Article

A long time coming? The Firesetting Intervention Programme for Mentally Disordered Offenders (FIP-MO)[1]

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This article focuses on existing published accounts of firesetting treatment for mental health patients in the UK, highlights key challenges facing individuals tasked with designing and evaluating such programmes, and then provides an overview of ongoing multi-site firesetting treatment and associated research currently being undertaken in secure forensic mental health hospitals in the UK. Finally, information is presented for practitioners who are interested in adopting the programme and partaking in the wider research evaluation.

FOR MANY YEARS NOW, practitioners within secure mental health services – and indeed non-mental health establishments – have had to assess and treat male and female arsonists or firesetters[2] within the context of very little standardised guidance. Consequently, although in-house treatment programmes for firesetters have been developed in UK medium secure hospitals, no national standardisation of such programmes exists (Palmer, Caulfield & Hollin, 2005). As a result, the content, implementation, and theoretical underpinnings of such programmes appear highly variable (Palmer et al., 2005) making it almost impossible to obtain sample sizes large enough for any meaningful evaluation of programme effectiveness. In this article, we examine existing published reports of treatment programmes for firesetters in UK mental health settings. We then consider some of the key issues facing practitioners tasked with providing effective interventions for firesetters within their service. Finally, we outline our newly-developed firesetting programme for mental health patients, and describe its implementation and proposed evaluation in the UK.

Published treatment evaluations for firesetters in mental health settings

There have been very few published descriptions or evaluations of treatment programmes for firesetters in the UK; and those that have been published either focus on a single case study (Clare et al., 1992), individualised interventions (Russell, Cosway & McNicholas, 2005), or relate to group treatment (typically cognitive-behavioural) in mental health settings (Swaffer, Haggett & Oxley, 2001; Taylor et al., 2002, 2006). To illustrate, Swaffer et al. (2001) describe their arson intervention group for mixed sex mentally disordered patients. Patients referred to the group were required to attend 62 group sessions examining: *education on fire danger, coping and social skills, reflective insight* (including self-esteem/concept), and *relapse prevention* as well as individual sessions examining individual patient need. Evidence of treatment effectiveness was presented via a detailed case study. However, other information regarding clinical change was not provided due to the small numbers of patients involved (N=10). A seemingly similar programme for intellectually

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[2] The term 'firesetter' will be used to encompass all those individuals who set deliberate fires rather than those who are eventually convicted of arson.

disabled patients has been described by Taylor et al. (2002) who implemented treatment to separate groups of male and female patients. Forty treatment sessions were described which included content seemingly similar to that provided by Swaffer et al. (i.e. fire education, analysis of offending, coping strategies, family problems, and relapse prevention). Taylor et al. (2002) report some encouraging pre-post treatment shifts using questionnaire measures, however, the overall sample size was small (N=14), making it difficult to meaningfully compare male and female firesetters, and no control group was used for comparison purposes. In a later article, Taylor, Thorne and Slavkin (2004) outlined case studies of four intellectually disabled male patients who undertook similar treatment. Generally positive outcomes were documented for each although the sample size was too small to draw meaningful conclusions from pre-post psychometric measures.

In summary then, published reports of treatment programmes for male and female firesetters in the UK – and their evaluation – are scarce; mirroring a problem evident internationally (see Gannon & Pina, 2010; Gannon, 2010).

Challenges relating to firesetter treatment provision and evaluation

There are numerous challenges associated with setting up provision of firesetting treatment services generally and these exist over and above the challenges faced by those dealing with mental health populations. The largest problem encountered by those wishing to develop firesetting treatment provision has been the lack of research and associated theory pinpointing the likely treatment needs or dynamic risk factors associated with firesetting behaviour. As a result, professionals have faced some difficult to answer questions such as: 'Do firesetters actually require specialist treatment?', 'Does mental health play a role in firesetting?', 'Which factors specific to firesetting should be targeted?', and 'How do these factors differ from the factors targeted via conventional offending behaviour treatment programmes?' Furthermore, even if a treatment programme is developed, a formidable problem facing any scientist-practitioner is the establishment of *treatment effectiveness*. As noted above, existing published reports examining the effectiveness of firesetting treatment programmes describe programmes run with mentally disordered offenders which generally do not contain large enough samples to make even the most preliminary of conclusions. This is understandable given the relatively small size of many secure mental health units. A related problem concerns the inability of many sites to have large enough samples of control firesetter participants with which to make meaningful comparisons. Consequently, the task of both developing and effectively evaluating a firesetting programme for mental health patients can seem daunting, if not impossible.

The Firesetting Intervention Programme for Mentally Disordered Offenders (FIP-MO)

We have attempted to circumvent the issues presented above in order to develop a contemporary treatment programme for mentally disordered firesetters that engages large patient numbers and also a group of firesetters for comparison purposes. The resulting FIP-MO (Gannon & Lockerbie, 2011) is the product of latest offender rehabilitation theory as well as a comprehensive evaluation of existing firesetting literature which suggested that: (1) some firesetters require specialist treatment; (2) that particular factors associated with firesetting should be targeted; and (3) that mental health is related to firesetting in complex and unique ways. Following development of the programme and its successful pilot in Kent Forensic Psychiatry Services, came the standard difficulties of both gaining high enough patient numbers for a credible treatment evaluation and obtaining a control group. Thus, a multi-site research project examining the effectiveness of the FIP-MO

for male and female mental health patients has been developed and is currently being run with separate groups of male and female patients across NHS and non-NHS sites in the UK. Sites running the programme are provided with the materials and training to run the programme at their site and they – in return – request patients' consent to release pre-post clinical psychometric measures for the purpose of the treatment evaluation. Sites are also required to collect similar information – where available – on firesetters who are waiting for treatment (i.e. the comparison group).

Programme description

The FIP-MO (Gannon & Lockerbie, 2011) is a standardised – yet highly flexible – treatment programme which may be implemented to either all-male or all-female inpatient groups. The programme is primarily cognitive behavioural in orientation but also synthesises strong psychotherapeutic elements designed to encourage self-reflection, healthy emotional and social expression, and the development of a strong therapeutic relationship. In light of this, the underpinning treatment manual offers key guidance for facilitators on each session. However, the specific guidance becomes notably less structured as offenders begin to embark on more individualised aspects of the programme providing room for more sophisticated and responsive clinical skills and gender responsive therapy. The FIP-MO is underpinned by contemporary theories of offender rehabilitation (i.e. the *Risk Need Model;* Andrews & Bonta, 2003; and the *Good Lives Model;* Ward & Stewart, 2003) as well as the very latest comprehensive theory of firesetting (Multi-Trajectory Theory of Adult Firesetting; Gannon et al., 2011). Following a thorough clinical and psychometric assessment in which suitability for firesetting treatment and ability to partake in group treatment is assessed, the patient is admitted for the full FIP-MO treatment package. This involves seven months of medium intensity group and accompanying individualised treatment of approximately 85 to 100 hours in duration. Although FIP-MO currently runs as a closed group necessitating a modular programme, facilitators are encouraged to work on cognitive, affective, and behavioural aspects throughout the programme as and when they occur.

The FIP-MO aims to enable offenders to become more aware of the factors associated with their firesetting and to develop more sophisticated skills via the development of a personalised risk management/better life plan. The main treatment targets within the programme are based on the very latest research and theoretical knowledge relating to firesetting. The treatment needs targeted within the programme include (but are not limited to) *fire interest* (including fire safety awareness), *offence supportive attitudes* (general criminal attitudes or specific attitudes relating to fire), *social competence* (i.e. social skills, assertiveness, self-esteem, loneliness), and *self-management/coping skills* (i.e. emotional regulation, problem solving). Patients also engage in individualised tasks relating to understanding their offending, childhood, and mental health as well as planning for their future via strengths-based personalised plans. Patients who attend the programme are encouraged to engage in numerous skills-based exercises and tasks outside of the group to encourage self-reflection, emotional expression, and other psychological, social, and contextual phenomena associated with pro social behaviour.

The overall research evaluation will focus on pre-post test clinical shifts – assessed via a battery of psychometric tests – designed to measure the key treatment needs targeted within the programme. Most importantly, the research aims to compare any shifts demonstrated by firesetters attending the FIP-MO with shifts on the same psychometric tests evidenced by firesetters who do not attend the FIP-MO but who fill out the tests over the same approximate time period.

Participation in the FIP-MO Treatment and Evaluation Project

Any hospital interested in running FIP-MO and becoming part of the research evaluation project can still come on board at this stage. However, the following is required:

- At least one group of six to eight male or female inpatients who have a history of repeat firesetting or who have been identified by their clinical team as posing a possible risk of firesetting who can participate in a medium length treatment group.
- At least one group of six to eight male or female inpatients who have a history of repeat firesetting or who have been identified by their clinical team as posing a possible risk of firesetting who can complete the same psychometrics as those in the FIP-MO while they await treatment.
- Two facilitators dedicated to each group of six to eight patients participating in the treatment programme. One of these facilitators should be a Chartered Clinical or Forensic Psychologist. The other can be from any discipline. One or either of these facilitators should be willing to: (1) participate in one-day training from the treatment developer; (2) attend bi-monthly steering group meetings about the project; (3) administer the psychometrics associated with the treatment evaluation and return these to the research lead; and (4) run the clinical programme in full following training.

For hospitals that do not have enough patients to run a group at this time, there are still opportunities to partake in the project if staff are willing to become part of the research project and administer psychometric tests to patients who can act as a control to those undertaking treatment.

For psychologists in prison settings, a parallel research project is underway in which a standardised treatment programme for imprisoned firesetters is being developed. This will be evaluated in 2012–2013.

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