

Section II

ASSESSMENT AND TREATMENT OF DEAF SEX OFFENDERS

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INTRODUCTION:

- Hearing sex offenders have been able to access appropriate services through Prison Programmes, Probation services of NHS Treatment Programmes specifically designed for sex offenders. Deaf people were unable to access appropriate services because of the cultural and linguistic implications of their Deafness, until 1997.
- Since 1997, Specialists within Deaf Mental Health Services, have developed an assessment and treatment package for sex offenders. Deaf Sex Offender Groups delivered in BSL and accessible through open and secure Deaf Services, have been developed further since 1998.
- Very little was known about Deaf Sex Offenders. Not aware of any research which specifically focuses on the effectiveness of treatment of the Deaf Sex Offender or current recidivism rates. A literature search of the Cochrane, Medline, cinahl, psychlit and embase databases in 2004 on the treatment of Deaf Sex Offenders produced no hits.
- During the 1990's there has been development of treatment programmes using cognitive behavioural therapies, aiming to encourage the offender to change the way he thinks about his offences and his victims, and to provide him with thought patterns to avoid re-offending. The Deaf Sex Offender Assessment and Treatment Programme adopts a CBT approach and adapted a programme to meet the needs of Deaf people.
- The outcome measure used for monitoring the effectiveness of CBT for hearing programmes is often recidivism rates. Statistics from the Home Office in England and Wales, state that the overall sexual re-conviction rate of sex offenders is low. It is also asserted that there is a substantial amount of "hidden" sex offending, that does not result in conviction and that the "real" rate is much higher. These figures relate to the hearing population.
- Within the Deaf population, research by Young et al 2001, shows of the total number of offences, a high proportion are sexual offences. No studies have been carried out to establish Deaf sex offender re-conviction rates.
- The effectiveness of the Deaf sex offender programme is monitored by Risk Assessment and Risk Management.
- American studies on hearing Sex Offenders shows that CBT may reduce recidivism. Unless evidence is provided to support a more affective intervention, CBT, will continue to be the primary intervention within the Deaf Sex Offender Treatment Programme.

ASSESSMENT:

- The main aim of the assessment is to provide an overall picture of the offenders behaviour. The assessment includes considering the offender's, cycle of offending, sexual knowledge and attitudes, cognitions and distorted thinking, sexual interests, arousal and fantasy, assessing degree of victim empathy, self esteem, relationships and intimacy, use of alcohol and drug and the Deaf person's own victimisation and abuse experiences.
- The Risk Assessment Tools include the T.E Hogue (1992) Clinical Rating Form. The tool is a dynamic rating system considering 12 different domains. The domains include:
 - acceptance of guilt for the offence
 - show insight into victim issues
 - show empathy for their victims
 - accept personal responsibility
 - recognise cognitive distortions
 - minimisation of consequences
 - understand lifestyle dynamics
 - understand offence cycle
 - identify relapse prevention concepts
 - disclose personal information
 - participate in treatment
 - motivation to change behaviour
- Each Sex Offender is assessed using the risk for Sexual Violence Protocol (RSVP). This provides professional guidance on assessing risk of sexual violence. Like the Hogue Clinical Rating Form, the RSVP has been developed on hearing sex offenders. The RSVP is intended to help the evaluators to conduct comprehensive assessments of risk of future sexual violence, in Clinical and forensic settings. It defines sexual violence risk assessment as a process of gathering information about people to make decisions regarding their risk of perpetrating sexual violence. The evaluator needs to characterise the risk posed by the individual in terms of the nature, imminence, severity and frequency of the sexual violence the person might commit and also to determine what steps should be taken to minimise those risks. We can speculate about the reasons that people chose to commit sexual violence in the past, or put differently, to determine whether various factors such as sexual deviation, anti-social attitudes, irrational beliefs, labile effect, interpersonal stresses, influence their past choices about sexual violence or might influence their decisions in the future.

There are a number of considerations that need to be taken into account in providing this service for Deaf people. These issues may influence risk factors, for example:

- Psychosocial development
- Intellectual ability
- Educational background
- Family dynamics
- Language development
- Communications and language skills
- Knowledge of sexual issues

Additional Considerations for deaf Sex Offenders:

Deaf people are likely to experience limited access to information and social interaction for a number of reasons, e.g. few significant others that can sign, levels of literacy may be poor, some Deaf people have limited linguistic abilities in any language. Therefore there

are “real barriers” to acquiring knowledge of appropriate sexual behaviour. Ultimately, some Deaf people’s range of experience may effect their understanding of moral reasoning and criminal behaviour (Young et al 2000).

Research by Iqbal et al 2004 summarises that very few Deaf sex offenders had received formal education and/or had inadequate awareness of sexual health issues. It also found that reports of inappropriate sexual activities by Deaf children in residential schools was high, again suggesting limited education.

There is evidence to suggest that organic features associated with some causes of Deafness, e.g. brain damage and rubella maybe connected to impulse control problems, with aggressive and sexually disinhibited behaviour.

A combination of Deafness and intellectual disability compounds difficulties in devising appropriate treatment programmes for this group.

Sex Education:

- General knowledge, access to appropriate information
- Understanding of terminology
- Sexual development
- Sexual attitudes, relationships, social awareness skills.

Knowledge of the Law:

- Age of consent
- Conceptualising

Language Skills:

- Mode of communications
- First or preferred language
- Linguistic competence
- Possible specific language disorder
- Work with Language and Communication therapists to develop communication profile.
- Neuro psychological assessment

Family Dynamics:

- Relationships
- Other Deaf family members
- Evidence of abusive relationships/deprived environment?

Education:

- School philosophy – e.g. oral v sign language
- Residential placements
- Deaf school/mainstream education/partial hearing unit
- Language support systems in a learning environment.

Intellectual Development:

- Psychological/Psychosexual
- Learning Experiences
- Learning Environment

- Ability to Conceptualise
- Aetiology of Deafness
- Development Disorder

Emotional Understanding:

- Awareness of emotional feelings
- Understanding of emotional concepts
- Understanding and ability to perceive another person's emotions
- Ability to express emotions
- Ability to deal with negative emotions e.g. anger.

Self Concept:

- Self esteem
- Confidence
- Deaf identity

This information is needed for the Deaf sex offender due to the diversity of their experiences of family life/education and appropriate access to social development.

Treatment:

The areas that need to be addressed are dependant on the individual needs outlined following the assessment. Communication and Language issues, education deprivation for some Deaf Sex Offenders, difficulties in understanding abstract concepts, modification and breakdown of tasks and more regular repetition of key points are necessary in providing effective treatment programme.

One question that is constantly asked is "are the group members learning what therapists think they are learning"?

By adapting and modifying sessions and programmes, often with the support of neuropsychological and communication language assessment, enable the Deaf person to achieve their potential within treatment. Hearing programmes are presented in written English language. There is no written version of British Sign Language (BSL). BSL is a visual, gestural language with its own grammatical structure. Therefore, programmes are facilitated by Deaf staff and hearing staff who are competent BSL users.

There is a lot more emphasis on planning in terms of how information is communicated. Finger spelling or signing words, such as grooming and cognitive distortions will have no meaning to most Deaf people. Terminology used within sex offender work has led to the development of new signs to explain these terms. This must be supported by an explanation of what the sign means. For example, cognitive distortions is a concept that most Deaf people we treat find difficult to understand. This might be translated to "thinking excuses to allow us to offend". To further support the understanding of this concept, non offence and offence examples will be provided using visual pictures and role play.

Some Deaf sex offender's limited conceptual abilities are obstacles to effective assessment and treatment, and result in more concrete ways of working, e.g. if they cannot understand the concept of cognitive distortions, an alternative strategy is to set up a scenario whereby "an angel" is on one shoulder giving statements that support not offending and "a devil" is on the other shoulder giving statements to support offending. Other group members may take on the roles of the angel and devil. The aim is that the group member listens to the angel and ignores the devil.

There must be an awareness that we often presume wrongly that Deaf people have an understanding of the terminology/signs they are using and that they understand the signs that we are using, for example it is not unusual for a Deaf sex offender to use the sign for "rape" to describe a sexual assault. Their understanding of the word "rape" is often based on observations on TV, e.g. visually observing a woman being pushed to the floor, having her clothes ruffled and being sexually assaulted. The implications of a Deaf person using the sign "rape" incorrectly in a Police interview, whereby the Police man or woman does not have an understanding of Deafness are very serious. During preparation, information presented is supported by examples and there is always an awareness that the Deaf person's level of understanding must be checked.

The programmes are delivered by staff who are Deaf aware and have an understanding of Deafness and of Sex Offender assessment and treatment. Deaf staff co-facilitate the Deaf sex offender group and are often involved in co-facilitating for the assessment and treatment of Deaf sex offenders seen on an individual basis.

There is a greater use of visual modes of communication e.g. maps, diagrams and pictures. Role play is an important way of interaction to get across concepts and situations.

Facilitators have to repeatedly clarify levels of understanding. Assessment and treatment involves the Multi Disciplinary Team which further supports whether the patients can develop internal coping strategies to manage their own behaviour to reduce future risk of offending.

As stated earlier, many Deaf sex offenders have limited conceptual abilities which can be linked to the cause of their Deafness, and intellectual ability. This results in external restraints being put into place to manage their behaviour. Ongoing assessment and treatment enables the treating team to provide a clinical opinion on the level of support, structure and supervision required to minimise the risk of future offending.

Risk issues are paramount and evidence needs to be provided about Deaf Awareness and Communication support to assess and manage risk.

There is evidence that supports that there is a high incidence of sexual offences amongst Deaf people and this could be related to the aetiology of the person's Deafness, e.g. brain damage, rubella and psychosocial implications of Deafness, and these features need to be taken into consideration during the assessment and treatment process.

Relapse Prevention:

Relapse prevention is designed to address problems related to maintenance, and the avoidance of "lapses and subsequent relapse". (Launay 2001).

Progress can be monitored within the individual and group work. Also there is ongoing work with staff to assess the attitude and behaviour of the offender on a day to day basis. e.g. general observations, social skills, awareness of interest in specific materials, e.g. the type of TV programmes, and what reading materials are being accessed.

All escorted and unescorted leave is planned. Men who have committed sexual offences against children, need to minimise contact with children. Work is completed to make them aware of high risk situations e.g. parks, schools, swimming pools. High risk thoughts and planning is discussed with the Deaf sex offender in terms of their relapse prevention strategies. The aim is that they will show a good understanding of their offence, be able to proactively avoid high risk situations, have an awareness of high risk thoughts and have strategies to manage their behaviour in the future. There needs to be evidence that they

can recognise the links between their previous lifestyle and their sexual offending and change their lifestyle as part of an overall relapse prevention plan.

Treatment Effectiveness:

For hearing sex offender studies, the outcome measure against which interventions are evaluated is recidivism rates. This is methodologically flawed as there are problems with generalisability, definitions of recidivism, most studies are American, lack of standardisation and problems using comparison groups. Questions have to be asked about the results and the statistical significance of results.

No studies have been carried out to establish Deaf sex offender reconviction rates. The authors of this paper are not aware of any sexual re-offending amongst those Deaf people who are undertaking, or have completed the treatment programme.

The programme has allowed Deaf people to access appropriate assessment and treatment programmes, which allows a comprehensive assessment of risk and the development of a risk management/relapse prevention plan.

Some Deaf people have developed an understanding of their offending behaviour and have learnt coping strategies to manage their own behaviour and have returned to live in the community. Deaf people who have limited conceptual abilities, often as a result of factors related to the aetiology of their Deafness cannot develop internal strategies and often lack an understanding of emotions, have difficulty taking the victim's perspective and cannot show empathy. As a result, they will score as "high risk" on the TE Hogue (1992) Risk Assessment and these people often require external risk management, such as supervision, structure and support.

Conclusion:

Deaf sex offender studies show that they share many characteristics with their hearing counterparts. For example, the majority are male, have child victims, deny their offence and have a history of repeated sex offending behaviours.

During the 1990's there has been a substantial development of treatment programmes using cognitive behavioural therapies (CBT), aiming to make the offender change the way he thinks about his offences and his victims and to provide him with thought patterns to avoid re-offending. Treatment studies in America suggest CBT reduces recidivism. Until evidence is provided to support a more effective intervention, CBT will be the primary intervention within the Deaf sex offender group.

There is a need for research, e.g. what works for what type of offender and in what circumstances. Lessons can be learnt when conducting research on the Deaf sex offender programme, e.g. use sound methodologies and move away from solely positivistic science. Questions such as, what motivates participants to attend the group?, what has been learnt in the group?, and what treatment is needed?, need to be addressed.

The plan is to evaluate the Deaf sex offender programme using qualitative and quantitative methods. Evidence based practice needs to involve the patient, and treatment options should be decided by what suits the patient best. One approach is to target people who have had a positive effect as a result of treatment.

The programme has been adapted from hearing programmes. Up until now, we have not had the opportunity to develop a treatment manual for Deaf sex offenders. This work has recently commenced.

All of the facilitators are members of NOTA (The National Organisation for the Treatment of Abusers) and this paper will be submitted to their annual conference in 2007 to increase sex offender worker's awareness of a specialist nature of work with Deaf people.

This presentation gives the audience information about Deaf Sex Offenders that we hope will benefit members of the audience in their Clinical/Academic and Research practice, we would welcome any comments, observations or questions.

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