

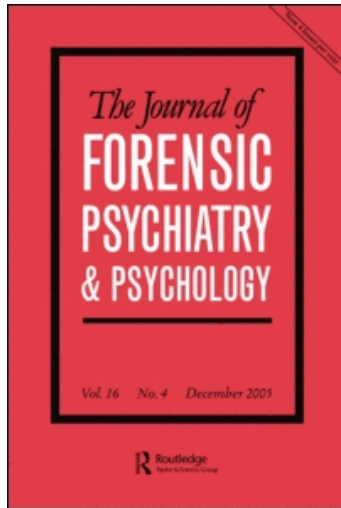
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### Assessment of Deaf people in forensic mental health settings: A risky business!

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## Assessment of Deaf people in forensic mental health settings: A risky business!

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### Abstract

Despite the recent development of specialist services for Deaf mentally disordered offenders, there remains a paucity of research describing this unique population. The evidence base on which service delivery is provided is in its infancy and consequently relies on models and techniques validated within the hearing population. Deaf people have a distinct cultural and linguistic identity, and those who come into contact with forensic mental health services require a service which is suitable to their specific cultural and linguistic needs. Several papers have attempted to describe the characteristics, prevalence, offence taxonomy, and legal issues pertinent to Deaf mentally disordered offenders. This paper attempts to address two omissions in this literature. The first is to bring together a succinct account of what is currently known about Deaf offenders while emphasising what we consider to be the priorities for research in this area. The second is to provide a more detailed account of issues surrounding the assessment of Deaf mentally disordered offenders, as this underpins much of the work carried out with Deaf offenders (e.g., decisions regarding fitness to plead, diagnosis, formulation, intervention, and risk prediction). In doing this we hope to encourage greater synchrony in the research activity and development of Deaf forensic mental health services with the view to establishing an evidence base which is valid for the Deaf population.

**Keywords:** *Deaf, assessment, risk assessment, research*

### Introduction

Only recently have we begun to explore the small population of Deaf people with mental health problems who offend, and as such just a handful of papers are available on this subject. This paucity of research extends to those Deaf offenders who pass through the criminal justice system without mental health issues and reflects our limited theoretical

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understanding of Deaf offenders generally. Much of the current literature focuses on prevalence rates, fitness to plead, rates of diagnosis, and difficulties arising in the legal process due to cultural and linguistic differences (Harry, 1986; Harry & Dietz, 1985; Vernon, Steinberg, & Montoya, 1999; Young, Howarth, Ridgeway, & Monteiro, 2001; Young, Monteiro, & Ridgeway, 2000), the generalisability of which is hampered by small sample sizes, inconsistent inclusion criteria for deafness, and the fact that the 'evidence' is often anecdotal rather than empirical.

In the UK, Rampton Hospital in Nottinghamshire provides specialist forensic mental health services for Deaf people in conditions of high security. More recently, Alpha Hospitals (formerly Mayflower) have established a medium secure unit for Deaf people in Greater Manchester. Both services provide intervention within the therapeutic milieu of a Deaf community, aiming to foster a positive Deaf identity within service users. The aim of this paper is, first, to provide a summary of our existing understanding of the characteristics of this population by drawing on previous literature reviews and epidemiological research. Emphasis will then be placed on issues surrounding forensic mental health assessment. Research currently in progress within the UK specialist Deaf forensic services will also be described.

### **Models of D/deafness**

There are two dominant models of deafness. The disability model, which stems from a medical construction, views deafness in audiological terms as a physical deficiency in the ability to hear (e.g., the extent of decibel loss). The cultural model takes a social constructivist approach, where deaf people are viewed as different rather than disabled. The former has historically contributed to the oppression of deaf people (see Lane, 1984) and those who identify with the disability model are often referred to in the literature as 'deaf' or 'hard of hearing'. Those who identify with the cultural model are referred to as 'Deaf', with an upper case D (Woodward, 1972) and are likely to be members of the Deaf Community, a distinct group defined by their own cultural norms and language. This paper is concerned primarily with the latter group, whose identity is defined both by membership of the Deaf Community and use of British Sign Language (BSL). The cultural-linguistic barriers that exist between hearing and Deaf people underpin many of the issues that arise when Deaf people come into contact with forensic services.

### **Deaf people in prison and secure mental health settings: An overview of current literature**

The number of Deaf people with mental health problems in both prison and psychiatric settings has been difficult to establish. Lack of Home Office

statistics regarding Deaf prisoners generally precludes the ability to define prevalence with any accuracy (Tumin, 1995). Projected figures regarding the number of Deaf prisoners with or without mental health problems are skewed because surveys fail to distinguish between deafness as a hearing loss later in life and early deafness associated with cultural identity and BSL. Identifying the number of Deaf prisoners with mental health problems is further complicated as prison doctors often experience difficulty communicating with Deaf prisoners, may not have access to interpreters, and may rely on passing notes in written English which many Deaf people will not understand (Fiskin, 1994). Alternatively, one might predict psychiatric prevalence in Deaf prisoners by extrapolating from figures in the hearing forensic population. This would be also be flawed, however, as Deaf people in prison may be at greater risk for developing mental health problems due to social isolation associated with lack of opportunity for communication (Ackerman, 1998). Young et al. (2000) suggest that in the absence of reliable evidence, it is reasonable to predict that communication deprivation, isolation, and the inherent stresses of prison life are likely to increase mental health problems.

There is a general consensus that within secure psychiatric facilities, the prevalence of Deaf people exceeds that within the general population. In a maximum-security facility in the US, Harry and Dietz (1985) identified the prevalence of Deaf people to be five times higher than in the general population at a rate of 5.1 per 1000. In the UK high-security services Monteiro et al. (1999) report even higher rates at 12.3 Deaf people per 1000 compared to the general non-forensic population at 1 per 1000. They partly attribute this to the absence of medium-secure services for this population at that time which meant that Deaf patients were detained in conditions of high security for longer than necessary.

In summary, the prevalence rates of Deaf offenders with mental health needs are not known with any reliability. It is hypothesised that Deaf individuals are over-represented in forensic settings compared with the general population. The reason for this at present is unclear, and if we are to identify ways of preventing first-time and recidivist offending in the Deaf community then research should now aim to address this issue. Moreover, if vulnerability to psychological distress is greater for Deaf prisoners, then it is important that research aims to establish the true prevalence of Deaf people within prison, the rates of mental illness in this population, and the factors that increase such vulnerability, so that ultimately the mental health needs of Deaf prisoners can be identified and addressed.

Young et al. (2001) described the age, gender, offence taxonomy, court disposal, and diagnoses of all 389 Deaf offenders with mental health needs referred to UK specialist Deaf psychiatric services between 1968 and 1998. They report a mean age at first conviction, caution, or court disposal of 24.3 years ( $SD = 8.9$ ) with a peak of 17–18 years for

the overall sample. This is consistent with offending in the general population (Barclay et al., 1995) and contradicts earlier suggestions that first conviction or court appearance will occur at a later age for Deaf offenders (e.g., Denmark, 1994).

In the UK and the US, research reports higher rates of sex offence convictions within Deaf offending populations than hearing forensic populations (Denmark, 1985; Klaber & Falek, 1963). Miller and Vernon (2003) report that 41 out of 97 deaf offenders in a maximum-security facility in the US were convicted of a sexual offence. This was a little over four times the number of sexual offence convictions found in hearing offenders in the same establishment. Young et al. (2001) report that 38.6% of their sample had been convicted of a sexual offence, which is higher than would be expected in the general offending population. Explanations for this are anecdotal and vary from organic brain injury related to the aetiology of some hearing loss (Vernon & Rich, 1997), to psychosocial deprivation, lack of information regarding appropriate sexual behaviour, deprivation of normal emotional relationships through maturing in a linguistically inaccessible environment (Andrews & Conley, 1977), and the experience of childhood sexual abuse (Miller & Vernon, 2003). Each of these factors may play a causal role in sexual offending; however, empirical research is needed to establish which are the most pertinent risk factors for later offending.

With regards to the legal consequences of offending, previous accounts suggest that Deaf offenders are less likely than hearing offenders to be given probation supervision, receiving either a custodial sentence or no sentence at all, as language barriers complicate the provision of supervision (Denmark, 1994). Young et al. (2001) argue against this, reporting that out of 270 Deaf offenders 49% had received a probation order while 24.5% were currently serving or had previously served at least one prison sentence.

In the past, Deaf defendants have been more vulnerable to being judged as unfit to plead – a ruling which subsequently leads to hospital detention. It is because of this that true rates of mental illness within the Deaf forensic population are unclear. Young et al. (2001) report that 53% of a sample of Deaf defendants referred for specialist pre-trial psychiatric assessment was classified as having no mental disorder. Assessment at a specialist Deaf psychiatric service most likely improved the accuracy of the diagnostic outcome because professionals will have been aware of the issues pertinent to assessing Deaf individuals. As such, a large proportion of cases were found to suffer no mental disorder. These figures are taken to confirm that within the criminal justice system Deaf people are commonly misconceived as having a mental impairment or disorder.

The patterns of clinical presentation in Deaf mentally disordered offenders remain unclear, due in part to the paucity of empirical research and the very fact that true rates of mental illness in this population are

blurred by the lack of accuracy and validity in assessment. These complexities are described below.

### **Assessment of deaf people in prison and secure mental health settings**

A person coming to the attention of forensic mental health services will be assessed at different times for various purposes. The individual will have been subjected to police interviews to establish details of the offence, and an assessment to establish fitness to plead and to ascribe the individual to a diagnostic category. If admitted to a forensic mental health service, further psychological assessment of risk, intellectual ability, personality, and cognitive, emotional, and behavioural factors will follow. This may involve clinical interview, self-report questionnaires, criterion-based psychometric tests, and observational methods of assessment. The reliability and validity of these established methods with Deaf people is questionable (Braden, 1994).

#### *Fitness to plead*

Young et al.'s (2001) study provides evidence that a high proportion of Deaf offenders referred for a specialist mental health assessment require an opinion regarding fitness to plead. The referrer, usually a solicitor, is either aware of the difficulties the Deaf person may have in understanding trial proceedings, or carries misguided assumptions of incompetence. In determining whether a defendant is fit to plead an assessment of mental health is usually conducted by a psychiatrist or psychologist. Prior to the Criminal Procedure Insanity and Unfitness to Plead Act (1991), those deemed unfit were automatically admitted to hospital. The Act now allows for a 'trial of facts' to establish the likelihood of guilt in cases of unfitness to plead and permits a range of disposals. In the US, Deaf individuals can potentially be deemed legally incompetent to stand trial due to linguistic incompetence. Vernon et al. (1999) reported on 28 Deaf murderers, 13 of whom were classed as functionally illiterate with no sign language or speech ability. Of those 13, three were ruled linguistically incompetent, two of whom were released despite probable guilt. The remaining defendant remains detained in a psychiatric facility and after 20 years is still being taught American Sign Language (ASL) with the view of eventually being fit to stand trial. This remains a controversial issue.

Harry (1986) described how during competency assessment, the interviewer, who often has little expertise in Deaf issues, assumes that the subject shares a common language with the same features of communication. Unfortunately, this is not the case. Even for those Deaf people fluent in BSL, concerns have been expressed regarding the accessibility of some

legal concepts and the errors that may occur in sign language interpretation (Brennan & Brown, 1997). Many legal terms used in court proceedings lack a sign language equivalent, at least one which forms part of the sign repertoire of the majority of Deaf people (Vernon et al., 1999). The Miranda Warning, which is read to offenders prior to interview or arrest in the US, has been found to be at a conceptual, syntactical, and lexical level above 90% of prelingually Deaf adults (Vernon & Coley, 1978). Phrases such as 'the right to remain silent' and 'without a lawyer present' are considered difficult to convey accurately (Vernon, Raifman, & Greenberg, 1996) and even when finger spelled will mean little to a Deaf person who is illiterate and has not mastered English syntax (Vernon et al., 1999). Translating the UK police caution onto a BSL video has also produced difficulties (Denmark, personal communication, 1997). Brennan and Brown's (1997) study of BSL interpreting in court also supports the notion of a 'mismatch' of language between the jargon-laden verbal legal system and the visual system of BSL.

Vernon et al. (1996) also note that Deaf people may be accustomed to signing papers they do not understand or to nodding agreement to questions so as to avoid appearing stupid. This may apply to the forensic setting where documents such as the Miranda Waiver, search forms, and written confessions are signed through fear of not complying and to avoid appearing ignorant (Vernon, Raifman, Greenberg, & Monteiro, 2001).

### *Diagnostic error*

Diagnostic classification is most commonly guided by nosological systems such as the DSM-IV or ICD-10. These are inherently culturally based and assume an equivalent presentation of mental health problems across different cultures. Presentation of psychological distress that does not fall into a category appears not to exist (Bhugra & Bhui, 2001). Lane (1992) describes these systems as 'audiocentric' and as such inappropriate for Deaf people.

Young et al. (2001) describe how Deaf people are vulnerable to several diagnostic errors. Emphasis on movement and facial expression as part of BSL may be misinterpreted as aggressive or sexually inappropriate which may lead to the Deaf person being erroneously diagnosed as mentally disordered. Lack of speech may be misinterpreted as a cognitive deficit. Conversely, lack of communication and ignorance as to the mental health experiences of Deaf people may lead to a failure to recognise mental health needs. On one hand, then, it seems deafness creates a false impression of mental disorder, while on the other it can mask such a problem (Vernon et al., 1999).

Vernon et al. (1999) suggest a high prevalence of misdiagnosed Deaf people in the USA. They describe one Deaf murderer who was

administered the Minnesota Multi-Phasic Personality Inventory (MMPI) despite severe reading deficits. The subject attempted to mask his difficulties by giving random answers and consequently was assigned a diagnosis that the psychologist felt was validated by his jumbled responses. Limitations in vocabulary have meant that some Deaf people with IQs as high as 120 have been hospitalised and erroneously diagnosed as learning disabled (Vernon & Andrews, 1990). Thacker (1994a) studied 35 mentally ill Deaf people (30 were diagnosed with schizophrenia and five with bipolar disorder) and a matched group of Deaf controls. BSL interviews were videoed and transcribed. Various errors were categorised, some of which have parallels in English thought disorder such as perseveration and echopraxia; however, most categories were also found in the healthy sample. This has obvious implications for misdiagnosis.

Cross-cultural studies also illustrate how psychological distress and symptoms present differently across different cultures, reflecting how such matters are conceptualised according to a culture and its use of language (Bhugra & Bhui, 2001). Theoretically this would apply to Deaf people; however, there are few studies on this. Thacker (1994a) identified certain disorders of 'form and content' in BSL such as 'flights of ideas' reflected in links between hand shapes rather than spoken words.

A diagnosis of personality disorder is vulnerable to cultural bias. Awareness of cultural norms is essential in order to assess how a person deviates from them. There is therefore a danger of viewing 'Deaf' characteristics as indicative of personality disorder, or of excusing deviant behaviour on the grounds of deafness when it is also deviant in the Deaf community.

#### *Clinical interview and offence analysis*

An offence analysis relies partly on a clinical interview with the Deaf patient and is vulnerable to all the inaccuracies noted above. It requires a detailed description of events before, during, and after the event, victim characteristics, and the emotional and cognitive state of the individual at the time. Work carried out in court settings highlights the difficulties that arise when framing questions from a 'hearing perspective' (Brennan & Brown, 1997). The clinician may ask general open-ended questions to avoid leading the person in any way. However for Deaf people using BSL, expressive open-ended questions can be confusing (Hoyt, Siegelman, & Schlesinger, 1981). Brennan and Brown (1997) observed many interpreters turning open-ended questions (e.g., 'How did you feel?') into closed, multiple-choice type questions (e.g., 'How did you feel? Happy, sad, angry?'). This was not to be deliberately misleading but reflects the way BSL tends to be used by Deaf people. This presents a dilemma as Deaf people may be vulnerable to being led (Vernon et al., 1996). Further



research is needed which looks at the process and content of the interview with Deaf people (O'Rourke & Beail, 2004).

One of the main tasks of the clinical-forensic interview is to identify cognitive distortions. These are styles of thinking that neutralise or excuse offending behaviour and as such contribute to and maintain such behaviour. There is very little research on the ways in which Deaf people specifically rationalise their offending behaviour; however, they are likely to do so in a similar way to hearing offenders. Dennis and Baker (1998) identified cognitive distortions that may be specific to deafness. Deaf offenders may blame their deafness, or state they were 'curious' or that they never had the opportunity to learn appropriate sexual behaviour. This strategy is likely to have paid off in the past by enabling the Deaf person to avoid taking responsibility for his or her actions. It may be useful to look further at the cognitive distortions that occur in Deaf offenders and to explore how they reflect and differ from the categories of neutralisation that have been identified in hearing offenders. This may then inform research looking at potential cognitive-behavioural techniques to restructure such distortions.

#### *Psychometric and phallometric assessment*

Psychometric assessment of hearing offenders typically involves measures of intellectual ability, neuropsychological assessment, personality questionnaires, questionnaires relating to particular mental health problems, and various tools to measure static and dynamic factors related to recidivism (this latter group of measures, most commonly referred to as risk assessment, will be discussed separately in light of its significance in forensic settings). In addition, phallometric assessment of sexual offenders may be undertaken using a penile plethysmograph (PPG).

Measures of intellectual ability and neuropsychological functioning most often have a large verbal component and as such poor performance may be interpreted as a deprivation in learning or impairment in brain function. While non-verbal scales in psychometric tests may be used to assess intellectual ability or neurological impairment (Braden, 1994), instructions will need to be translated into sign language, which presents further problems. Language skills within the Deaf community are extremely varied and as such there will be variation in Deaf patients' understanding of the instructions given in psychometric assessment. This in turn will mean that the way in which instructions are interpreted into sign language will vary, reducing the level of standardisation that can be achieved. In the UK the most common method of measuring intellectual ability is via the Weschler Adult Intelligence Scales (third edition; WAIS-III). For Deaf patients, linguistic issues prohibit the use of verbal scales and as such, performance scales are administered and a performance IQ score is obtained. A tentative

comparison can then be made between the Deaf subject and the hearing normative population; however, this does not inform where that individual falls within a distribution of the Deaf community. This can be accomplished using Braden's (1994) norms, compiled using the performance scale scores of a group of Deaf individuals.

With regard to personality measures and other questionnaires, despite attempts to provide 'simple English', 'BSL English', or even BSL/ASL video versions, the reliability and validity of these is highly questionable. Linguistically the difficulty is in adhering closely to the original items; the sign language version may be unintelligible to the Deaf person. However, an ecologically valid interpretation of the concept may be so far from the original as to be an entirely different test. The added difficulties of a lack of Deaf norms, plus the exclusion of concepts important within Deaf culture, would indicate the use of questionnaire measures is not to be recommended at present.

Within general mental health there has been an attempt to produce a BSL version of the Present State Examination (Thacker, 1994b). This is strengthened by the fact that, as a semi-structured interview, it does not rely on exact translation of questions but gathers information to be scored by the assessor. This is encouraging when considering semi-structured risk measures used within forensic settings such as the Psychopathy Checklist-Revised (Hare, 1991) and the HCR-20 (Webster, Douglas, Eaves, & Hart, 1997).

Phallometric assessment may be indicated in the assessment of sexual offenders. However, with the Deaf offender this may prove difficult. With certain individuals there are ethical concerns relating to the capacity to give informed consent (for the cultural and linguistic reasons mentioned earlier). While video material may be useful in assessing offenders against adults, ethical considerations preclude the use of sexually explicit pictures of children (Dennis & Baker, 1998). For hearing individuals this problem is overcome by audiotaped descriptions of sexual acts with children, yet this is not possible for Deaf offenders. Consideration therefore needs to be given to alternative ways of assessing arousal in Deaf people with a history of sexually abusing children. There may be possibilities of developing PPG assessment material using computer graphics or line drawings in order to avoid ethical concerns regarding exploitation of children.

It is well documented that assessment of Deaf people within the criminal justice system is problematic in terms of police interviews and psychiatric and psychological assessment. The dangers of erroneous assessment in the forensic setting are clear and involve the potential failure to identify psychological distress, or identification of mental health problems that are not present. Given the potential power that mental health professionals have over their patients, this can lead to unwarranted and prolonged detention under the Mental Health Act, the inappropriate placement of an

individual in a prison, special hospital, or the community, and a failure to identify high risk of harm to self or others. Even when a Deaf offender has been appropriately placed in a forensic mental health setting the variety of methods used to assess aspects of the psychological problem and offence are unreliable, making it difficult to formulate the problems and devise interventions based on the client's true needs. It seems appropriate therefore that research should be focussing now on the development of assessment methods, psychometric tools, and normative data that parallel those in the hearing setting and reduce the current cultural and linguistic constraints.

### *Risk assessment*

The prediction of risk is vital in forensic mental health services and the development of reliable assessment methods is crucial in this area where professionals and their agencies may be held publicly accountable and legally liable (Carson, 1996; Monahan, 1993). Risk assessment may be defined as a 'probability calculation that a harmful behaviour or event will occur, and involves an assessment about the frequency of the behaviour/event, its likely impact and who it will affect' (Kemshall, 1996).

The basis of assessing risk is research relating to offending behaviour – both base rates and factors relating to recidivism. With regard to the Deaf community, such research does not exist. One of the difficulties of looking at base rates within the Deaf population is that the courts do not keep a record of deafness (Young et al., 2001). The same difficulty exists in the USA (Vernon & Greenberg, 1999).

Risk factors associated with violent and sexual recidivist offending of hearing people have been researched for several decades. Recent meta-analyses of the literature report that static and dynamic variables such as age at first offence, gender, criminal history, juvenile delinquency, response to treatment, level of violence of index offence, use of weapon, living with parents until adulthood, alcohol/substance misuse, personality disorder, previous admissions, intelligence, marital status, victim type, family stability, insight, and pro-criminal attitudes make a significant contribution to the risk of re-offending (Bonta, Law, & Hanson, 1998; Hanson & Bussiere, 1998). Multivariate statistical procedures have led to the development of a plethora of standardised assessments instruments which are now used throughout forensic mental health and prison settings. Commonly employed measures include the Violence Risk Appraisal Guide (VRAG; Harris, Rice, & Quinsey, 1993; Quinsey, Harris, Rice, & Cormier, 1998), the HCR-20 (Webster et al., 1997), Static 99 (Hanson & Thornton, 1999), and the Psychopathy Check List – Revised (Hare, 1991).

Research has only recently begun to describe the characteristics of Deaf people with mental health problems who offend (Young et al., 2001).

Lack of knowledge about this group and the absence of specialist services have severely hampered the assessment of risk. Clinicians have to rely on assessments validated within hearing samples without any knowledge of whether factors predictive of risk generally are relevant to Deaf people. The implication of this is that Deaf patients may be assessed as higher risk than is the case, or lower risk, based on faulty actuarial risk prediction.

### *Static risk factors*

There are theoretical reasons why static factors predictive of risk and used in measures such as the VRAG or PCL-R may not be the same for Deaf and hearing individuals. For example, anecdotally it appears that Deaf people may be frequently 'protected' from the criminal justice system by virtue of their deafness. In 'hearing' assessments the level of risk is increased by greater numbers of convictions and the younger the individual is at their first conviction. The HCR-20 and VRAG predict an increase in recidivism risk if the individual has experienced early maladjustment. Cultural differences in the Deaf community suggest this may have less potency in Deaf cases as Deaf – hearing dynamics within the family make it more likely that early maladjustment appears on historical records. Risk levels are also enhanced on the VRAG if the offender did not live with both parents until the age of 16 years. Conversely, this may be a protective factor with Deaf individuals as it may suggest attendance at residential Deaf school and subsequent assimilation into the Deaf community.

There may be issues of relevance that are specific to deafness which are not captured in current measures, such as aspects of Deaf identity, relationship with the Deaf community, or particular aetiologies of deafness. For example, prelingual deafness is commonly a result of brain damage which has also been linked to aggression, impulsivity, and sexually disinhibited behaviour (Vernon & Rich, 1997). This remains speculative and warrants further study. A further complication is the dubious accuracy of historical information where Deaf people are concerned. Kitson and Thacker (2000) advise scepticism regarding the use of previous assessments by non-specialists, particularly where psychiatric diagnoses are involved. Lack of access to services, lenient treatment by the criminal justice system, or being protected by attendance at residential Deaf school may all impact on the reliability of historical information.

Rates of sex offence convictions in Deaf offending populations are disproportionately high when compared with the hearing populations and it is important that the contributing factors to this are identified. One hypothesis is that attendance at residential schools increases a child's risk of suffering sexual abuse (Dennis & Baker, 1998; Sullivan, Vernon, & Scanlon, 1987). Deaf children may therefore be at an increased risk of becoming abusers themselves (Freund, Watson, & Dickey, 1990; Miller & Vernon, 2003).

*Dynamic risk factors*

Similar problems arise when attempting to assess dynamic/clinical risk variables. The two factors of the PCL-R relate to anti-social behaviour and the personality traits of psychopathic personality disorder. The latter requires an assessment of items such as 'glibness or superficial charm' and a 'callous lack of empathy' which cannot easily be inferred by a hearing clinician who is communicating with a patient via a BSL interpreter. A fluent signing professional, however, may be able to assess these characteristics. Similarly the HCR-20 allows historical data to be modified by clinical features such as lack of insight or negative attitudes. Lack of knowledge resulting from lack of access to incidental learning can masquerade as lack of empathy or poor insight and may or may not be relevant to risk.. Therefore, not only is it more difficult to identify such clinical features in Deaf people, the features may not have the same degree of significance as for hearing people.

**Conclusion**

In this paper we have attempted to summarise the current state of play regarding the characteristics of Deaf mentally disordered offenders, the prevalence of Deaf people in the criminal justice system, and more explicitly the issues to consider in the assessment of Deaf mentally disordered offenders. In doing this we have also attempted to highlight priorities for research in this field, so that specialist services can begin to move forward and develop an evidence base to guide the assessment and treatment of this population. To summarise, we have identified the following key areas for research:

- prevalence of Deaf people in both the prison and secure mental health services
- rates of mental illness in Deaf prisoners
- factors contributing to mental illness in Deaf prisoners
- risk factors for sexual offending
- cognitive distortions involved in offending
- developing valid and reliable assessments
- norming current standardised assessment on the Deaf population
- risk factors for violent and sexual recidivism

Specialist services in the UK have now begun to explore some of these issues. Alpha Hospitals Ltd and Rampton Hospital are currently collaborating on a national project which aims to identify static risk factors for violent and sexual recidivism and base rates for recidivism, and to develop standardised risk assessment on a par with those available to the hearing population.

The Department of Health has also funded a six-month scoping exercise which will produce an estimate of need in relation to Deaf prisoners and mental health. It is hoped that this will be the basis for developing more appropriate inreach to Deaf people in the penal system.

## References

- Ackerman, N. (1998). *Deafness & Prisons – a study of services for Deaf prisoners and the experience of being deaf within a prison environment*. Unpublished BA honours dissertation, Department of Applied social studies. Oxford Brookes University.
- Andrews, J., & Conley, J. (1977). Beer, pot and shoplifting: Teenage abuses. *American Annals of the Deaf*, 122, 557–562.
- Barclay, G. C., Tavares, C., & Prout, A. (Eds.), (1995). *Information on the Criminal Justice System in England and Wales*. London: Home Office.
- Bhugra, D., & Bhui, K. (2001). *Cross-cultural psychiatry: A practical guide*. London: Arnold.
- Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin*, 123, 123–142.
- Braden, J. P. (1994). *Deafness, deprivation and IQ*. New York: Plenum Press.
- Brennan, M., & Brown, G. (1997). *Equality before the law: Deaf people's access to justice*. Durham, UK: Deaf Studies Research Unit.
- Carson, D. (1996). Risking legal repercussions. In H. Kemshall & J. Pritchard (Eds.), *Good practice in risk assessment and risk management* (Vol. 1, pp. 3–12). London: Jessica Kingsley.
- Denmark, J. C. (1985). A study of 250 patients referred to a department of psychiatry for the deaf. *British Journal of Psychiatry*, 146, 282–286.
- Denmark, M. (1994). *Deafness and mental health*. London: Kingsley.
- Dennis, M. J. P., & Baker, K. A. (1998). Evaluation and treatment of deaf sexual offenders: A multicultural perspective. In W. L. Marshall, Y. M. Fernandez, S. M. Hudson, & T. Ward (Eds.), *Sourcebook of treatment programmes for sexual offenders*. New York: Plenum Press.
- Fiskin, J. (1994). *The deaf in prison*. Unpublished dissertation, Cropwood Fellows University.
- Freund, K., Watson, R., & Dickey, R. (1990). Does sex abuse in childhood cause paedophilia: An exploratory study. *Archives of Sex Behaviour*, 19, 557–568.
- Hanson, R. K., & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism. *Journal of Consulting and Clinical Psychology*, 66, 348–362.
- Hanson, R. K., & Thornton, D. (1999). *Static-99: Improving actuarial risk assessment for sex offenders* (User report 97-04). Ottawa: Department of the Solicitor General of Canada.
- Hare, R. D. (1991). *Manual for the Revised Psychopathy Checklist*. Toronto: Multi-Health Systems.
- Harris, G. T., Rice, M. E., & Quinsey, V. L. (1993). Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior*, 20, 315–335.
- Harry, B. (1986). Interview, diagnostic, and legal aspects in the forensic psychiatric assessment of deaf persons. *Bulletin of the American Academy of Psychiatry and the Law*, 14, 147–162.
- Harry, B., & Dietz, P. E. (1985). Offenders in a silent world: Hearing impairment and deafness in relation to criminality, incompetence, and insanity. *Bulletin for the Academy of Psychiatry and the Law*, 13, 85–162.
- Hoyt, M. F., Siegelman, E. Y., & Schlesinger, H. S. (1981). Special issues regarding psychotherapy with the deaf. *American Journal of Psychiatry*, 138, 807–811.
- Kemshall, H. (1996). *Reviewing risk: A review of research on the assessment and management of risk and dangerousness: Implications for policy and practice in the probation service* (Report for the Home Office Research and Statistics Directorate). London: Home Office.

- Kitson, N., & Thacker, A. (2000). Adult psychiatry. In P. Hindley & N. Kitson (Eds.), *Mental health and deafness*. London: Whurr.
- Klamber, M., & Falek, A. (1963). Delinquency and crime. In J. Rainer, K. Altscholer & F. Kallman (Eds.), *Family and mental health problems in a deaf population* (pp. 141–154). New York: Columbia University Press.
- Lane, H. (1984). *When the mind hears*. New York: Random House.
- Lane, H. (1992). *The mask of benevolence*. New York: Knopf.
- Miller, K., & Vernon, M. (2003). Deaf sex offenders in a prison population. *Journal of Deaf Studies and Deaf Education*, 8, 357–362.
- Monahan, J. (1993). Limiting therapist exposure to Tarasoff liability: Guidelines for risk containment. *American Psychologist*, 48, 242–250.
- Monteiro et al. (1999). Personal Communication.
- O'Rourke, S., & Beail, N. (2004). Suggestibility and related concepts: Implications for clinical and forensic practice with deaf people. In S. Austen & S. Crocher (Eds.), *Deafness in mind*. London: Whurr.
- Quinsey, V. L., Harris, G. T., Rice, M. E., & Cormier, C. A. (1998). *Violent offenders: Appraising and managing risk*. Washington, DC: American Psychological Society.
- Sullivan, P. M., Vernon, M., & Scanlon, J. (1987). Sexual abuse of deaf youth. *American Annals of the Deaf*, 132, 256–262.
- Thacker, A. J. (1994a). A sign language version of the Present State Examination: CIDI-SCAN. *International Journal of Research in Psychiatry*, 3, 204–205.
- Thacker, A. J. (1994b). Formal communication disorder: Sign language in deaf people with schizophrenia. *British Journal of Psychiatry*, 165, 818–823.
- Tumin, S. (1995). "In Double Sentence." Two Programmes of "Sign On" broadcast by Channel 4 T.V. 4 & 11 November 1995.
- Vernon, M., & Andrews, J. E. (1990). *The psychology of deafness: Understanding deaf and hard of hearing people*. New York: Longman.
- Vernon, M., & Coley, J. (1978). Violation of constitutional rights: The language impaired person and the Miranda Warnings. *Journal of the Rehabilitation the Deaf*, 11, 1–8.
- Vernon, M., & Greenberg, S. F. (1999). Violence in deaf and hard of hearing people: A review of the literature. *Aggression and Violent Behaviour*, 4, 250–272.
- Vernon, M., & Rich, S. (1997). Paedophilia and deafness. *American Annals of the Deaf*, 141, 302–313.
- Vernon, M., Raifman, L. J., & Greenberg, S. (1996). The Miranda Warnings and the deaf suspect. *Behavioural Sciences and the Law*, 14, 121–135.
- Vernon, M., Raifman, L. J., Greenberg, S. F., & Monteiro, B. (2001). Forensic pre-trial police interviews of deaf suspects: Avoiding legal pitfalls. *International Journal of Law and Psychiatry*, 24, 43–59.
- Vernon, M., Steinberg, A. G., & Montoya, L. A. (1999). Deaf murderers: Clinical and forensic issues. *Behavioral Sciences and the Law*, 17, 495–516.
- Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). *The HCR-20 scheme: The assessment of dangerousness and risk* (Version 2). Simon Fraser University, Burnaby, Canada: Mental Health, Law, and Policy Institute.
- Woodward, J. (1972). Implications for sociolinguistics research among the deaf. *Sign Language Studies*, 1, 1–17.
- Young, A., Howarth, P., Ridgeway, S., & Monteiro, B. (2001). Forensic referrals to the three specialist psychiatric units for deaf people in the UK. *Journal of Forensic Psychiatry*, 12, 19–35.
- Young, A., Monteiro, B., & Ridgeway, S. (2000). 'Deaf people with mental health needs in the criminal justice system: A review of the UK literature'. *Journal of Forensic Psychiatry* 11(3): 556–570.