

# ***Firesetters in the PICU and LSU***

Dr Bradley Hillier

ST6 Forensic Psychiatry

South Thames Higher Specialist Training

# Structure of This Talk

- Defining the Terminology
- Epidemiology: The Extent of the Problem
- Association with Mental Disorder
- Classificatory Approaches
- Clinical and Risk Assessment – A Care Pathway Approach

# The Minefield of Terminology

**FIRESETTING**



**ARSON**



**PYROMANIA**

## Arson – “The Crime” (1)

Defined within Section 1 of the Criminal Damage Act 1971 (Criminal Damage Act 1971 (c48))

**(1)** A person who without lawful excuse destroys or damages any property belonging to another intending to destroy or damage any such property or **being reckless** as to whether any such property would be destroyed or damaged shall be guilty of an offence. **SIMPLE ARSON – EITHER WAY OFFENCE**

**(2)** A person who without lawful excuse destroys or damages any property, **whether belonging to himself or another:**

**(a)** Intending to destroy or damage any property or being reckless as to whether any property would be destroyed or damaged; and

**(b)** Intending by the destruction or damage to endanger the life of another or being reckless as to whether the life of another would be thereby endangered;

shall be guilty of an offence. **ARSON WITH INTENT/RECKLESS ENDANGERING LIFE – INDICTABLE OFFENCE**

**(3)** An offence committed under this section by destroying or damaging property by fire shall be charged as arson.

# Arson – “The Crime” (2)

- Thus ‘Arson’ comprises the specific criminal act of destruction, comprising the specific criminal act of intention; an ‘arsonist’ has been convicted of the crime of arson.
- **THE COURTS TAKE ARSON VERY SERIOUSLY – LIFE SENTENCE POSSIBLE – RESTRICTION ORDERS CONSIDERED**
- **Psychiatric Reports Recommended**
  - *R. v Calladine* November 25, 1975 Psychiatric reports should be obtained before sentencing.

# Firesetting – A Behavioural Phenotype

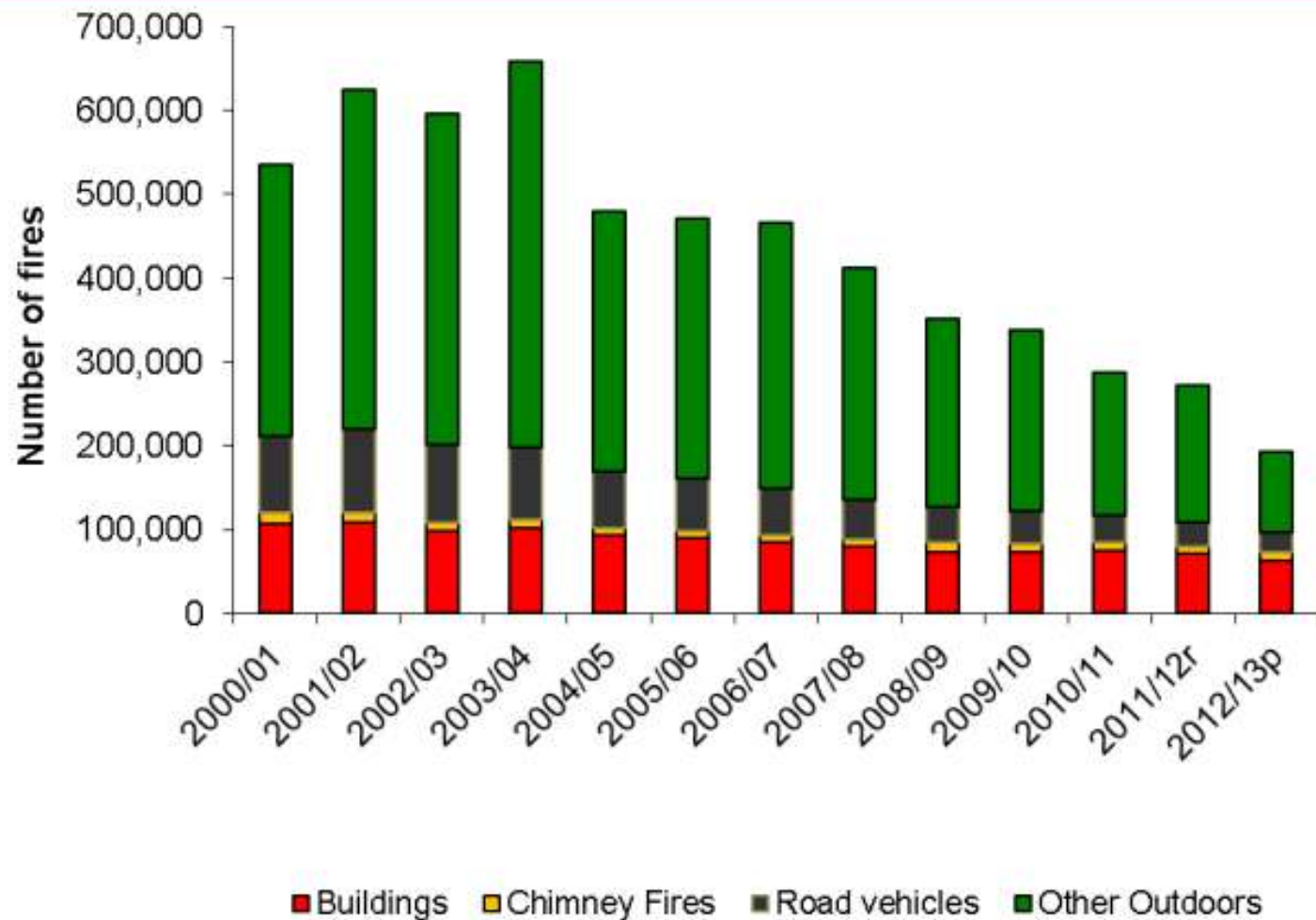
- Includes all intentional setting of fires, whether a criminal charge is attracted or not.
- **Multiple** reasons that fires may not be detected or charges pressed:
  - Insufficiently severe to cause damage
  - Fire not detected as deliberate
  - Not possible to identify who has set the fire
  - Insufficient evidence to secure a conviction
  - Young age of the fire setter
  - **? Occurrence by mentally unwell individuals as inpatients – leniency of staff/services?**

# Pyromania – “Impulse Control Disorder”

- Disorder of adult personality and behaviour in the ICD10 at F63.1
- Also known as “Pathological firesetting”
  - *A disorder characterized by a fascination with fire and recurrent episodes of fire setting during which the individual experiences a rising subjective sense of tension before the fire setting and a sense of gratification or relief when setting the fire. There is no ulterior motive (such as monetary gain or the expression of political ideology) to the fire setting.*
  - *The behaviour cannot be more appropriately explained by organic mental disorder, intoxication with substances, mental illness such as schizophrenia, antisocial personality disorder or conduct disorder*
- Pyromania in the DSM 5 has been re-classified from being a distinct disorder in itself owing to lack of evidence as a distinct disorder.
- Incorporated within (e.g.) “Impulse disorders not otherwise specified” and as manifestation of Conduct Disorder
- (American Psychiatric Association Diagnostic Statistical Manual, 5<sup>th</sup> Edition, 2013)

# Epidemiology

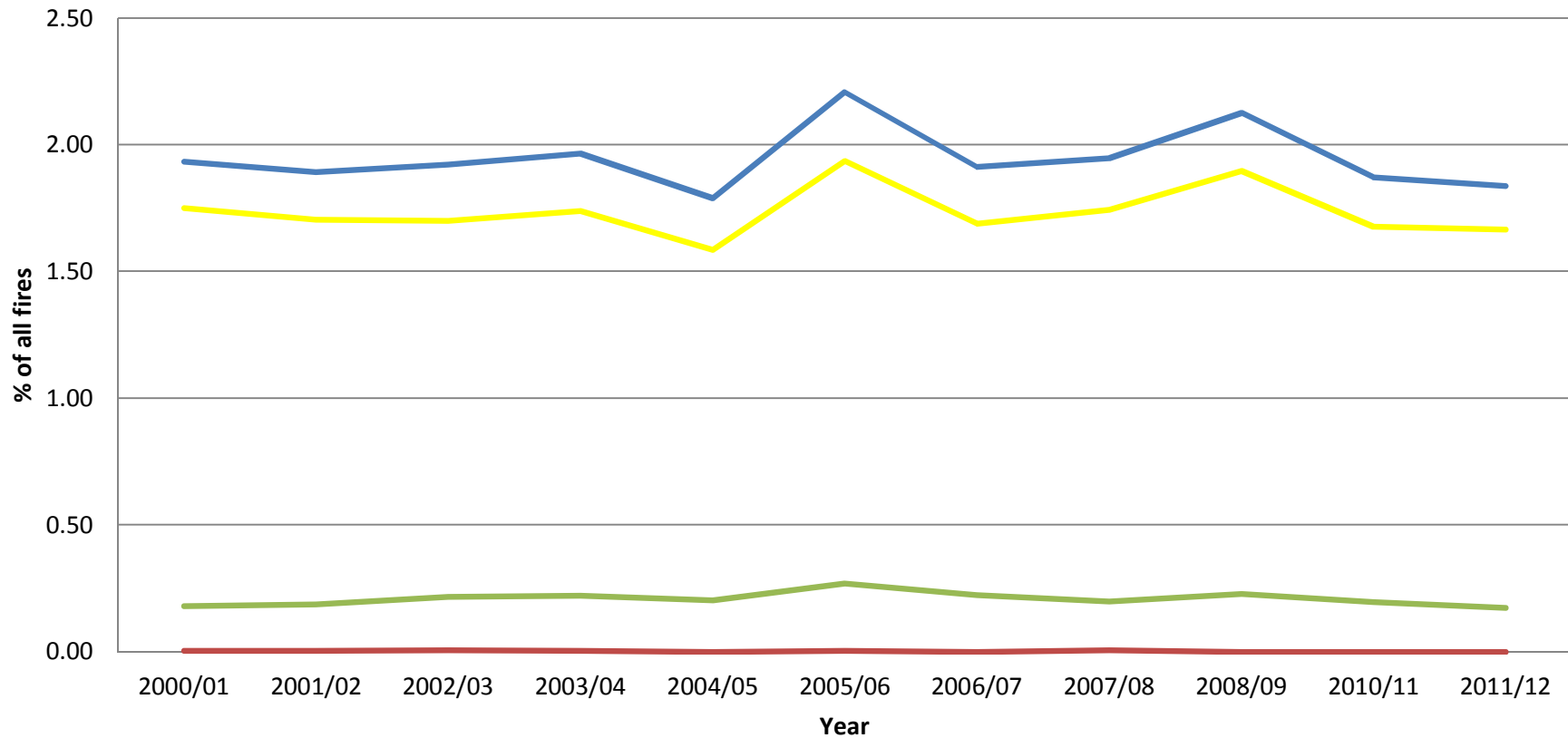
Figure 1.1: Primary fires by location group and chimney fires, Great Britain, 2000/01 – 2012/13p





# Fires in Healthcare Settings






Percentage of total UK deliberate fires in hospital shown by degree of injury:  
trends 2000–2012



— Total Fires in Hospital (%) — Fatal Fires in Hospital (%) — Non-fatal Fires in Hospital (%) — No Harm Fires in Hospital (%)

# Relationship with Mental Disorder – Population Studies (1)

Lifetime Psychiatric Comorbidity of individuals with and without lifetime history of firesetting

| Comorbid psychiatric disorders  | Firesetters<br>N=407 |     | General population<br>N=41,552 |     | Adjusted Odds Ratios (95% Confidence Intervals) |            |   |            |
|---|----------------------|-----|--------------------------------|-----|---|------------|---|------------|
|   |                      |     |                                |     | Sociodemographic Characteristics                |            | Sociodemographic Characteristic and Other Psychiatric Disorders |            |
|   | %                    | SE  | %                              | SE  | AOR   | 95% CI     | AOR   | 95% CI     |
|  Any Psychiatric diagnoses    | 95.1                 | 1.3 | 53.6                           | 0.9 | 12.8  | (7.3-22.4) | 12.8  | (7.3-22.4) |
|  Any Axis I diagnoses        | 90.9                 | 1.9 | 51.2                           | 0.9 | 7.2   | (4.5-11.5) | 3.6   | (2.2-5.9)  |
|  Any Substance Use Disorder | 80.4                 | 2.5 | 38.2                           | 0.8 | 4.3   | (3.0-6.3)  | 2.5   | (1.7-3.6)  |
|  Any alcohol use disorder   | 71.7                 | 3.0 | 29.9                           | 0.8 | 3.8   | (2.7-5.3)  | 1.6   | (1.1-2.3)  |
|  Any drug use disorder      | 48.4                 | 3.0 | 10.0                           | 0.3 | 5.4   | (4.0-7.2)  | 2.4   | (1.8-3.3)  |
| Any mood disorder   | 40.3                 | 3.2 | 18.5                           | 0.4 | 3.3   | (2.5-4.29) | 1.0   | (0.8-1.4)  |

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|--------------------------------|----------------------|-----|--------------------------------|-----|---|--------------|--|--------------|
|                                |                      |     |                                |     | Sociodemographic Characteristics <sup>a</sup>   |              | Sociodemographic Characteristic and Other Psychiatric Disorders <sup>b</sup> |              |
|                                | %                    | SE  | %                              | SE  | AOR   | 95% CI       | AOR  | 95% CI       |
| Any Psychiatric diagnoses      | 95.1                 | 1.3 | 53.6                           | 0.9 | 12.8  | (7.3- 22.4)  | 12.8   | (7.3- 22.4)  |
| Major Depressive Disorder      | 15.9                 | 2.1 | 13.5                           | 0.3 | 1.4   | (1.0- 1.9)   | 0.7  | (0.5- 1.0)   |
| Bipolar Disorder               | 23.0                 | 2.9 | 4.3                            | 0.2 | 5.6   | (4.0- 7.9)   | 1.6  | (1.1- 2.2)   |
| Conduct disorder               | 9.0                  | 1.7 | 1.0                            | 0.1 | 6.9   | (4.4- 10.9)  | 6.1  | (3.6- 10.4)  |
| Pathological Gambling          | 2.7                  | 0.8 | 0.4                            | 0.0 | 4.8   | (2.4- 9.5)   | 1.4  | (0.6- 3.0)   |
| Psychotic Disorder             | 1.6                  | 0.6 | 0.3                            | 0.0 | 5.0   | (2.2- 11.4)  | 1.3  | (0.5- 3.4)   |
| Any personality disorder       | 68.9                 | 2.7 | 14.5                           | 0.3 | 11.2  | (8.8- 14.2)  | 7.9  | (5.9- 10.6)  |
| Avoidant                       | 6.7                  | 1.6 | 2.4                            | 0.1 | 2.6   | (1.6- 4.4)   | 0.6  | (0.3- 1.5)   |
| Dependant                      | 1.9                  | 0.7 | 0.5                            | 0.1 | 3.3   | (1.4- 7.9)   | 0.5  | (0.2- 1.5)   |
| Obsessive-compulsive           | 30.4                 | 2.9 | 7.8                            | 0.2 | 4.7   | (3.6- 6.2)   | 2.2  | (1.5- 3.1)   |
| Paranoid                       | 17.2                 | 2.3 | 4.4                            | 0.2 | 4.4   | (3.1- 6.2)   | 1.0  | (0.6- 1.7)   |
| Schizoid                       | 11.0                 | 1.6 | 3.1                            | 0.1 | 3.4   | (2.4- 4.9)   | 0.9  | (0.5- 1.7)   |
| Histrionic                     | 12.1                 | 1.9 | 1.8                            | 0.1 | 5.8   | (4.0- 8.6)   | 1.5  | (0.9- 2.7)   |
| Antisocial                     | 51.5                 | 2.9 | 3.2                            | 0.1 | 21.8  | (16.6- 28.5) | 14.3   | (10.1- 20.3) |

<sup>a</sup>Odds ratios adjusted for sex, race, nativity, age, personal income, marital status, and region

<sup>b</sup>Odds ratios adjusted for sex, race, nativity, age, personal income, marital status, region, and other psychiatric disorders.

# Relationship with Mental Disorder – Forensic Population Studies

- Significant data from convicted Arsonists sent for psychiatric assessment.
- May be suggestive of burden of the morbidity within the psychiatric population as a whole.
  - Tyler and Gannon 2012 – diversion from custody data.
  - Anwar et al 2011 noted increased odds ratios in psychosis, significantly greater than in other types of violent crime.

# Classification of Firesetters

- Typological
  - Often no empirically derived data and are usually lists of potential motivations and psychotherapeutic sexualised motivations that have been superseded
- Systems
  - Incorporating Explanatory Elements

# Typological Classifications (1)

## Harris and Rice: Classification for MDOs

- Psychotics: 33% with few previous incidents of fire setting
- Unassertives: 28% with little history of aggression and offending, but considered to have revenge motivations
- Multi-firesetters: 23% with disturbed childhoods, younger, criminal versatility and high recidivism risk
- Criminals: 16% with disturbed backgrounds, likely to have personality disorder diagnosis, assertive and high risk of recidivism including for new offences.

» Harris and Rice (1996)

# Typological Classifications (2)

- Canter and Fritzon (1998) “Two Axis Model”

|         |              | Object  |   |
|---------|--------------|---|---|
|         |              | Person  | Object  |
| Purpose | Instrumental | <ul style="list-style-type: none"> <li>• Often arise from dispute</li> <li>• Often prior threats</li> <li>• Associated with discernible trigger</li> <li>• Serve specific purpose, usually revenge</li> </ul> | <ul style="list-style-type: none"> <li>• Associated with opportunistic firesetting</li> <li>• Often to achieve criminal ends</li> </ul> |
|         | Expressive   | <ul style="list-style-type: none"> <li>• Fire set in attempt to restore emotional balance</li> <li>• May be coupled with need for attention and deliberate endangerment of life</li> </ul>                    | <ul style="list-style-type: none"> <li>• Often involving serial offences</li> <li>• Public buildings in particular</li> </ul>           |

# Explanatory Models

## Jackson's Functional Analysis

• Source: Jackson et al. (1987)

### Antecedents

- Psychosocial disadvantage ( mental illness, intellectual disability, social inadequacy)
- Dissatisfaction with life and the self (low self esteem, depression)
- Social ineffectiveness (isolation, poor problem solving)
- Specific Stimuli ( such as previous expose to fire)
- Triggers ( over which individual may be powerless).

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### 2. Behaviour - fire setting behaviour

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### 3. Consequences

- Positive reinforcers: Attention on the arsonist, financial or political gain
- Negative reinforce: Protection from stressor.

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### 4. Factors indicating pathological fire-setting

- Recidivism
- Fire setting to property rather than person
- Acting alone or repeatedly with an identified accomplice
- Evidence of personality, psychiatric or emotional problems
- Absence of financial or political gain



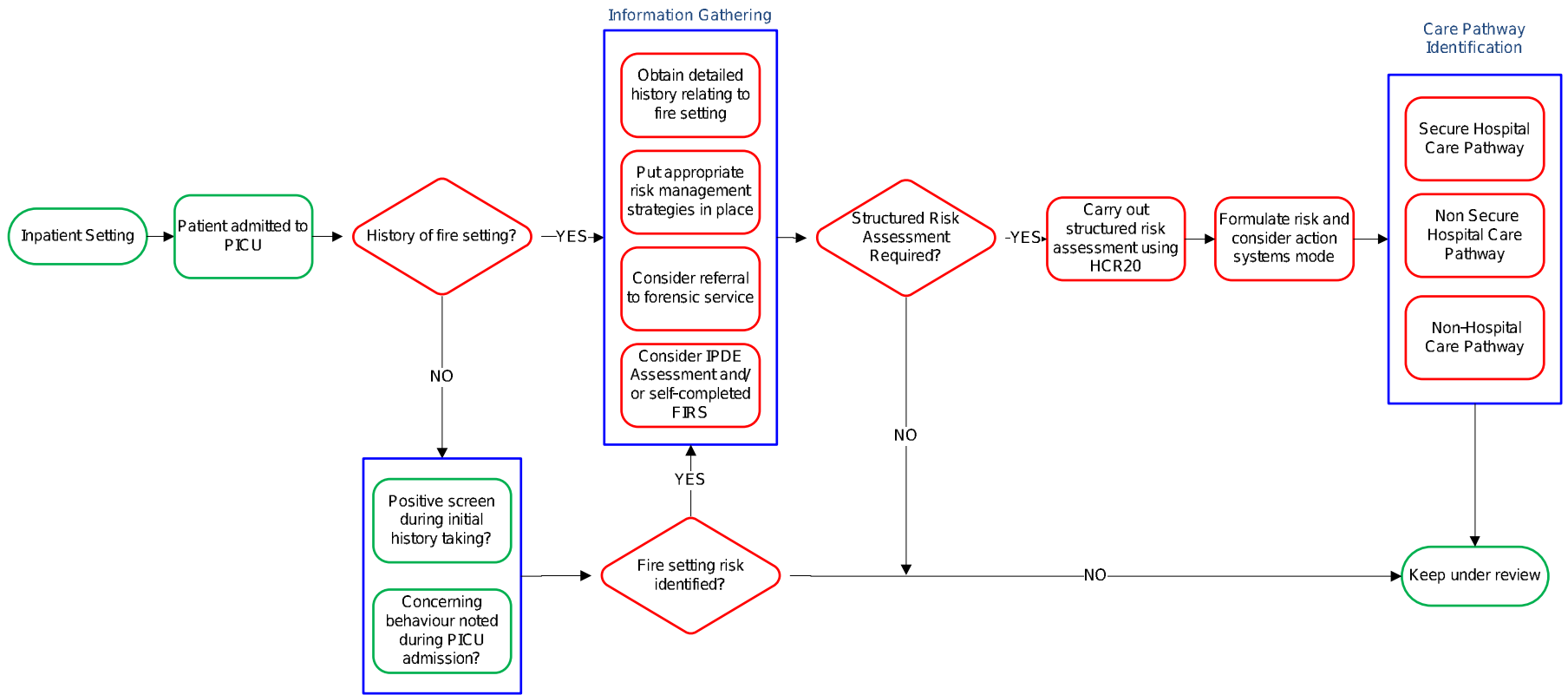
# Action Systems Model

| Source of Action | Effect of Action | <i>Mode</i>                | Characteristics   |
|------------------|------------------|----------------------------|---|
| Internal         | Internal         | <b><i>Integrative</i></b>  | e.g. internal distress resulting in firesetting, self-directed, within own home with suicidal features; often remains at scene.   |
| Internal         | External         | <b><i>Expressive</i></b>   | e.g. exercising power on the external environment, potentially associated with emotional acting out, vicarious attention, remains at scene, often serial offender.  |
| External         | Internal         | <b><i>Conservative</i></b> | e.g. acts that may arise from external events provoking desire for revenge, remove cause of internal distress, to redress emotional well-being, gain emotional relief, may have witness who may be the main source of distress. |
| External         | External         | <b><i>Adaptive</i></b>     | e.g. responding to external events and making adjustments to the environment, probably opportunistic, aim to gain or vandalise, cover up another crime.   |

# Clinical and Risk Assessment of Firesetting – Diagnostic Considerations



# Suggested Assessment and Care Pathway for Fire Setting in Inpatient Settings



## Information Gathering Stage

- 1 – Review / Establish diagnosis and mental state
- 2 – Assess co-morbidity e.g. autism spectrum disorder, intellectual disability, substance misuse
- 3 – Characterise pattern, severity, motivational factors
- 4 – Characterise situational factors and precipitants of fire setting
- 5 – Characterise personality related factors
- 6 – Consider social and demographic factors
- 7 – Assess current criminal justice service involvement
- 8 – Obtain collateral information from informants
- 9 – Consider obtaining police records
- 10 – Assess response to treatment of any identified disorder

## Structured Risk Assessment HCR20

- 1 – Multi-Disciplinary Input from trained professionals
- 2 – Scenario Planning and Risk Management Strategies
- 3 – Overall impressions of risk
- 4 – Consider Forensic Support if necessary/appropriate

## Care Pathway Identification

- 1 – Response to and availability of treatment including psychological, pharmacological, behavioural
- 2 – Appropriateness of current level of security
- 3 – Concurrent involvement with criminal justice system
- 4 – Changes in level of risk
- 5 – Consider Forensic opinion and involvement

## **Box 8: Suggested practical risk management strategies specific to firesetting**

- Ensure that there are clear procedures and rules regarding firesetting threats and behaviours, and that boundaries are known to patients and are adhered to.
- Ensure fire detection and safety equipment and fire safety procedures are known to staff.
- Take any threats to make a fire seriously, and consider as an opportunity to engage with a patient to obtain further information to inform the risk assessment.
- Pay close attention to the circulation of lighters or matches on the ward (count required), particularly at smoking times. Consider enhanced staff presence at these times.
- Be aware of accelerants being obtained or secreted (e.g. wax crayons, soap bars, tissue paper) and whether these are present on the ward.
- Consider whether 1:1 observations are appropriate if risk is escalating.
- Consider whether the physical, procedural and relational security of the ward is sufficient to manage the risk.

# Treatment

- Identification and Treatment of underlying disorder
- Group Work
- Pharmacotherapy