service 1, 2 and 3.

Service 1 comprised an inpatient medium-secure unit and a residential service, managed by a local housing organization. The inpatient unit consisted of two 10-bedded wards run along therapeutic community principles. The residential service provided social care for eight residents and assisted in exploring local opportunities for education, employment and other activities. The service started admitting inpatients in June 2005 and residential service users in October 2005.

Service 2 comprised an inpatient medium-secure unit and a community team. The inpatient unit was a 16-bedded ward that offered a treatment programme based on cognitive behavioural principles and which incorporated both individual and group treatments. The community team offered an assessment and treatment programme aimed at reducing risk of harm to others. The service started admitting community service users in November 2003 and inpatients in January 2005.

Service 3 comprised an inpatient medium-secure unit, a community team and a residential service, consisting of two hostels. The inpatient unit comprised a 15-bedded ward and the hostels provided support for 10 residents. The service aimed to provide 'integrated care' across the three service components, using a treatment programme based on the Violence Reduction Programme (Wong *et al.*, 2007). The service started admitting inpatients in December 2004 and residential service users in November 2004.

At least one permanent member of staff from each professional group (psychology, psychiatry, nursing, occupational therapy and social work) was selected for inclusion in the study and asked if they were willing to participate. The services employed clear inclusion and exclusion criteria and only treated men with a primary diagnosis of PD, aged 18–65 years, with an IQ of no less than 70. All service users were eligible to participate in the evaluation, with the exception of those who were deemed to be too high a risk to themselves or others at the time of the study. Staff interviews were conducted between November and December 2006. Service user interviews were conducted between June 2006 and March 2007.

Procedures

Ethical approval was obtained from the local Research Ethics Committee. Written consent was obtained from all staff and service user participants. Service users were paid £10 for their participation and a further £10 for their participation in a focus group.

Having obtained their written informed consent, each staff and service user participant took part in an audio-taped in-depth interview with a research worker. Interviews were conducted in private on the inpatient unit or in an office at the community team base. Interviews lasted 60–90 minutes and were based on a topic guide. The topic guide was drafted following a review of the literature and with input from the expert steering group. The service user interview covered the process of entering the service, the experience of the service and treatment, outcomes or changes experienced, relationships with staff, and suggestions for improvements. The staff interviews covered the service and treatment model, training, safety and the challenges of undertaking the

clinical work. We continued to interview participants until reviews of field notes suggested that no new themes were emerging (Strauss & Corbin, 1990; Denzin & Lincoln, 2000). Basic clinical and demographic information on service users was also obtained from case files.

Once preliminary analysis of the data and field notes had taken place, one focus group per site was conducted with service users for respondent validation. All service users who took part in an interview were invited to participate. Key themes were fed back to the groups and participants were asked if the findings accurately reflected their opinions. Groups were facilitated by two members of the research team.

Data analysis

We adopted a thematic approach to the analysis of data obtained from the interviews and focus groups. Thematic analysis is a method for identifying, analyzing and reporting patterns within data that is not bound to a particular theoretical framework and that leads to a detailed account of data (Braun & Clarke, 2006). This method of analysis allowed us to investigate experiences in the new services, while being responsive to concepts emerging from the data through a largely inductive, data-driven approach. It also allowed us to capture service-specific themes as well as those generic to all services and helped to illustrate key differences and convergence of opinion between staff and service users.

All interviews were transcribed verbatim. Staff and service user transcripts were analyzed separately. Transcripts were re-read and checked for accuracy against the original recording by another researcher. Transcripts were then entered into NVivo (qualitative data analysis software). Interviews were read several times in order to identify initial themes. A coding framework was then devised and each interview was systematically analyzed, with each data item coded according to the coding framework. After a proportion of interviews had been coded, the same interviews were coded by another researcher using the same framework, in order to check the reliability of the coding process. Results were compared for reliability, discrepancies were discussed and the coding framework was refined accordingly. The revised framework was then used to code all of the interviews. Emergent themes fell into two categories: service-specific themes and themes that arose across all three services.

RESULTS

Characteristics of service users

Thirty service users were recruited and interviewed from the three services: seven from Service 1; 14 from Service 2; and nine from Service 3. Two service users refused to participate. The majority of the sample ($n = 26$) were white and average age at time of interview was 39 years (range 22–56). Average length of treatment at the time of interview was 12 months (range 1–23 months). Detailed historical data were available on 25 of the participants. Over 80% of these participants had experienced some form of severe childhood maltreatment and had previously engaged in drug misuse. Over 70% had previously engaged in alcohol misuse and self-harming behaviour. Twenty five had one or more violent convictions, including five with a conviction for homicide. Structured PD assessments were available on 21 of the men, of whom over half had a diagnosis of dissocial PD and 10% had a diagnosis of emotionally unstable PD. Forty four per cent of the

sample had been referred from prison; 24% from high and medium security; and the remainder were derived from a variety of sources, including 16% from the community.

Characteristics of staff

Twenty two staff were interviewed: 12 males and 10 females. The staff group consisted of six managers (including one consultant forensic psychiatrist and one senior nurse), one consultant forensic psychiatrist, three consultant psychologists, three senior nursing staff, two newly qualified nursing staff, three healthcare assistants, two occupational therapy staff and two probation/social work staff. Their mean age was 43 years (range 29–60). All staff had been working in the services for between 18 months and three years at the time they were interviewed.

The experience of receiving treatment

Across all three services, the service users told us that they appreciated the help that was being offered to them. More importantly, many perceived that they were making positive changes in the areas of anger management, communication, reduced self-harm, improved self-esteem and improved insight into their difficulties.

‘Learning how to control my anger, which I think I am doing very well. Um, not creating any riots – I manage that... I get angry a little bit, but not as much as I used to... now, I think before I act, whereas before, I didn’t think, I just acted straight out, or said it, whatever, but I actually think first before I approach someone which... this place has taught me you know.’ *Service user respondent 12*

‘Since May, I haven’t self-harmed at all, even though I have been [under] pressure to do it, I haven’t done it. And I suppose you got to give the testament to the staff in their duty, the way they got it done. They talk to you about [it]... that’s the thing, they will talk to you about [it]...’ *Service user respondent 13*

‘Well I’ve learned a lot about my diagnosis and how it affects me, you know what, how it’s likely to affect me in the future and how I can work around that. You know, I’ve learned a lot about like, where my violent behaviour in the past came from, what led into it and how I can sort of head it off before it becomes a problem again.’ *Service user respondent 6*

Although service users reported that treatment had been helpful, it was also described as being challenging and stressful. Many found the experience of examining and sharing their feelings with others to be overwhelming.

‘People are at us all the time about how I feel, “How do you feel about this?”, “How do you feel about that?”. You know, have a conversation, “What do you feel?” – bombarded by “how you feel” questions, you know it’s just... I know why they are doing it, because the logic is not enough to stop us from getting in trouble again to have an emotional connection to what I have done in the past with my crimes and to have an emotional connection between what’s wrong and right makes a difference in whether or not I will reoffend again. But I know why they are doing it, but it doesn’t make it easy. Does my head in some days you know, really does my head in.’ *Service user respondent 23*

Service users differed in their views about which aspects of treatment were most helpful. For some, group work was cited as being the most helpful component of treatment, while others pinpointed the educational aspects of treatment. However, both staff and service users highlighted the importance of their relationships in undertaking successful work. Successful relationships were characterized by a perception of mutual trust and respect and these invariably occurred with staff who were (in the views of service users) honest, tolerant and non-judgemental in their manner.

Delivering treatment

Each of the services faced major organizational challenges over the course of the study, many of which were generic to the setting-up of any new service. For example, Service 1 had to abandon plans for a community team, resulting in a considerably increased workload for the inpatient staff team. Additional staffing problems arose in this service, including changes in key personnel and the absence of a senior manager for long periods of time. This latter issue had a particularly detrimental effect on the cohesion and morale of the overall team. Another challenge faced by all three services was the fact that the inpatient units changed premises during the course of our evaluation, leading to a great deal of disruption for both service users and staff.

In addition to these general organizational challenges, each service had to deal with problems that are more specifically related to setting up a dedicated PD service. For example, staff working in Service 2 told us that working relationships between disciplines on the inpatient unit were extremely strained and that there had been bitter ‘power struggles’ between discipline leaders who were reported to be ‘fighting’ for overall leadership of the group. The net effect of this was that some staff reported being unclear about who held ultimate clinical responsibility.

Many of the staff participants told us that they had underestimated the emotional impact of the clinical work. This was particularly the case for those engaged in regular face-to-face contact with service users in an inpatient setting. Many of these staff described the clinical work as being ‘relentless’ and ‘draining’. In addition, nearly all the staff described moments when they had felt afraid of service users.

‘There’s been times where they’ve, you know they’ve... it’s just staff have felt completely worn out from the constant barrage of grievance and complaint and it’s so predictable now, that we know what’s going to happen.’ *Staff respondent 27*

‘I was afraid of one... my... my patient, I was petrified of him and I actually washed my hands. I said, “I can’t work with him anymore”... I felt quite intimidated, I felt he was very hostile towards [me]... I felt scared of him, um and I can’t change the way I felt. I tried really hard to work with him over a long time and in the end I couldn’t do it, to the point I actually felt sick coming into work... really physically sick.’ *Staff respondent 3*

Each site experienced difficulties in recruiting and retaining skilled staff and this was particularly the case for the three medium-secure units, where the daily working environment was particularly stressful. It became clear that professional qualifications alone were insufficient predictors of who could undertake this type of clinical work. In addition to displaying the obvious enthusiasm required for specialist PD work, staff also needed to be emotionally resilient, to have a clear sense of personal boundaries and to be in possession of a good sense of humour. The staff we interviewed told us that the pool of eligible staff from which the services were able to recruit was

small. Consequently, all the services struggled to maintain full staffing capacity over the course of the evaluation.

‘But I think more than anything it’s got to be the right people. It’s not what training they’ve had or what fancy tools or fancy treatment they can offer; it’s who they are as people and it’s getting somebody who is honest with themselves, very self-aware, somebody who is able to think imaginatively, um, and people who are really quite motivated.’ *Staff respondent 21*

In all three services, newly recruited staff were perceived by the service users to be naïve, vulnerable and easily manipulated.

‘The staff we have here are very young... just starting out in the game... you know they just left college and are still training really... they’re trusting, trusting in you... and to be quite honest, we’re not to be trusted to give staff advice. Really, not with our histories, that’s what I mean by some staff being naïve, you get the wrong person here and he [the service user] will take advantage of openings... [staff need] more training with our type of patients.’ *Service user respondent 10*

Difficulties in staff recruitment and retention meant that vacancy rates were reported to be in excess of 50% in some service components during the course of the study. Consequently, there was a heavy reliance on ‘bank’ or temporary staff. This caused further problems as service users felt they could not trust temporary staff and instead created ‘extra work’ for the remaining permanent staff by turning to them for help. Overall, frequent changes in the staffing structure were perceived by both staff and service users to be particularly unhelpful, as they hampered the formation of trusting, therapeutic relationships.

‘In a place like this you really need regular staff who are there day in day out, who can build up a rapport with the patients and who the patients feel comfortable in approaching to talk to about problems. Here, you’ve got a lot of staff who you might see every couple of months, like because they are not the nursing bank. And you’ve also got a lot of the bank staff who basically aren’t interested in doing anything other than the minimum amount possible and getting a pay packet at the end of the month... I feel that they are more committed to the pay packet than actually to you know, trying to help people.’ *Service user respondent 6*

Areas for improvement

Across all three sites, service users identified a number of areas where they felt that the treatment programmes might be improved:

The assessment process

Service users told us that they thought that the assessment process was too long. Many described having a series of interviews with various members of the multidisciplinary team where they felt they were repeatedly going over the same ground. Moreover, during this phase, there was reported to be no active therapy on offer and they were, in the words of one service user, ‘left to your own devices’. Dissatisfaction with the lengthy assessment process was also widely reported by staff. Some staff lacked confidence in the choice of measures and others were concerned that a lengthy assessment acted as a barrier to engaging service users in future treatment.

Better information

Some service users told us that they had not been given a clear explanation of the nature or consequences of treatment prior to being taken on by the service. Others said that they were not fully aware that they might be returned to prison after being assessed if they were not felt to be suitable for treatment. Indeed some referred to this process as a form of 'gate arrest'. When service users reported receiving information and pre-admission visits to inpatient units, these were perceived to be helpful.

Mixing offending profiles and mental health needs among service users

The fact that each treatment programme accepted people with a mixture of offending profiles and mental health needs was felt to be problematic. Some service users reported the existence of tension between 'ex-prisoners' and 'mental health patients'. Ex-prisoners felt that they were treated with less sympathy and at one site, concerns were expressed about the possibility of their peers' mental health problems or offending profiles 'rubbing off' on them.

'You can cut it [the atmosphere] with a knife sometimes... between the staff and patients. And patients and patients. Because you have a mixture of prisoners and mental health patients. Prisoners are treated with no real self-importance. The mental health patients are treated like royalty... I've never actually agreed with mixing prisoners, prison transfers, sex offenders and mental health patients together. I've seen the damage it causes.' *Service user respondent 5*

The need for a busy programme of treatment

While they appreciated that the services were still developing their treatment programmes, service users at all three sites told us that they wanted to be kept busy and some complained of boredom. On the inpatient units, community groups were highly valued, and there were many suggestions for other groups, particularly in the areas of substance misuse and practical skills groups where they might learn a trade and by doing so perhaps avoid going 'down the same road again' on discharge. Staff at all three sites were aware of this issue and at the time of the evaluation were further developing the group programmes.

DISCUSSION

The views expressed by service users and staff in this study provide a unique insight into what it is like to use and work within a forensic PD treatment service. At the time of evaluation, the services were still developing. In spite of this, both staff and service users reported that important changes were occurring in the lives of service users. These included a reduction in self-harm, improved anger management, an improved ability to communicate, and a greater understanding of their behaviour. Many service users told us that treatment had given them a renewed sense of purpose in life and hope for the future. Their testimonies provide some evidence to suggest that the treatments are having an impact on the quality of their lives. Whether treatment within a forensic PD service is successful in reducing long-term risk to others remains to be seen and charting any changes in patterns of reoffending will require much longer periods of follow-up (Davies *et al.*, 2007). In addition, while these services were valued by staff and patients, there was a large economic cost associated with providing them and research into the cost-effectiveness of these services is currently under way.

Room for improvement

Our findings demonstrate that PD offenders can competently comment on their experiences. Given that involving users in service development is an NHS policy requirement (Farrell, 2004), it is important that the new PD services have mechanisms in place to support such involvement.

Across all three sites, service users identified a number of areas where they felt that the treatment programmes might be improved, including shortening the assessment process, limiting the use of bank and inexperienced staff, and the dissemination of clearer information about the treatment programmes. While they appreciated that the treatment programmes were still being refined, service users told us that they wanted to be kept busy and some complained of boredom. This might be a particularly important point to take note of, as boredom has been linked to an increased likelihood of absconding behaviour from inpatient units as well as a potential source of aggression within high-secure units (Meehan *et al.*, 2006, 1999).

Staffing a forensic PD service

For staff, the experience of undertaking the clinical work was reported to be extremely stressful, particularly for those engaged in regular face-to-face contact with service users in an inpatient setting. Almost all staff described the work as draining and occasionally frightening, highlighting the need for regular supervision and support when undertaking this type of clinical work (Bowers, 2002).

Staff in all services identified interdisciplinary disputes over clinical leadership and the vision for the service. Bateman and Tyrer (2004) state that in order to achieve effective teamwork within a specialist PD team:

‘The team has to be willing to assign the responsibility of leadership to one of its members and that member must be willing to undertake the leadership role. Underlying rivalries within a team will inevitably bring with them inconsistency as individuals attempt to develop greater influence. For effective teamwork, the natural tendency of any one person to want to make an individual contribution has to become subordinate to the contribution of the whole team.’

Bateman and Tyrer go on to highlight the fact that effective teamworking can be achieved through ‘an iterative process of decision-making... in which the individual members move towards a consensus that is then held by the team itself’. Since we were evaluating comparatively new services, it was unsurprising to find that some of the teams were still at the stage of assigning responsibility of leadership and going through the ‘iterative process of decision-making’. This process is a normal group process – it takes time for the culture of any working group to establish and it would be premature to arrive at firm conclusions about how ‘healthy’ and successful any of the teams were when we evaluated them.

Each site experienced difficulties in recruiting and retaining skilled staff; this was particularly the case for all three medium-secure units where the daily working environment was particularly stressful. There was a shortage of suitable candidates for posts and it is clear that professional qualifications alone are insufficient predictors of who can successfully undertake this type of clinical work. It goes without saying that for this type of clinical work, when recruiting staff serious weight should be given to personal characteristics, as well as professional qualifications and experience (Bateman & Tyrer, 2004; Crawford *et al.*, 2008). There is quantitative evidence to support this view, showing that the clinician’s personality directly impacts on both the strength of the therapeutic alliance and treatment adherence in patients with borderline PD receiving psychotherapy (Spinhoven *et al.*, 2007).

An important aspect of the underlying ethos of a PD service is that it should provide some form of constancy (Bateman & Fonagy, 2000; Bateman & Tyrer, 2004). This is because frequent changes in professionals can easily reawaken feelings of loss and abandonment that may have previously characterized patients' relationships (Gunderson, 1996). Nonetheless, temporary staff had to be relied upon (sometimes heavily) in the new services. The use of 'bank staff' was unpopular with the service users, possibly because it was not consistent with their need for greater interpersonal consistency. On the basis of our findings, we therefore recommend that the use of bank staff within PD services should be kept to an absolute minimum and limited to a skilled pool of staff who are familiar with both the service and client group.

Methodological issues

The interviews were carried out at a time when the treatment programmes were still evolving and staff and service user opinions may have changed since we completed the study. The possibility of response bias also needs to be taken into account when interpreting study findings. Those working in the pilot services may have viewed this study as part of a process of evaluation that would influence future funding decisions. Equally, it is important to bear in mind the fact that many of the service users had psychopathology that included dichotomous thinking, and a tendency to distort information. The sample of staff and service users was non-random and while efforts were made to sample a wide range of service users and staff, the views expressed might not have been shared by those not interviewed. In light of the fact that these services were new and developing, research into the changing opinions of staff and service users is needed as the services grow and develop.

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