The Journal of Forensic Psychiatry Vol 12 No 1 April 2001 19–35

ARTICLES

Forensic referrals to the three specialist psychiatric units for deaf people in the UK

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ABSTRACT This paper presents the results from a national study of forensic referrals to the UK's three specialist psychiatric services for deaf people who are users of sign language. A search of 5,034 referrals identified 431 relevant cases. From these, data were collected on patient characteristics, offending behaviour, court disposal and diagnosis. In addition, data were used to estimate the need for a specialist forensic deaf service in the UK. The results show a steady and continuing rise in forensic referrals from the mid-1980s. They contradict previously held assumptions about the late age of first conviction and about the reluctance of the courts to impose probation supervision on deaf people. They confirm and expand our understanding of the high proportion of sexual and violent offences in this clinical population. Nearly 50% of the sample were found on assessment not to be suffering from a mental disorder – a category that excludes patients diagnosed with personality disorder. Figures from the past 30 years and from the past 5 years only are consistent in demonstrating that around 60% of this group would have benefited from a specialist forensic deaf service at some time in the assessment/treatment process.

Keywords: sign language, mentally disordered offenders, deafness

This paper concerns a clinical population of deaf people who use sign language, have had contact with the criminal justice system and have mental

The Journal of Forensic Psychiatry
ISSN 0958-5184 print/ISSN 1469-9478 online © 2001 Taylor & Francis Ltd
http://www.tandf.co.uk/journals
DOI: 10.1080/09585180010027842

health needs. The population is drawn from the three psychiatric services in the UK that provide assessment and treatment services specifically for deaf people. It offers comprehensive information on the size, nature and characteristics of this deaf forensic population and examines service response and predicted service need in light of this new information.

In the UK there are three specialist psychiatric services specifically for deaf people (henceforth referred to as the 'units'). Located in Manchester (formerly Whittingham), London and Birmingham, they were originally set up in 1968, 1979 and 1992 respectively and each currently has a national brief. (Between 1987 and 1994 the units had 'supra-regional' status.) Although the patients they serve all have, in audiological terms, a significant hearing loss and usually prefer to communicate through visual rather than spoken means, the patient group is a highly diverse one. Some use British Sign Language (BSL) – a fully grammatical visual spatial language as sophisticated as any spoken language (Sutton-Spence and Woll, 1999). Other patients have minimal language skills in any language but can usually best make themselves understood through visual communication. The majority of patients will be part of the 'Deaf Community' – regarded as a distinct cultural group possessing its own traditions, social structure and norms of behaviour (Ladd, 1988). The units do not usually serve patients who have been deafened and/or prefer to use spoken language/lip-reading. (The term 'deaf', therefore, as used in this paper refers to those who use sign language/are associated with the Deaf Community.) All three units are general psychiatric services rather than specific forensic services. Each offers inpatient, outpatient and community services, accepting patients with a wide range of difficulties including those with severe and enduring mental illness, behaviour and adjustment problems, patients with learning disabilities, and forensic patients.

For the purposes of this paper, the term 'forensic patients' is used in both its specific and its broad definitions. Specifically the units see patients: who have been dealt with under forensic sections of the Mental Health Act 1983 (the predecessors of this law and Scottish law equivalents); whom the courts or solicitors refer; who are held in prison, medium-security and high-security services. More broadly, the units see patients who have mental health needs and who may have histories of offending although this is not necessarily the reason for referral.

Very little is known about the forensic patients seen by these units other than that their numbers are significant enough to constitute a small but distinct group, and that there appears to be a bias towards sexual offences and offences of violence in their histories. In a study of 250 randomly selected patients referred to the then Preston Unit at Whittingham Hospital (relocated to Manchester in 1993), Denmark (1985) found that 33 were charged with criminal offences; of these, 7 had committed crimes against the person involving assault and 11 had committed sexual offences. These findings supported

an earlier study in the US (Klaber and Falek, 1963) which found that of 51 deaf people referred to a psychiatric unit for deaf people and 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 individuals suffering from paedophilia whom they have assessed/treated, although no indication is given of the size of the overall clinical population from which this sample is drawn.

More generally, the prevalence of offending either in the deaf population as a whole or in relation to those deaf people with mental illness is not known with any reliability. (For a review of UK literature see Young, Monteiro and Ridgeway, 2000.) However, there are abiding concerns that in contact with the criminal justice system deaf people are vulnerable both to a failure to recognize their mental health needs (Brennan and Brown, 1997) and to their being labelled as mentally ill when there is no psychiatric disturbance present (Ackerman, 1998; Monteiro and McNeeney, 1992). Factors contributing to these errors include mistaken assumptions about the ability of deaf people to lip-read or understand written English when in reality low levels of literacy lead to impaired understanding of the question-and-answer process as carried out in English (Fiskin, 1994). Cultural norms of behaviour common to deaf people who naturally use movement and facial expression as integral parts of a visual language, can be easily misunderstood as aggressive or sexually inappropriate (Denmark, 1994). Hearing professionals with little previous experience of deaf people can easily regard deafness when combined with lack of speech as being synonymous with cognitive deficit (Denmark, 1994).

In terms of service provision for deaf forensic patients, concerns have been raised recently about the inappropriateness of existing facilities for some patients. The three deaf units are all open ward environments and consequently there are some deaf patients who, because of the risk they pose, cannot be seen by those services (Mental Health Services of Salford NHS Trust, 1998). Few alternatives exist other than in the high-security environment of Rampton Hospital, which has a small deaf service (Oxley, Than, Robinson and Leesley, 1996) but may represent 'over-containment' for some deaf patients, or in other medium secure facilities in the UK which generally lack the deaf expertise or language skills to assess and treat deaf patients.

Against this background, the following research study was set up. Its aims were: (1) to identify the forensic referrals to the three specialist psychiatric services for deaf people in the UK (since those units were first established); (2) to describe the characteristics of this population. The study had two underlying objectives: to provide 'baseline' information on the clinical population of mentally disordered offenders who are deaf that would facilitate further research; to contribute to the ongoing evaluation of whether there is a demonstrable need for a specialist forensic service (incorporating medium secure facilities) for deaf people in the UK.

METHOD

Given that all three units accept the whole spectrum of mental health referrals – not only patients with a forensic history – the first task was to identify which patients, both currently and in the past, could be classified as 'forensic referrals'. There were four main criteria for inclusion in the forensic sample:

1 Offending history

The criterion was that a patient

(a) has a history of having been convicted of an offence, and/or
(b) has a history of having received an official caution for an offence, and/or
(c) has been found unfit to plead in relation to an indictable offence, and/or
(d) has been dealt with under a forensic section of the Mental Health Act 1983/Mental Health Act 1959
(e) or, in the case of someone with no previous criminal history, has contact with the unit as a result of a pending criminal charge/court case.

2 Patient status

The referral could be as an inpatient, an outpatient, a day patient or community patient.

3 Time-frame

There was no specified time-frame for referral other than its having occurred since each of the units was established. Thus the sample was from 1968 to 1999.

4 Age

Any patient meeting the criteria 1–3 was included regardless of age. Whilst it is unusual to include minors, adults and older people within the same sampling frame, in this case it was appropriate. All three units were, historically, established to cater to the needs of any deaf patient (regardless of age) and until the mid-1990s there were no specialist child and adolescent psychiatric services or any specialist psychogeriatric service for deaf people in the UK.

In order to identify patients who fell within these criteria, ethical approval was obtained to search patients' case-records. Only one out of the three units had a database in electronic readable format that was searchable. In the other two units, patient files were read individually to identify the relevant cases. All patient records from the foundation of each unit to the present day

Table 1 Total patient files located and checked

Unit	*Total number of patient files potentially available*	*Total number of patient files located/checked*	*Percentage of total number of patient files checked*
Manchester	3,364	3,276	97.4
Birmingham	746	739	99
London	1,061	1,019	96

Table 2 Percentage of total patient population that are forensic referrals

Unit	*Total number of patients referred*	*Total number of patients meeting the forensic referral criteria*	*Percentage of total patients that are forensic cases*
Manchester	3,364	325	9.7
Birmingham	746	28	3.8
London	1,061	78	7.4

(April/May/June 1999) were examined. This task involved consulting in person 4,295 case-files and searching electronically a further 739 case-records (Table 1).

When the relevant patients' files had been located, a predesigned data collection sheet was completed for each case. Information from the data collection sheets was transferred into the computer program Microsoft Excel for analysis. This data entry was then double-checked row by row with the original data collection sheets in order to identify mistakes and ensure consistency.

RESULTS

Sample size and referral data

Of the 5,034 files checked, 431 met the criteria for inclusion within the forensic referral data set, representing an average of 8.4% of total number of cases seen by the three units (Table 2).

However, the total number of case-files found is not the same as the total number of patients because some people had been referred over their history to more than one unit. A total of 42 patients (9.7%) in the sample were seen by more than one unit, with two of them being seen by all three units and 40

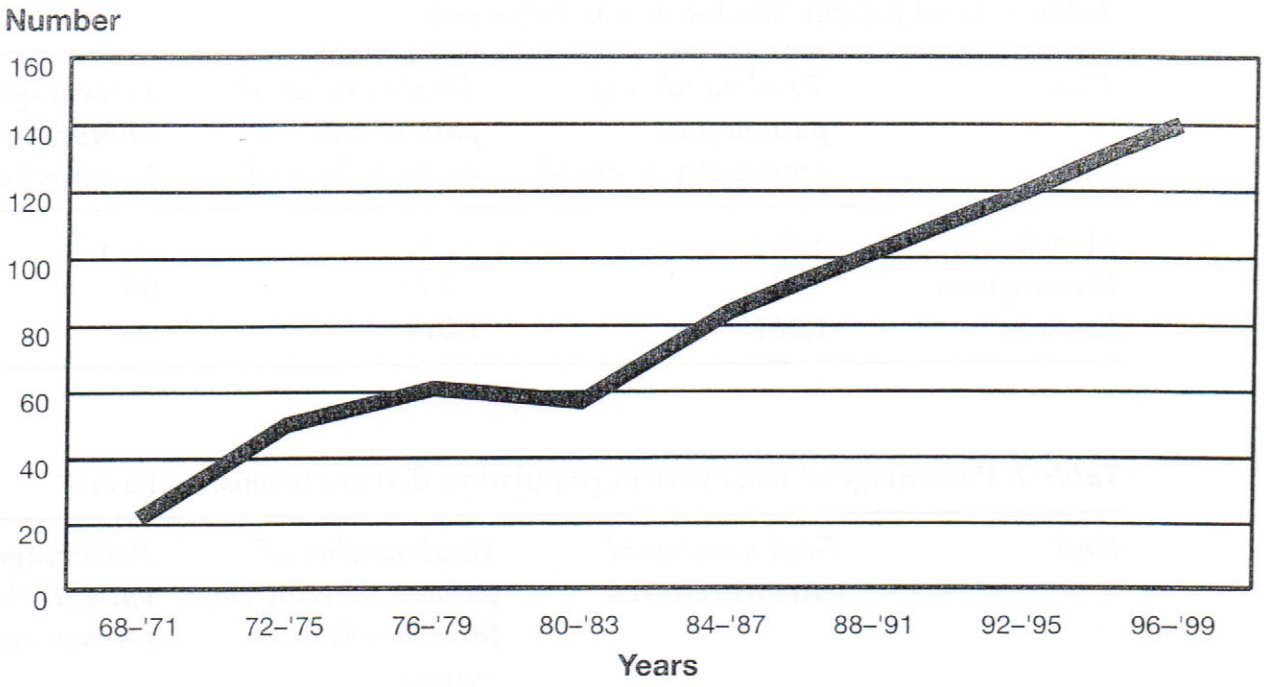

Figure 1 Total number of forensic referral episodes to all three units (N = 637) by year

seen by two units. Therefore, the sample size of 431 cases is equivalent to 389 individual patients.

Of the 389 individual patients, a substantial majority, 241 (62%), had only ever been the object of one forensic referral to one unit. But the 389 patients yielded a total number of 637 referral episodes, i.e. occasions on which they had been referred to *any* of the three units. Of these referral episodes, 501 (79%) were to the Manchester Unit. In a survey of the total referral episodes by decade, figures reveal a slow but steady rise in referrals from the late 1960s to the late 1970s before a sharper rise from the early 1980s onwards. This is a consistent growth trend that continues today (Figure 1).

In 405 out of 431 cases in the sample, it was possible to identify the geographical origin of the referrals. The vast majority of the cases came from the north-west, London and the south-east, and the Midlands – the same locations as the national units themselves (Figure 2).

Person characteristics

The overwhelming majority of the sample, 91.3%, were male (n = 356), with only 33 females (8.7%) out of a total of 389 forensic patients. It was not possible reliably to collect data on ethnic origin as this has not been routinely monitored at the units and is only rarely mentioned on the case-files. Any inferences the researchers might draw themselves were not regarded as reliable enough for inclusion.

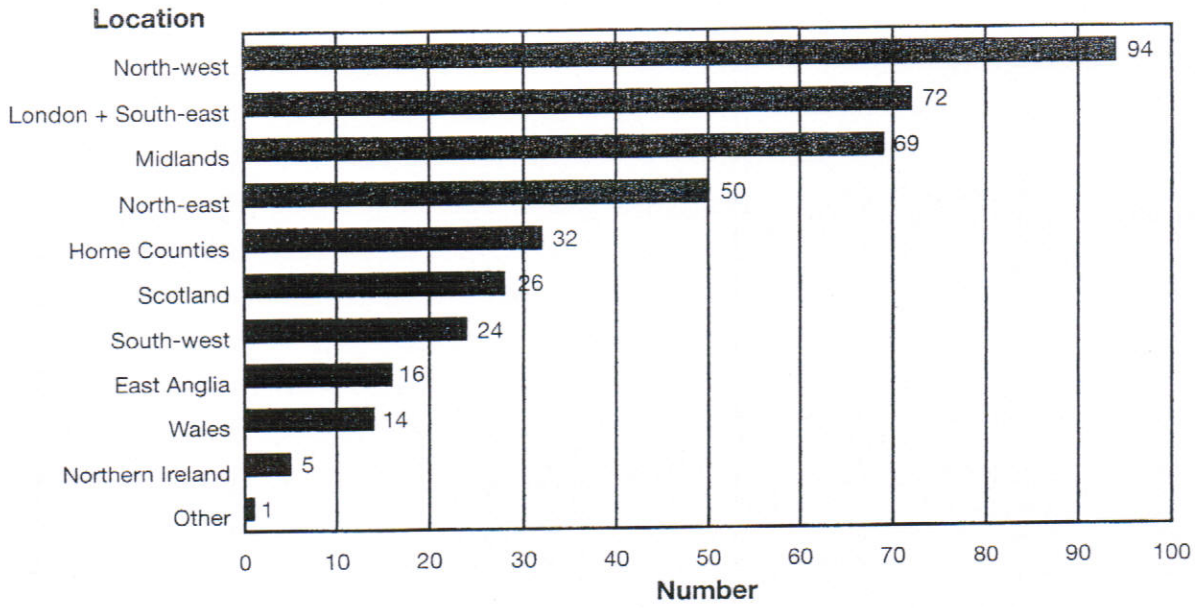

Figure 2 Geographical location of forensic cases (N = 405)

Offending behaviour/history

In 297 out of the 431 cases identified, it was possible to identify the age of first conviction, or age of first caution, or age of first other court disposal (e.g. a finding of unfitness to plead) – whichever historically came first in the patients' offending history. Of these 297 cases, 22 were women and 275 men. The mean age of first conviction/caution/court disposal was 23.4 years (SD 8.9). The distribution of the age of first conviction/caution/court disposal reveals a peak of 17 and 18 years old for the sample overall and this remains the same if males only are analysed (Figure 3). (The data on women involves such small numbers that it is not possible to draw any reliable conclusions about the peak offending age.)

In recording previous offences, it was not possible to be exact about the number of charges or 'counts' on which a patient had been convicted, nor the number of occasions on which he or she had been convicted because very often this information was not recorded in enough detail. In some cases, it was not possible to determine the outcome of the current offence for which the patient was charged and which had prompted a referral to the unit. Therefore, the following data on offences are presented as known convictions and/or offences for which the patient is currently charged. Furthermore, they are presented in terms of the number of patients who have been convicted/are currently charged with particular offences, rather than the number of convictions within each category of offence for this population.

The overall profile of offences demonstrates that a high percentage of the sample had been convicted of/were currently charged with offences of

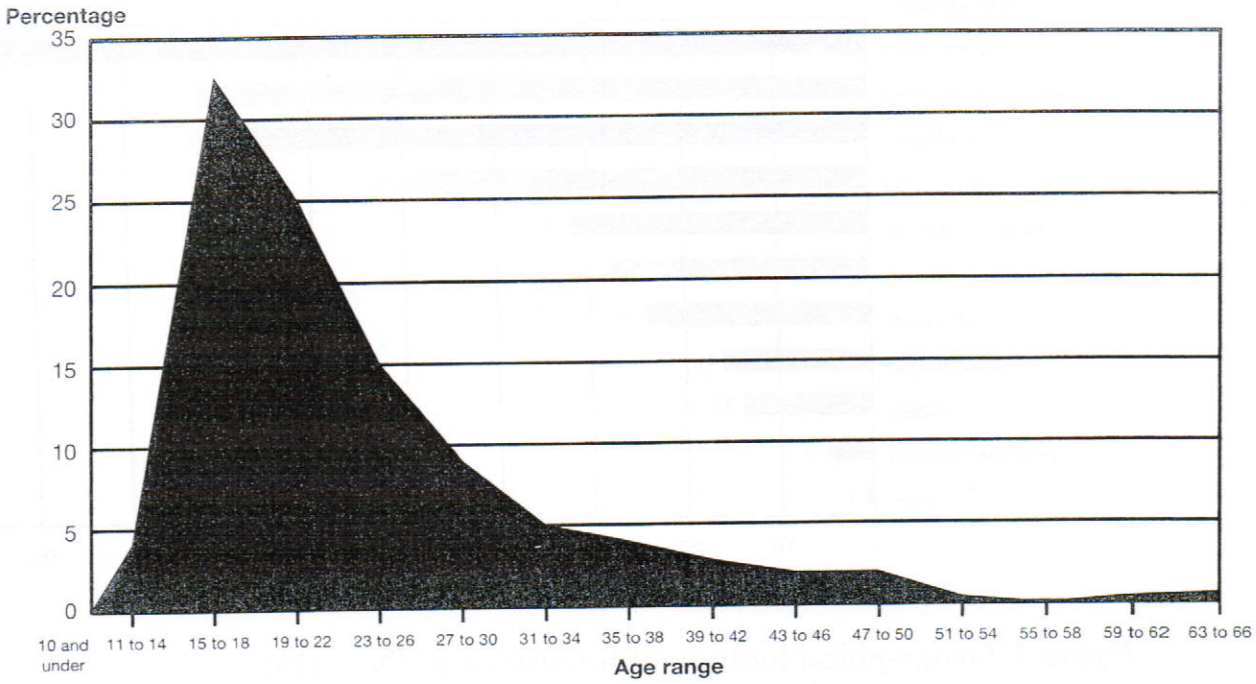

Figure 3 Age of first conviction/caution/court disposal for males (N = 275)

violence and sexual offences, with nearly one-fifth of the sample having committed (or being currently charged with) sexual offences and/or offences of violence against children (Figure 4).

Homicide

There were 27 patients (7.5%) who had been convicted of/were currently charged with murder or manslaughter or attempted murder. The median age of first conviction/current first charge for homicide was 28 years (range 17–65 years).

Sexual offences

There were 150 patients (38.6%) who had been convicted of/were currently charged with a sexual offence. This category encompassed both severe and less severe offences (e.g. gross indecency; rape, indecent assault; buggery; etc.). Of this group of sex offenders, over one-third (n = 58; 38.7%) were recorded as having reoffended.

Offences against the person

This category of offences against the person included assault, GBH, ABH, wounding, etc. There were 149 (38.3%) who had been convicted/were currently charged with such offences. There was not a strong relationship between this group who had been convicted of/were currently charged with

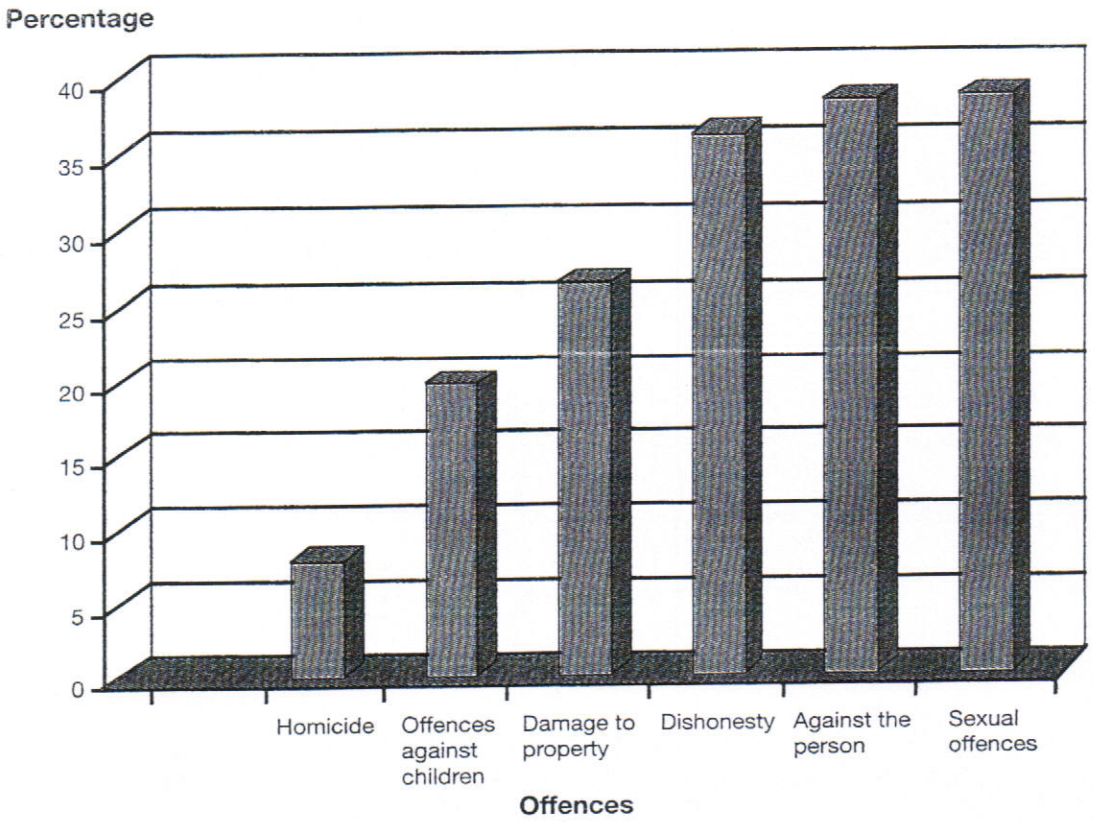

Figure 4 Percentage of sample (N = 389) convicted of/currently charged with different categories of offences

offences against the person and the sexual offences group. Only 38 people appeared in both categories.

Offences against children

This category includes all convictions/current charges for sexual offences against children and also convictions for violent offences against children such as assault (therefore, some patients who appear in this category also appear in those of sexual offences and offences of violence). Of the total sample of 389 patients, 77 (19.8%) had been convicted of/were currently charged with an offence against children.

Offences of damage to property

This category included, for example, offences of arson and of criminal damage. There were 103 patients (26.5%) who had been convicted of/were currently charged with such offences.

Offences of dishonesty

This category included theft, robbery, burglary, fraud, etc., and 141 patients (36.2%) had been convicted of/were currently charged with such offences.

Sentencing

Data were available on sentencing in 300 out of 429 cases. The 129 cases where no data were available are accounted for by first offences where the outcome of the court appearance is unknown, and/or lack of information on files. The 300 cases for which sentencing data were available were equivalent to 270 individuals (21 women and 249 men).

Probation

Of the 270 patients on whom sentencing data were available 132 (49%) had received probation supervision. Thirteen of this group were women, and 40 patients (30.3%) had been the subject of probation supervision on more than one occasion.

Prison

There were 66 patients (24.5%) out of the 270 who had served/were serving custodial sentences in prison (64 men and 2 women) and 17 of this group had served more than one prison sentence. (These figures do not include remands to prison.)

Fitness to plead

In 179 out of the 389 cases (46%) an opinion been given by the unit on whether the patient was fit to plead. This opinion was usually the result of a request by the court or a solicitor. Of these 179 patients, 114 (63.7%) had been classified as 'fit to plead', 61 (34.1%) as 'unfit to plead' and 4 (2.2%) as both at different times or according to different opinions.

Diagnosis

Of the sample of 431 cases, a diagnosis was recorded for 385 cases (89.3%). Where a patient had been referred more than once and during subsequent referrals that patient's diagnosis had changed, the most recent diagnosis was recorded in the data set. In the case of dual diagnosis, the primary diagnosis was recorded.

Of the 385 cases for which a diagnosis was available, 204 (53%) were diagnosed as having no mental disorder. This category of 'no mental disorder' did *not* include those with diagnoses of personality disorders who were recorded separately. However, of the 204 cases within the 'no mental disorder' category, 84 (41.2%) were also classified as having 'communication difficulties'. Also, in 162 (79.4%) of these 204 cases of no recorded mental disorder, a psychiatric opinion had been sought about the individual prior to a court appearance.

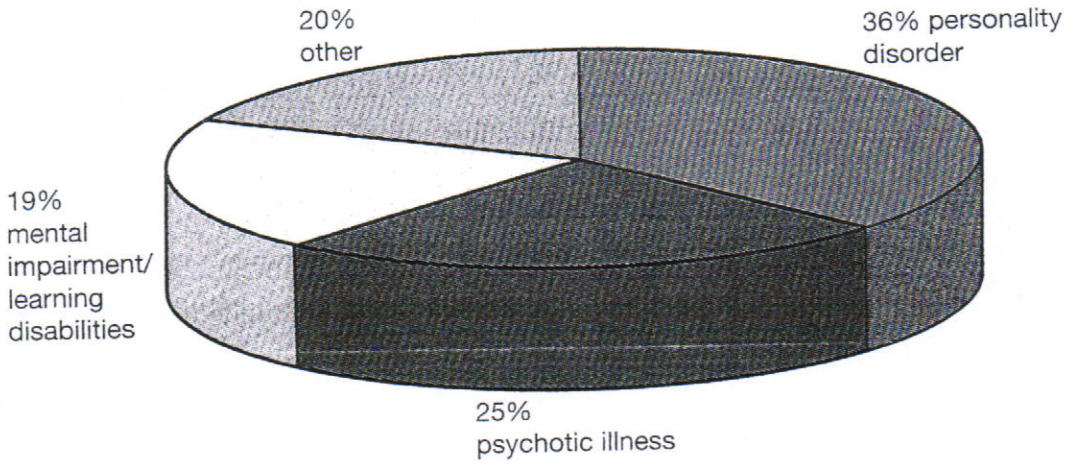

Figure 5 Distribution of diagnoses in the cases (N = 181) recorded as having a mental disorder
Note The category of 'other' included, for example, 'conduct disorders' and 'depression'.

The distribution of primary diagnoses in the 181 cases who were diagnosed and recorded as having a mental disorder were as shown in Figure 5.

Estimating the need for a specialist medium secure facility for deaf people

The data were also used to assist in estimating the need for a specialist medium secure facility for deaf people. To this end, cases were extracted from the total data set that met one or more of the following criteria:

- a specific note/comment had been made on the file indicating that the patient would have benefited from a specialist medium secure facility for deaf people were there one available.
- the patient had spent time in a high-security or medium-security hospital/unit
- all patients who had been held on any of the following sections of the Mental Health Act 1983 (s.35; s.36; s.37/41; s.47/49) and the equivalents under the old Mental Health Act 1959 and under Scottish law
- all patients whose index offence was murder, attempted murder, or manslaughter
- all patients who had been convicted of serious sexual assaults e.g. rape
- all patients who had committed offences of violence and/or sexual offences against minors
- all patients who had been remanded to prison.

(Patients who met more than one of these criteria were only counted once.)
Of the 389 individual patients in the data set, 237 met these criteria (60.9%).

In other words, nearly two-thirds of patients within the sample would potentially have been referred to or benefited from the assessment and/or treatment services of a specialist medium secure unit for deaf people at some stage of their assessment had one existed.

In order to assess whether this high percentage was simply a result of the cumulative effects of taking such a large time-frame (from 1968 to the present day) the same analysis was run using data from the Manchester Unit, for the past 5 years only. The Manchester Unit was selected because it was established that it had seen the greatest number of forensic patients (N = 93) over the past 5 years in comparison with the other units. Results from this slice of time were consistent with the overall picture. Of the 93 patients, 62 (66.6%) met the suggested criteria (outlined above) for those who potentially could benefit from the assessment/treatment service of a specialist forensic deaf service incorporating medium secure facilities.

DISCUSSION

These results confirm those of previous studies but significantly extend the scope of our knowledge about this deaf forensic population and raise many new questions that remain to be investigated. In the following discussion, comparisons with a general population are hard to make because there is no obvious comparison group. This sample is not representative of the total population of deaf people who use sign language – it is a clinical population of patients referred to the specialist units. Also it is not immediately comparable with other forensic groups studied in the hearing population because, although a clinical sample, the patients were not referred to a specialist forensic unit. However, some cautious comparisons will be made as appropriate.

Although the actual number of forensic deaf patients may seem very small given the 30-year time-frame, they none the less form a significant proportion of the workload of the three units. Furthermore, this is a patient group that in terms of demands on the service (as measured by referral episodes) is not remaining consistent but rather growing substantially over time. The cause(s) of this growth are difficult to determine but there are some key factors that contribute to an explanation. The steep rise in referral episodes from the mid-1980s onwards coincides with the appointment of a new consultant (one of the authors of this paper) at one of the units with a particular interest in forensic psychiatry and deaf people. Within a small and highly specialized world such as deafness and mental health, the effects of one individual's interests can be great. It could be that his special interest generated referrals from agencies who hitherto would not have known where to refer. More generally, the past 5 years have seen a greater awareness within the criminal justice system of the rights and needs of deaf people. The

revisions to the Police and Criminal Evidence Act (HMSO, 1995) and the new Code of Practice to the Mental Health Act 1983 (HMSO, 1999) specifically mention the linguistic and cultural needs of deaf people. One could speculate, therefore, that the services of the three units are more likely to be known and referred to than in the past and that this trend will continue.

The peak age of first conviction/caution/court disposal at 17–18 years for men is a surprising finding. Previous literature had suggested (though based on little evidence) that deaf people were not likely to come before the courts/be convicted at a young age. It was assumed that out of a misplaced sense of compassion, or simply because the language barriers were considered too great, the police would not pursue the cautioning or conviction of young deaf offenders (Denmark, 1994). This assumption has clearly been disproved by this study. Although not an exact comparison group, it is also interesting that this peak age is consistent with that of offending for males in the general population (Barclay *et al.*, 1995).

The high percentage of patients who have received probation orders is also a very surprising finding. Previous professional accounts had suggested that deaf people were less likely than their hearing counterparts to receive community sentences, including probation, because of the difficulties in supervising the orders. Almost no probation officers in the UK have sign language skills adequate to do so and the level of deaf awareness generally in the service is thought to be low (Kent, 1988). The results of this study clearly challenge those assumptions and raise significant questions about the training of both probation officers and magistrates in considering the implications of this sentencing option for deaf people. The authors could find only one research study that even mentions deaf people in passing, and then only to record that probation officers considered 'deaf-muteness' (*sic*) to be a considerable compounding problem in supervising offenders with mental health problems (Roberts, Hudson and Cullen, 1995).

The high proportion of patients who, having been referred, are subsequently found to have 'no mental disorder' is perhaps not surprising. There is a long history of deaf people who use sign language being mistakenly assumed to be mentally ill or mentally impaired (Altschuler and Rainer, 1969); or of a patient's communication difficulties/language disorder being mistaken for mental illness (Denmark and Eldridge, 1969); or of professionals who cannot communicate with deaf people jumping to false conclusions (Monteiro and McNeeney, 1992). Yet if it is the case that this study serves to confirm a tendency to erroneous assumptions about deaf people's mental state, then the most worrying question it raises is what of those patients who never reach these specialist deaf services to be correctly assessed as having 'no mental disorder'?

The high percentage of patients on whom an opinion was sought as to whether they were 'fit to plead' is a difficult finding to interpret. On the one

hand it is perhaps positive that solicitors and the courts, mindful of deaf people's rights, seek to assure themselves from specialist services of a deaf person's fitness to plead. On the other hand it may be indicative of long-standing assumptions or prejudice that deaf people who use sign language are likely to be 'unfit to plead'. There is certainly a significant legal history in the UK of deafness in combination with 'muteness' (*sic*) or sign language being problematic indicators of fitness to plead (Jackson, 1997). Previous research has indicated that the number of deaf people found by the courts to be unfit to plead in England and Wales is disproportionately high in comparison with their prevalence in the general population (Grubin, 1991).

The high proportion of patients who have been convicted of/currently charged with sexual offences confirms the findings of previous studies and raises a whole host of questions primarily focused on why this should be the case. It has been suggested that the coincidence of organic brain damage in association with some aetiologies of deafness may be a contributing factor (Vernon and Rich, 1997). In other fields, such as that of Asperger's syndrome, exploration of the links between developmental disorders and later sexual offending (Chesterman and Rutter, 1993) has begun. It is known both that a significant proportion of deaf people suffer a variety of developmental delays and that underlying developmental disorders are consequently not always recognized (e.g. Hindley and Kroll, 1998). From a psycho-social perspective access to information about appropriate sexual behaviour and personal experience of a range of emotional relationships may be severely limited for some deaf people who are not exposed to social and educational environments that are linguistically accessible (Andrews and Conley, 1977). A disproportionately high number of deaf people suffer sexual abuse as children (Ridgeway, 1998), a contributing factor that has been linked in the general population to later sexual offending. However, although these factors may all be considered relevant, very little is known about causal mechanisms in associating such factors with deaf people's sexual offending and no straightforward connections or consequences can be assumed without further detailed work.

In terms of future service provision, this study has shown that there is a steady, though small in number, demand for forensic services from specialist mental health and deafness services. Furthermore, a significant proportion of that demand is indicative of the services of a medium secure assessment and treatment provision that specializes in deafness and sign language. Indeed the likely take-up that has been demonstrated is probably an underestimate because the number of deaf people currently in non-deaf specialist medium secure facilities in the UK is unknown. A further national study focusing on unmet or inappropriately met need for deaf forensic clients is required for a full understanding of the scale of the service requirement. Currently, a business case is being presented to the National Health Service in the UK in order to establish a specialist deaf medium secure facility (Mental Health Services

of Salford NHS Trust, 2000); however, at this stage it is unknown whether the proposal will be successful.

CONCLUSION

Thirty years ago, almost nothing was known about deaf people and mental health, and no specialist psychiatric services existed. Astounding progress has been made in the intervening years; however, for forensic deaf patients very little has happened. Furthermore, as this study has demonstrated, the size of this population making demands on clinical services is increasing and there is no sign that the trend is likely to stop. The profile we now have of a near complete sample from the specialist units in the UK, has provided a starting-point from which researchers, clinicians and professionals in the criminal justice system can consider future work that needs to be accomplished to try to meet the special needs of this population. An important area of need is the provision of forensic services, including medium secure facilities for deaf mentally disordered offenders.

ACKNOWLEDGEMENTS

We express our sincere thanks to the three units who participated in this research project – in particular, to the consultant heads of each unit, who strongly supported it, Ken Ferguson who greatly assisted us at the Birmingham Unit, and all the secretaries and administrators who put up with our disruption to their filing systems. We thank Dr Stephen Hardy for the legal advice associated with this paper. We appreciate the British Deaf Association's encouragement of this work. This research was jointly funded by the Institute for Health Research, University of Salford, and Mental Health Services of Salford Trust.

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