Deaf People who Come into Contact with the Criminal Justice System and who have Mental Health Needs: A Review of the UK Literature

Alys Young PhD, MSc Oxon., BA (Hons.) Cantab., CQSW Associate Head (Research), School of Community, Health Sciences and Social Care, University of Salford.
Brendan Monteiro M.B.B.S., L.R.D.P., M.R.C.S., MRC Psych, Consultant Psychiatrist, National Centre for Mental Health and Deafness, Mental Health Services of Salford Trust.
Sharon Ridgeway PhD, MSc, BA (Hons.), CQSW, Research Psychologist and head of Counselling Services, National Centre for Mental Health and Deafness, Mental Health Services of Salford Trust.

Address for Correspondence:

Dr A.M. Young
School of Community, Health Science and Social Care
University of Salford
Allerton Annexe
Frederick Road
Salford
M6 6PU

A.Young@social-work.salford.ac.uk

Abstract

This paper concerns Deaf people who use sign language, who come into contact with the Criminal Justice System in the UK, and for whom mental health needs are associated with their offending behaviour. It critically reviews the existing literature regarding evidence of the prevalence and characteristics of this group drawing evidence from a range of contexts: prisons, high security services, specialist mental health services, and the police and courts. Particular attention is paid to the relationship between deafness, sign language use, mental disorder and unfitness to plead. Also, consideration is given to the extent to which a limited range of linguistically appropriate disposals for Deaf mentally disordered offenders may account for their twelve times higher prevalence in the high security population than in the general population. Finally, the clinical characteristics of this population are discussed in relation to a range of psycho-social consequences of Deafness and sign language use in the UK today. The paper is written by a bilingual team of both Deaf and hearing professionals spanning the academic and clinical disciplines of psychiatry, psychology and social science.

Key Words: Deaf; deafness; sign language; BSL

Word count: 4,950 (excluding reference list)

Introduction

The focus of this paper is the small population of Deaf people in the UK who come into contact with the Criminal Justice System, and for whom there are psychiatric concerns associated with their offending. Whilst the more straight forward expression 'deaf mentally disordered offenders' may seem a more succinct description, as this paper will demonstrate, all of those four words contain significant myths and misconceptions when applied to this population. Furthermore, despite the increasingly needs-led approach to mentally disordered offenders in general, this is a group of people whose needs remain consistently ill defined, to whom the Criminal Justice System finds it particularly difficult to respond, and about whom current evidence is sparse, contradictory and in many cases unreliable.

The aims of this paper, therefore, are: to give clarity to a definition of this population; to review critically the evidence available on the prevalence and characteristics of Deaf people with psychiatric needs within the Criminal Justice system in the UK; and to consider a range of theoretical explanations that attempt to account for this evidence.

Defining Deafness

Over eight million people in the UK have some kind of hearing loss, with the vast majority losing their hearing as a consequence of aging (RNID, 1998). However, there is a much smaller, distinct group of people for whom the description 'Deaf ' does not define that they cannot hear, but rather that they have a distinct way of life (Ladd, 1988). This is the group of people usually referred to as the Deaf Community. They have their own language – British Sign Language (BSL). It is not a visual

representation of English or some form of gesturing, but rather a fully grammatical, living language as complex as any other (Sutton-Spence and Woll, 1999). Over the centuries, a clearly identifiable minority culture has evolved through the association of users of this language with each other (Lane, 1992). Deaf culture has its own traditions, history, values, characteristics, attitude and norms of behaviour (Higgins 1980). For people who are in this sense, 'culturally Deaf', hearing impairment does not represent a loss or a deviance from that which is normal (i.e. to be hearing). Rather, to be 'Deaf' is to possess characteristics and heritage that form a positive identity that is distinct from that of hearing people. Hence the convention has arisen that 'deaf' with a lower case 'd' refers to the audiological condition of not being able to hear, whilst 'Deaf' with an upper case D refers to cultural/linguistic identity (Woodward 1972).

It is Deafness in this sense of language use and cultural identity with which this paper is concerned and specifically the group of people, drawn from this community, who come into contact with the Criminal Justice System and who have psychiatric needs. [In what follows *'Deaf'* people is taken to refer to this cultural-linguistic minority and not the larger population of people with a hearing loss and for whom spoken language is the usual means of communication.]

In terms of the Deaf Community as a whole, estimates of the number of people in the UK for whom BSL is their first, preferred, or only language range from 62 – 70,000 (BDA, 1999; HMSO 1996). The distribution of intelligence in this group is largely consistent with that in the general population (Conrad, 1979), although aetiologies of deafness associated with organic brain damage skew the distribution slightly at the lower end (Hindley, 1997). Despite this largely normal distribution of

intelligence, the majority of Deaf people who may be fluent in BSL, are likely to have achieved poor levels of English literacy. The average reading age of a deaf school leaver was found in the late 1970s to be 8.9 years (Conrad, 1979) and there is no evidence to suggest this has substantially improved (Powers, Gregory and Thoutenhooft, 1999). A minority of Deaf people will develop intelligible spoken language skills, however, even amongst those who do, many do not rely on spoken language for general communication. With regard to receptive communication, many Deaf people who use sign language are, in audiological terms, severely/profoundly deaf. For this group, hearing aids provide little auditory input and lip-reading is unreliable without significant auditory clues. In other words for *Deaf* people, British Sign Language is the only potentially completely accessible means of communication.

As will become clear, consistent failure adequately to understand these basic characteristics of this community has significantly impacted on the reliability of the evidence we have about Deaf people in the Criminal Justice System, and on the way they are treated by that system. Associated psychiatric aspects compound the picture further.

Prevalence

Evidence from the Prison Population

It is impossible to state with any accuracy the number of Deaf prisoners in the UK with psychiatric needs or for whom psychiatric disorder is concurrent with their offending. Firstly, there is in general no official Home Office policy on keeping statistics on Deaf prisoners in England and Wales (Tumin, 1995). Neither the Northern Ireland Office nor the Scottish Office keeps an official register of prisoners

who are Deaf or have a hearing impairment (Phillips, Dobash and Bruce, 1994; Smiley, 1998). Secondly, the surveys that have been carried out do not make a distinction between deafness as hearing loss and Deafness associated with sign language use and cultural identity. Consequently, official figures regarding the number of Deaf prisoners should be viewed with some caution.

Home Office surveys in 1987, 1996 are consistent in recording that around 0.1% of the prison population in England and Wales have a "hearing impairment", with the actual numbers rising from 45 in 1987 to 52 in 1996 (Home Office, 1996; HM Prison Service, 1996). In a survey of all Scottish prisoners Phillips et al (1994) identified 25 prisoners with a 'hearing impairment' (0.5% of the prison population). However, as in the case of the Home Office surveys, no differentiation was made between prisoners with a hearing loss and prisoners who were sign language users. Indeed further confusion was created by separately categorising 'hearing impaired' and 'speech impaired'. A tighter definition of 'profoundly deaf' prisoners or deaf prisoners who use sign language has suggested that there are usually between 63 and 100 Deaf Prisoners in England and Wales at any one time (Gibbs and Ackerman, 1999; Straw, 1998; Tumin, 1995).

With regard to mental health, there are very little data on psychiatric assessments or on the general mental health of Deaf prisoners (Brennan and Brown 1997). In the 1987 Home Office study, prison doctors assessed that 14 out of the 45 prisoners (i.e. 31%) defined as 'deaf' within the terms of that survey, required psychiatric treatment. However, the reliability of this figure is difficult to determine as prison doctors also reported considerable difficulties in communicating with Deaf prisoners, in taking a medical history, and highlighted the lack of interpreter provision

available to them (Fiskin, 1994). Such communication difficulties can easily result in both false attribution of psychiatric need, and in lack of recognition of such need (Monteiro and Neeney, 1992). Ackerman (1998) reports the case of a Deaf prisoner placed on a hospital wing simply because prison staff were unable to communicate with him to find out the source of his irritable and angry behaviour. Deaf prisoners themselves have reported the inadequacies of initial medical/psychiatric screening on reception into prison when it is carried out by means of passing notes between themselves and the doctor, and when the prisoner does not necessarily fully understand the written English in the first place (Fiskin, 1994).

In the general prison population, a recent Health Advisory Committee Report (1997) concludes that 6% of remand prisoners and 39% of sentenced prisoners in England and Wales have mental health problems. A survey of mental disorders among prisoners found that over 7 out of 10 prisoners in England and Wales were assessed as having more than one of the main types of mental disorder (HMSO 1998). However, extrapolation from these figures to the Deaf prison population may not be a valid way of estimating the prevalence of mental health problems in the Deaf prison population.

There is some reason to believe that Deaf prisoners are more likely than their hearing peers to have mental health difficulties whilst in prison because of the way in which their communication needs compound the isolation and stress of prison life (Ackerman, 1998; Channel 4 TV, 1995). Despite the Prison Service's attempts to redress the situation (Ross, 1999), it is still the case that few prison officers are able to use sign language to explain even the most basic procedures and information about prison life (Egan, 1996). Communication with fellow inmates is also likely to be

severely limited (Ackerman 1998). Consequently, basic information about what is happening to them, supportive contact with prison staff, understanding of their rights as prisoners, and social interaction are all likely to be missing (Gibbs and Ackerman, 1999). The isolation is further compounded by the inaccessibility of the usual distractions from the tedium of prison such as watching television and being in telephone contact with friends and relatives (Fiskin, 1994). A HM Prison survey of facilities for 'disabled prisoners' found that none of the 118 establishments that responded had a minicom (i.e. a text telephone with a keyboard that can be used by Deaf people along the conventional phone lines). No establishment reported having a teletext television that could broadcast subtitled programmes, and only 3 had a loop system available that assists in amplification for hearing aid users (HM Prison Service, 1997).

These factors when combined, and which make up the usual experience of Deaf prisoners in the UK, result in *an experience of severe communication deprivation* within an enclosed and isolated environment. Consequently, circumstances such as these are unlikely to be supportive of good mental health amongst Deaf prisoners. However, no reliable evidence currently exists with which to substantiate this assumption.

Evidence from Secure Facilities

A formal service for Deaf people was established at Rampton, one of the four high security psychiatric hospitals in the UK, in 1987 (Robinson and Collins, 1996). At time of the review of Deaf Services there in 1995/1996, there were 5 in patients and 1 patient who had very recently left who participated in that review (Oxley et al, 1996).

A recent point prevalence survey of high security psychiatric hospitals in the UK found that there were 13 detained Deaf patients (Monteiro, Ridgeway and Young, 1999), i.e. patients who use sign language and who had associations with the Deaf Community. Although these numbers are of themselves very small, the pertinent question is whether Deaf people are *over represented* in the high security psychiatric hospital population.

Certainly, research from the USA (Harry and Dietz, 1985), and Sweden (Remvig and Sturup, 1957) has all suggested that Deaf patients are likely to be over represented. For example, a population based study (Harry and Dietz, 1985) of 'profoundly deaf defendants' admitted to maximum security facilities in Midwestern State Mental Hospital in the USA, found the prevalence rate of "prelingual deafness" in this special hospital population to be 5.1 per 1,000. They concluded that this was 5 times higher than the prevalence rate for prelingual deafness in the general population that at the time was estimated at 1.0 per 1,000. If a similar analysis is carried out on figures from the recent UK study (Monteiro, Ridgeway and Young 1999) using data only from England and Wales, we find a prevalence rate for Deaf people in high security hospitals of 12.3 per 1,000[i]. This compares with the prevalence of Deaf people who use sign language in the general population of England and Wales of just under1 per 1,000 (HMSO 1996).

Clearly, when dealing with such small numbers of people and population figures, some of which are themselves, only best estimates, there is a margin of error. However, the differences in prevalence between the Deaf population and the general population with regard to detention in high security psychiatric hospitals is so large, that the central issue of over representation remains valid.

Why there should be such over-representation is a complex question to pose. Certainly one important structural contributor to this result is the lack of any specialist Deaf medium secure facility in the UK. Specialist facilities only exist in the high security/high dependency setting of Rampton, or in the 'open ward' environments of the three specialist general psychiatric units for Deaf adults in the UK, based in London, Birmingham and Manchester. Consequently, if it is not appropriate for a forensic patient to be treated on an open ward, there are few options other than to be cared for within the specialist high security psychiatric facility at Rampton, or within a medium secure facility that has no specialist knowledge of Deafness or sign language, or in a few cases within other high security facilities that have no specialist Deaf knowledge/training. Consequently, there are some Deaf patients in the UK kept in conditions of high security who would be more appropriately treated in conditions of medium security, if such specialist Deaf medium secure facilities existed. However, precise numbers of this group are not known.

Clearly within the general forensic population the problem also exists of 'over-containment' in special hospitals where long term medium secure facilities would be more appropriate if more beds were available (Eastman, 1993). But the consequences for Deaf patients of a limited range of secure accommodation is particularly difficult because of the necessity of meeting their linguistic and cultural needs, and of providing an appropriate therapeutic milieu in sign language. There is some evidence to suggest that because of this linguistic imperative, the specialist Deaf psychiatric open ward environments have attempted to take some forensic patients who would ideally require conditions of greater security/dependency. However, the cost in resources and extra staffing, and the negative consequences for other general

psychiatric patients on the same ward, has made this strategy largely unfeasible (MHSST 1998).

In short, it may be that these structural circumstances around available provision, rather than psychopathology per se, account for the seemingly high prevalence of Deaf people in special hospitals although that hypothesis remains to be tested.

Evidence from Statistics on 'Unfit to Plead'

The relationship between mental disorder, Deafness and fitness to plead is a complex one. Historically, Deaf people have been automatically regarded as 'unfit to plead' simply because they were Deaf and did not speak, and regardless of formal education or understanding e.g. Rex. v. Pritchard (1836). (Jackson (1998) provides an historical account of case law surrounding Deaf defendants from the 18th Century onwards).

Under the current 1991 Criminal Procedure Insanity and Unfitness to Plead Act, the Court has a duty to determine whether any defendant is 'unfit plead'. The designation 'unfit to plead' is founded on two main criteria: inability to understand the Court proceedings including the charge and the evidence, and inability to instruct counsel in one's own defence including being able to challenge a juror. Prior to the 1991 Act, under the previous legislation (The 1964 Criminal Procedure (Insanity) Act), if the Court found a defendant unfit to plead they had "no option but to make an order that the accused be admitted to such a hospital as may be specified by the Home Secretary" (Butler Report 1975) - usually a secure hospital. There was no requirement to establish the guilt of the defendant, nor to establish whether s/he were suffering from a mental illness or not. Thus those found unfit to plead, by nature of

their disposal, became classified as 'mentally disordered offenders' regardless of whether there was an identifiable mental illness present or not, and they were held in secure accommodation regardless of whether they had committed the crime or not. The case of a Deaf man, Glen Pearson, was amongst the most publicised examples of the injustice of this law prior to reform. He was accused of stealing two lightbulbs and £5.00 (Fogarty 1990). When the case came to Court he was found 'unfit to plead' on grounds of, as a sign language user, not understanding the charge and of not being able to instruct counsel. He was not found to be mentally ill nor severely mentally handicapped (Carvel, 1990). However, he was detained in a special hospital for nearly four months until a highly public and successful appeal was made to a mental health review tribunal (Fogarty, 1990). By contrast the new 1991 Act allows for the possibility of what is termed 'trial by facts', the aim of which is to establish the likelihood or not of guilt in cases of unfitness to plead (Eastman, 1993). It also provides for a range of disposals including supervision and probation orders, rather than detention in hospital. Thus, inability to understand the legal process is not rendered necessarily synonymous with mental disorder and detention in a psychiatric hospital.

Against this background, the limited available evidence, suggests a significantly high incidence of Deaf defendants amongst the population of unfit to pleads in England and Wales prior to 1991, and a consistently high number of Deaf people post 1991 whose fitness to plead is questioned by the Courts. In a retrospective study of all incidences of 'unfit to plead' in England and Wales between 1976 and 1988 (Grubin, 1991), 2.4% of the total were 'deaf'. In an audit of 77 referrals to the National Centre for Mental Health and Deafness (based it the North West of England)

between 1981 and 1997 (MHSST 1998), the question of fitness to plead was part of the reason for referral in 39% of cases (n=30). Of these 30 clients, 14 (47%) were subsequently assessed as unfit to plead (although the more intriguing figure is perhaps that of the 53% who despite the Courts' concerns were fit to plead).

In the context of the legal situation outlined above, there are a number of reasons that may explain these figures in the Deaf population. Firstly, it is only recently that the Criminal Justice System in the UK has recognised the legitimacy of British Sign Language as an adequate language of both thought and communication in the Court setting (Brennan and Brown, 1997) and consequently its users as potentially competent defendants. In the wider context, the status of BSL as a full language grammatically distinct from English was only demonstrated linguistically in the early 1980's (Kyle and Woll 1985), its status as an indigenous language of the UK only recognised by the European Parliament in 1988 (Resolution OJ c 187) and to date this European directive has remained unratified by the UK government. In these circumstances it is hardly surprising that the use of BSL has been regarded as a problematic indicator of fitness to plead. The suspicion persists that Deaf people are assumed not to be able to instruct counsel or understand the Court proceedings simply because they use sign language, rather than for any other reason.

However, these socio-linguistic issues that may lead to injustice (Brennan and Brown, 1997) should also be set against evidence that a small but significant part of the general Deaf community have minimal language skills in any language, be it British Sign Language or otherwise (Conrad, 1979). This situation tends to arise as a result of early language deprivation and/or other organic, cognitive, or language disorders coincidental with their deafness (Gregory and Hindley, 1996).

Consequently, there will be Deaf people coming before the Courts with minimal language skills who on these grounds, rather than on sign language use per se, may be found unfit to plead.

Thus, the key issue with regard to Deaf defendants and the designation 'unfit to plead', is the extent to which the Courts are able to unpack the complex relationship between the semantic capacity of sign language per se, and any given individual's cognitive/communicative capacity who is a user of that language.

Evidence from the Police, Courts and Probation Services

It is virtually impossible to obtain any data on how many Deaf people have come before the Courts in the UK. This is because the Courts do not specifically keep records of incidences in which defendants or witnesses were Deaf. In a recent study of all Magistrates Courts within the Duchy of Lancaster, attempts were made to estimate the number of Deaf defendants over a three year period by means of tracing the number of times the Court paid for a sign language interpreter (Young, Monteiro and Ridgeway, 1999). However, 12 out of the 20 Courts contacted, kept no such records, or if they record payments to interpreters did not record what kind of interpreter. In a study of sign language interpreting mainly within the Crown Courts (Brennan and Brown, 1997), the research team, unable to ascertain any retrospective data, had to make arrangements to be alerted to cases as they occurred. However, as the number of Deaf people coming before the Courts is small because the Deaf population overall is small, this method was also erratic, time consuming and unpredictable.

Despite lack of research evidence significant assumptions exist, and are anecdotally, consistently reported, about the way in which Courts deal with Deaf people, particularly with regard to sentencing (e.g. Green, 1990). It is suggested, that Deaf defendants are more likely than their hearing counterparts to receive custodial sentences, or no sentence at all rather than alternatives such as probation, community or supervision orders (Denmark 1994; Kent 1988). The reason offered is that such orders are unfeasible because few probation officers have any sign language skills with which to attempt to supervise them. With regard to mental health needs and Court appearances, an audit of 77 forensic referrals (1981-1999) to the National Centre for Mental Health and Deafness, based in Manchester, found that 40% were made in relation to psychiatric assessments prior to Court appearances or sentencing. Although this number of referrals seems reassuringly high, in that it appears that the mental health needs of Deaf defendants are being considered seriously, it remains a figure largely without context. It is not known in how many cases overall, the mental health needs of Deaf defendants are not considered or recognised, nor the number of cases where pre-Court or pre-sentence assessments are sought but not from specialists in mental health and deafness who can sign.

The other significant and recurring assumption made with regard to Deaf people and their treatment by the Courts, is linked to the notion of Court Diversion Schemes. These are schemes designed to identify the mental health needs of people at point of detention in police custody and subsequently to divert them away from the court system into appropriate psychiatric and social services instead. In the case of Deaf people there is some concern that this system does not operate appropriately. Some reports indicate that the Police may actually decide not to arrest Deaf people for

minor offences, out of a misplaced sense of compassion, or because it would be troublesome to proceed because of the necessity of meeting the Deaf person's language needs (Denmark 1994). If this were the case, then opportunities become significantly limited to recognise and respond early to Deaf people's mental health needs that may be associated with anti –social behaviour or minor offending. However, once again no hard evidence exists to substantiate these observations that have been made by professionals working with Deaf people.

Characteristics of the Population

Little is known of the characteristics of Deaf people's offending behaviour and the nature of their mental health problems. The difficulty is that there are long standing assumptions, based on evidence of questionable reliability, that Deaf people are both more likely than hearing people to commit crime (Andrews and Conley, 1977; Hentig, 1967); and more likely to commit particular sorts of crime – namely crimes of violence and sexual offences (Denmark, 1985; Harry and Dietz, 1985; Klaber and Falek, 1963). However, in reality there is very little evidence about the patterns and characteristics of offending behaviour in the Deaf population in general. Studies that do exist have tended to be carried out amongst the clinical population of Deaf people in specialist psychiatric facilities. Therefore, whilst this evidence may tell us quite a lot about the co-incidence of offending behaviour and serious psychiatric illness, it is actually evidence from a highly specific sub set both of the general Deaf population and of the population of Deaf people with mental health needs. Furthermore, very few research studies have been carried out in the UK (most of the studies cited in this section are drawn also from the US literature).

In a study of 250 randomly selected patients referred to a Department of Psychiatry for Deaf People in the UK, 33 were charged with criminal offences of which 7 had committed crimes against the person involving assault and 11 had committed sexual offences (Denmark 1985). Denmark (1994) concluded that this figure demonstrated a significantly greater likelihood than hearing people to commit such offences. These findings supported an earlier study in the USA (Klaber and Falek, 1963) which found that of 51 Deaf people indicted for various offences, 19 were charged with sexual offences and 8 with assault. Vernon and Rich (1997) present a retrospective study of 22 cases of deaf individual suffering form paedophilia, although no indication is given of the size of the overall clinical population from which this sample is drawn. In an audit of 77 patients with forensic referrals to the National Centre for Mental Health and Deafness (MHSST 1998), 89 offences were recorded in connection with the referral. Of these, 25 were offences of violence (such as assault and attempted murder) and 39 were sexual offences (including e.g. sexual assault, rape/attempted rape and unlawful sexual intercourse).

Various explanations have been offered to account for this high proportion of violent and sexual offences. It had been considered that there was a specific "Deaf personality" that was characterised by impulsive aggressive behaviour with few internal physiological inhibitors to such behaviour (e.g. Altschuler et al, 1969). Consequently this character set was presumed to explain the tendency towards violent and sexual crimes (Hentig 1969). However, whilst the pathologising of Deaf people as possessing a deviant personality structure has now been rejected (Lane 1992), there is growing evidence to suggest that organic features associated with *some* aetiologies of deafness, in particular brain damage and rubella, may indeed be connected with

impulse control problems (Chess and Fernandez 1980), and aggressive and sexually disinhibited behaviour (Vernon and Rich 1997).

Psycho-social factors are also held to contribute to an explanation of the heightened rate of violent and sexual offending. As already discussed, Deaf people are likely to experience severely limited access to information and social interaction for a variety of reasons –few significant others who sign; they cannot easily pick up information through hearing/overhearing; levels of literacy are likely to be poor; some Deaf people have severely restricted linguistic abilities in any language. Consequently, it has been suggested that it is much harder for Deaf people to acquire knowledge of appropriate sexual behaviour, and receive social feedback about their own sexual behaviour (Denmark, 1994). More generally poor communication and interaction within both developmental and adult environments have been linked to a range of experiences that may restrict Deaf people's ability to understand moral reasoning and the significance and consequences of criminal behaviour. Factors mentioned included the inconsistency of social feedback (Luterman 1978); a severely restricted range of social interactions (Decaro and Emerton, 1978); deficits in role taking ability (Couch, 1985); restricted ability to assume the perspectives of others (Bachara, Raphael and Phelan, 1980); and inaccurate and misconceived information about the social world (Andrews and Conley, 1977).

Whilst these experiences clearly may be relevant to Deaf people's offending behaviour and mental health problems associated with it, we are a long way from understanding the nature of the corollaries and connections between these factors and offending behaviour. Put another way, it is just as important to pose the question why so many Deaf people who may share these experiences of linguistic and social

deprivation do *not* commit offences of a violent or sexual nature. The fact that the limited evidence that does is exist is drawn from a clinical sub set further restricts our ability to establish normative understanding of the offending behaviour of Deaf people in general.

Conclusions

Deaf people who have been the subject of this paper are a very small proportion of the general population. Those within that community who have mental health needs and who come into contact with the Criminal Justice System are an even smaller group. However, as this paper has demonstrated, the size of the population is not really the issue. This is a group whose needs are primarily not recognised or not met because of mis-defintion, misunderstanding and inadequate or inappropriately designed responses to their offending behaviour. In important ways, that we do not yet fully understand, the pattern of offending behaviour and the mental health needs associated with it, seem to differ from that of the hearing population. There remains a great deal of research to be carried out in order to do the most simple thing – to describe adequately this population and to provide appropriate and targeted responses its needs.

References

Ackerman, N. (1998) 'Deafness and Prisons – A study of services for deaf prisoners and the experience of being deaf within a prison environment'. (unpublished BA Hons. dissertation, Dept. of Applied Social Studies, Oxford Brookes University).

Altschuler, K., Rainer, J.D. (1969) *Comprehensive Mental health Service for the Deaf* 2nd ed. New York: New York State Psychiatric Institute.

Bachara, G.H., Raphael, J., Phelan, W.J. (1980) 'Empathy Development in Deaf Pre-adolescents'. *American Annals of the Deaf* **125**: 38-41.

BDA, (1999) *The British Deaf Association On-Line.* http://www.bda.org.uk/

Brennan, M., Brown, G. (1997) *Equality before the Law. Deaf People's Access to Justice.* Durham: Deaf Studies Research Unit.

Carvel, J. (1990) 'Help for those unfit to plead is shelved'. Guardian Newspaper, June 16th.

Channel 4 Television, (1995) 'In Double Sentence', two programmes of 'Sign On' broadcast 4th and 11th November.

Chess, S., Fernandez, P. (1980) 'Neurological Damage and Behaviour Disorder in Rubella Deaf Children'. *American Annals of the Deaf* **125 (8):** 998-1001.

Cohen, A., Eastman, N. (1997) 'Needs Assessment of Mentally Disordered Offenders and Others Requiring Similar Services'. *British Journal of Psychiatry* **171:** 412-416.

Conrad, R. (1979) *The Deaf School Child, Language and Cognitive Function.* London: Harper Row.

Couch, C.G. (1980) 'A Test of Kohlberg's Theory: the evelopment of moral reasoning in deaf and hearing individuals'. Unpublished doctoral dissertation, University of North Carolina at Greesboro.

DeCaro, P., Emerton ,R.G. (1978) 'A Cognitive-Developmental Investigation of Moral Reasoning in a Deaf Population'. Paper presented to American Educational Research Meeting.

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, J.C. (1994) *Deafness and Mental Health.* London: Jessica Kingsley.

Department of Health and Home Office, (1992) 'Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services: Report of the Official Working Group on Services for People with Special Needs'. London: HMSO.

Egan, D. (1996) 'Deafness Behind Bars'. *See Hear Magazine!*, March, 8-9.

Eastman, N.L.G. (1993) 'Forensic Psychiatric Services in Britain: A Current Review'. *International Journal of Law and Psychiatry* **16:** 1-26.

European Parliament, (1988) Resolution on Sign Languages, June 18, Resolution OJ c 187.

Fiskin, R. (1994) 'The Deaf in Prison', unpublished dissertation undertaken during a Cropwood Fellowship.

Fogarty, (1990) 'A Plea for those Unfit to Plead'. Guardian Newspaper, February 7th.

Gibbs, A., Ackerman, N. (1999) 'Deaf Prisoners. Needs, Services and Training Issues'. *Prison Service Journal* **122:** 32-33.

Green, J. (1990) 'Who do you turn to when justice is deaf?' Independent Newspaper, April 17th.

Gregory, S., Hindley, P. (1996) 'Annotation: Communication Stratgies for Deaf Children'. *Journal of Child Psychology and Psychiatry* **37(8):** 895-905.

Grubin, D.H. (1991) 'Unfit to Plead in England and Wales 1976-88, A Survey'. *British Journal of Psychiatry* **158:** 540-548.

Harris, R.I. (1978) 'Impulse Control in Deaf Children: research and clinical issues'. In L.S. Liben (Ed) *Deaf Children Developmental Perspectives*. Orlando: Academic Press, pp. 137-156.

Harry, B., Dietz, P.E. (1985) 'Offenders in a Silent World – hearing impairment and deafness in relation to criminality, incompetence, and insanity'. *Bulletin of the American Academy of Psychiatry Law, V* 13 (1): 85-96.

Health Advisory Committee, (1997) *The Provision of Mental Health Care in Prison*. London: HMSO.

Hentig, H. (1967) *The Criminal and his Victim- Studies in the Sociology of Crime.* Archon Books.

Higgins, P. (1980) *Outsiders in a Hearing World: A Sociology of Deafness.* London: Sage Publications.

Hindley, P. (1997) 'Psychiatric Aspects of Hearing Impairment'. *Journal of Child Psychiatry* **38(1):** 101-117.

HM Prison Service, (1996) 'Survey of Provision for the Physically Disabled'. London: HM Prison Service.

HMSO (1964) *Criminal Procedure (Insanity) Act.* London: HMSO.

HMSO (1975) .Report of the Committee on Mentally Abnormal Offenders' Cmd. No. 6244 [The Butler Report]. London: HMSO.

HMSO (1991) *Criminal Procedure Insanity and Unfitness to Plead Act.* London: HMSO.

HMSO (1996) *The Informability Manual.* London: HMSO.

Home Office, (1987) Survey of Deaf or Hearing Impaired Inmates. Directorate of Health Care, unpublished.

Jackson, P. (1998) *Deaf Crime Casebook.* Ipswich: Cox and Jackson.

Kent, A. (1988) 'Deaf people, the Courts and Prison'. Criminal Justice **4.**

Kershaw, C., Renshaw, G. (1997) 'Statistics of Mentally Disordered Offenders in England and Wales 1996. Home Office Statistical Bulletin, Government Statistical Service.

Klaber, M., Falek, A. (1963) 'Delinquency and Crime'. In: Rainer, J. Altshuler, K.,. Kallman F., (eds) *Family and Mental Health Problems in a Deaf Population.* New York: Columbia University Press.

Kyle, J.G., Woll, B. (1985) *Sign Language.* Cambridge: Cambridge University Press.

Ladd, P. (1988) 'The Modern Deaf community'. In: Miles, D. (Ed) *British Sign Language: A Beginner's Guide.* London: BBC Books.

Lane, H. (1992) *The Mask of Benevolence.* New York: Alfred A. Knopf.

Luterman, D. (1987) *Deafness in the Family.* Boston: College-Hill Press.

Mental Health Services of Salford NHS Trust (MHSST), (1998) 'Clinical Audit Report, National Centre for Mental Health and Deafness John Denmark Unit, Audit of Forensic Referrals'April 1998, (unpublished document, MHSST).

Monteiro, B., Neeney, M. (1992) 'Forensic aspects of deafness', *Proceedings of the Second International Congress, Namur* 1991, (European Society for Mental Health and Deafness).

Monteiro, B.T., Ridgeway S.R., Young A.M. (1999 unpublished) 'A point prevalence study of deaf people in high security psychiatric hospitals in the UK'.

Oxley, R., Than, R., Robinson, D., Leesley, G., Robinson, S., Hartley, D. (1996) 'Rampton Deaf Services Review'. Internal publication, Rampton Hospital.

Phillips, R., Dobash, R.P., Bruce, A. (1994) 'Physically Disabled Prisoners in Scotland', Scottish Prison Service Occasional Papers Report No. 2/1994.

Powers, S., Gregory, S., Thoutenhooft E., (1999) *The Educational Achievements of Deaf Children.* London: DfEE.

Pray, J.L. (1983) 'Special Problems of Deaf Persons and Criminal Justice'. In: Roberts, A.R. (Ed) *Social Work in Juvenile and Criminal Justice.* Springfield: Charles C. Thomas.

Remvig, J., Sturup, G. (1957) 'Dovestumme lovovertraedere i social-psykiatrisk belysning '. *Nord T. Kriminmalvidenskab* **45:** 177-193.

RNID, (1998) *Deaf and Hearing Impaired People.* London: Royal National Institute for Deaf People.

Robinson, D., Collins, M. (1996) 'Bridging the Communication Gap: a survey of services for deaf people in a secure hospital'. *Deaf Worlds* **2(12):** 9-14.

Ross, J. (1999) 'The Disability Discrimination Act. Plans for the Future'. *Prison Service Journal* **122:** 34.

Smiley (1998) Personal correspondence, Northern Ireland Prison Service..

Straw, J. (1998) Annual conference, Federation of Deaf People, Blackburn, November.

Sutton-Spence, R., Woll, B. (1999) *The Linguistics of British Sign Language.* Cambridge: Cambridge University Press.

Tumin, S. (1995) 'In Double Sentence', two television programmes broadcast 4th and 11th November, Sign On, Channel 4 TV.

Vernon, M., Grieve, B.J., Shaver, K. (1980) 'Handicapping Conditions Associated with Congenital Rubella Syndrome'. *American Annals of the Deaf* **125 (8):** 993-997.

Vernon, M., Rich, S. (1997) 'Pedophilia and Deafness'. *American Annals of the Deaf* **142 (4):** 300-310.

Woodward, J. (1972) 'Implications for Sociolinguistics Research Among the Deaf'. *Sign Language Studies* **1:** 1-17.

Young, A.M., Howarth , P. Ridgeway, S.M., Monteiro, B.T., (1999, unpublished) 'A study of forensic referrals to the three specialist psychiatric services for deaf people in the UK'.

Young, A.M., Monteiro, B.T., Ridgway S.M. (1999 unpublished) 'A study of deaf people before the Magistrates' Courts in the Duchy of Lancaster 1996-1999'.

Law Reports

Rex. v. Pritchard (1836) 7 Car. &P. 304

Acknowledgements

This work was jointly funded by the Institute for Health Research, University of Salford and The National Centre for Mental Health and Deafness, Mental Health Services of Salford NHS Trust. We are particularly grateful to all those who supplied us with hitherto unpublished information and without which we could not have presented such a comprehensive picture.

Endnotes

[i] There are 10 Deaf patients in England and Wales out of a total high security psychiatric hospital population in England and Wales recorded as 1226 (Kershaw and Renshaw, 1997).