3.3.2 Offence-specific

Three studies included in the review evaluated a group work intervention specific to offending behaviour; two for interventions to address violence and one to address firesetting. This relatively small number of studies is surprising given that the vast majority of individuals admitted to high secure services have committed or are suspected of having committed a criminal offence (NHS England, 2013). Braham, Jones, & Hollin (2008) describe the development and evaluation of a violent offender treatment programme (VOTP). Thirteen male patients with a history of violence were referred to the VOTP and ten of these completed the programme. The VOTP is described as a pilot programme aimed at helping patients develop interpersonal skills, reframe pro-offending and pro-violence attitudes, and equip patients with practical skills to maintain progress and prevent relapse. A particular strength of the VOTP is the recognition that motivation to change is dynamic and can be influenced by a range of internal and external factors.

Outcome was assessed via the use of self-report measures assessing anger, thinking styles, and impulsivity administered pre- and post-treatment. Patients were also assessed pre- and post-treatment using the Violence Risk Scale (Wong & Gordon, 2000) and were assessed at four time points (pre, post, and at two points partway through treatment) using the Clinical Rating Form-Violence (Braham & Jones, 2007). Post-treatment, patients reported lower levels of anger, criminal thinking styles, and impulsivity. Patients' dynamic risk scores also decreased, as did clinical ratings related to acceptance of guilt and responsibility, and minimisation. Empathy, disclosure, participation, and motivation to change ratings also showed improvements.

Although these results are encouraging, Braham et al. (2008) do not report significant levels or effect sizes and did not employ a control group for comparison purposes. It is therefore difficult to draw conclusions about the true extent of positive outcomes. The absence of follow-up data also highlights questions concerning the long-lasting impact of the programme.

A later, purely qualitative, study was conducted by Stewart, Oldfield, & Braham (2012) which utilised interpretative phenomenological analysis to explore interviews of seven service users' experiences of the VOTP, within a high secure psychiatric hospital. Four broad themes were found: consistency, learning and application, the group experience, and programme structure. Findings indicated that participants held positive views of the VOTP. They could relate to the material covered and felt this had enhanced their ability to manage violence and aggression. Recommendations to improve the programme included simplifying programme material, maintaining patient motivation, and ensuring effective communication.

A more recent study by Daffern, Simpson, Ainslie, & Chu (2017) also evaluated the impact of an inpatient violent offender treatment programme, Life Minus Violence-Enhanced (LMV-E). LMV-E is a cognitive-behavioural treatment programme comprising of seven modules delivered over a 10 to 12 month period. The LMV-E

programme employs multiple therapeutic methodologies (e.g. group discussion, skills role plays, and cognitive rehearsal) and was delivered by psychology and nursing staff trained in delivering the programme and supervised by the treatment manager.

The treatment group consisted of 33 male patients, and the comparison group consisted of 42 male patients receiving TAU. A quasi-experimental design was used with the authors citing randomisation to a clinical or comparison group as ethically contentious. The authors note that the original approach to data analysis was to analyse pre, post, and follow-up (1 year following completion of the group) data; however, only a single comparison group member participated in the follow-up assessment. As such comparisons were made between the groups for pre- and post-treatment only. Results showed that FPs in both groups demonstrated reductions in aggressive behaviour, social problem solving, and anger regulation, as well as a reduction in aggregate risk as measured by the HCR-20 Total Score (this reduction was greater for the comparison group). Participants in the LMV-E treatment group showed a reduction in sensitivity to provocation; however, this finding was not extended between post-treatment and follow-up in the LMV-E group.

Daffern et al. (2017) note that the dynamic risk factors included in the study were not exhaustive and this may have impacted upon results given that there are limits to the number of tests that can be imposed upon FPs participating in a clinical treatment programme. Furthermore, it is argued that the small sample size likely impacted the power to detect differences between groups as both groups reported improvements in a number of areas related to aggressive behaviour and anger regulation.

The studies by Braham et al. (2008) and Daffern et al. (2017) provide preliminary support for the effectiveness of violent offender treatment for FPs resident in high security. However, although improvements in anger, impulsivity, and social problem solving corresponded with reduced aggressive behaviour during treatment, the lack of follow-up data begs the question as to whether these gains may be sufficient to effect reductions in violent recidivism in future. The authors acknowledge that future research should explore change following treatment and link these changes with recidivism data.

In the only paper in this review to evaluate an intervention to address firesetting, Annesley, Davison, Colley, Gilley, & Thomson (2017) evaluated group and individual interventions for women firesetters in high secure mental healthcare at the UK's National Women's Service (NWS). For the purposes of this review, their evaluation of two group

Arson Treatment Programmes utilising a cognitive behavioural and cognitive analytical approach will be reported on. All women referred to the groups (n = 22) had a history of firesetting and 86% had arson/firesetting convictions. Some motivation to engage in arson treatment was required. A control group was not included due to ethical issues of withholding treatment, and the authors acknowledged that selecting controls from a wider population would be challenging given the specific population of women within the NWS.

Two Arson Treatment Group Programmes (ATGP1 and ATGP2) developed, delivered, and evaluated between 2007 and 2015. Major developments over time included the introduction of a module on trauma; more experiential and diverse teaching methods; and greater patient involvement. Also, the measures used to assess outcome changed after ATGP1 due to patients' struggles to understand some tests, difficulties administering numerous measures, and researcher advice to use fewer measures.

Post ATGP1 participants reported much less interest in fire, less use of fantasy, less personal distress and less loneliness. Socially desirable responding and blame attribution remained very similar pre- and post-treatment. Participants reported the important roles of social attention, depression, and anger as motivators for fire setting; and post-treatment recognised anxiety as an additional important factor. ATGP2 participants showed improvements post-treatment in all areas of self-capacities, all areas of problem solving, all areas of emotional problems, and on self-liking and global self-esteem. Scores for impression management and self-deceptive enhancement varied slightly but remained within the average range. It was also noted that attrition rates were low for both groups. Thematic analysis was used to analyse qualitative data and positive feedback was obtained along the themes of â€˜good group, great benefitsâ€™ and â€˜(positively) changing attitudes to the group over timeâ€™.

This study evidenced high levels of engagement with group arson treatment programmes, several post-treatment psychometric gains, and positive qualitative feedback and ratings. However, in interpreting the findings it is important to note self-report measures were predominantly used; although results from the deception scales do not suggest invalid scores or areas of concern. As with other studies included in this review, the evaluation is limited by the small sample size and absence of a control group, as well as the lack of follow-up data to monitor recidivism. Furthermore, there are questions with regards to the generalisability of results to male FPs resident in high security.

Reference

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