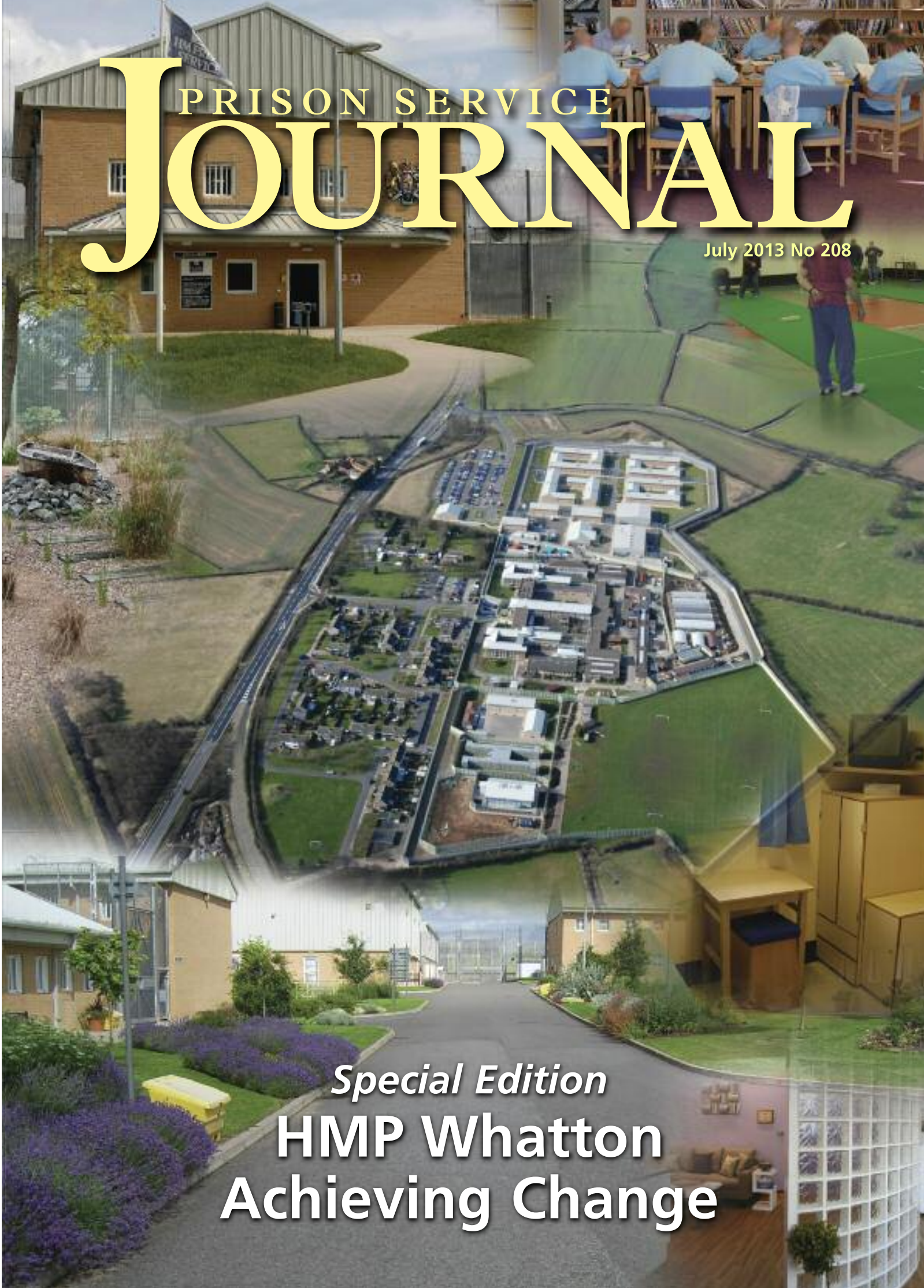

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HMP Whatton Achieving Change

Treating Deaf Sexual Offenders:

Theory, Practice and Effectiveness

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Background

According to the Royal National Institute for the Deaf more than 100,000 adults can be categorised as having severe to profound deafness. The extent of the hearing loss, along with the age at which a person becomes deaf have a significant effect on the way they communicate, which ranges from lip reading to using British Sign Language, (BSL)[1].

A lack of systematic recording means that the number of deaf offenders in prisons is unknown. In 2003[2] there were estimated to be 100 deaf offenders in custody and deaf offenders were said to be over represented in prisons compared to hearing offenders[3]. Gerrard[4] identified that over 75 per cent of deaf offenders regarded BSL as their first language and found the written word a restrictive and frustrating activity. One-in-four deaf prisoners do not have an interpreter in court hearings and so enter prison without fully understanding the charges they have received. Prisons are not designed to accommodate people with hearing loss[5], meaning deaf offenders are often denied the same opportunities and access to services as hearing prisoners.

The number of deaf *sexual* offenders in the prison service is equally unknown[6], this is partly because many deaf sexual offenders receive probation orders and do not enter into the prison system unless they have committed a serious or repeated sexual offence. One explanation for this is that judges are more lenient in their sentencing due to their 'condition' of being deaf[7].

Treating deaf sexual offenders

Some argue that, for treatment programmes to be accessible to deaf sexual offenders they require interpreters for communication between facilitators and group members. However, other researchers[8] suggest the use of interpreters raises a number of issues, including the effect on the therapeutic relationship of the triadic relationship of interpreter, facilitator and group members.

Despite these difficulties, interpreters are recognised as being the appropriate way to communicate with deaf offenders in a treatment setting[9]. Only a small number of prisons pay for interpreters[10] therefore, lack of access to this support, makes it more difficult for deaf sexual offenders on indeterminate sentences to demonstrate that they have lowered their risk. This implies that many are refused parole as they have not attended treatment, when in fact there is insufficient provision to enable them to access the help they need[11]. As a consequence, deaf sexual offenders can spend longer in prison, which impacts on their feelings of isolation and mental health[12].

At present, forensic services for deaf sexual offenders are inadequate[13] and only psychiatric services in the UK provide assessments and treatment for deaf sexual offenders with mental health conditions. These include a high secure and medium secure unit which both offer treatment for deaf sexual offenders. The treatment processes are found to be effective despite the use of BSL trained staff rather than interpreters[14]. However, measuring the effectiveness of such programmes relies on psychometric testing, which

1. Austen, S., & Coleman, E. (2004). Controversy in deafness: Animal Farm meets brave new world. In: Austen, S., Crocker, S, eds. 2004. *Deafness in Mind – Working Psychologically with Deaf People across the lifespan*. London: Whurr.
2. Department of Health, (2005). *Mental Health and Deafness, Towards Equity and Access*, NIMHE. HMSO.
3. Miller, K. (2003). Deaf Sex Offenders in a Prison Population. *Journal of Deaf Studies and Deaf Education*, 8, 3: 357–361.
4. Gerrard, H. (2000). *A double sentence: Deaf prisoners in the UK*. London: Deaf Prison Project.
5. Gibbs, A., & Ackerman, N. (1999). Deaf prisoners: Needs, services and training issues. *Prison Service Journal*, 22, 32: 31–32.
6. Berry, M., & Brown, J. (2006). Some aspects of possible vulnerability of Deaf people in the forensic world. *Forensic Update*, 85: 27–33.
7. Ibid.
8. Marshall, W. L., Fernandez, Y. M., Hudson, S. M., & Ward, T. (1998). *Sourcebook of Treatment Programmes for Sexual Offenders*. New York/London: Plenum Press.
9. Bramley, S. (2007). Working with deaf people who have committed sexual offences against children: The need for an increased awareness. *Journal of Sexual Aggression*, 13, 1: 59–69.
10. Ireland, J. (2005). Personal communications in response to an earlier draft. UK.
11. Gerrard, H. (2000). *A double sentence: Deaf prisoners in the UK*. London: Deaf Prison Project.
12. See n11.
13. Department of Health, (2002). *A sign of the times: Modernising Mental Health Services for People who are Deaf*. London. Department of Health.
14. Young, A., Howarth, P., Ridgeway, S., & Monteiro, B. (2001). Forensic referrals to the three specialist psychiatric units for deaf people in the UK. *Journal of Forensic Psychiatry*, 12: 19–35.

typically involves a large verbal component. As deaf language skills are extremely varied, this impacts on the internal validity of the measure if questions are posed differently and lose meaning. That has an impact on the level of standardisation and highlights that measures of effectiveness based on psychometric testing are only as reliable as the assessors administering them[15].

There are currently no services within prisons for deaf sexual offenders. Little is known about recidivism among this group as the number of deaf sexual offenders in custody is unclear. However, recidivism is estimated at 30 per cent, so the need to develop better service provisions for deaf sexual offenders is clear[16].

HMP Whatton is developing a new Sexual Offender Treatment Programme (SOTP) for deaf sexual offenders. In trying to address such obstacles, provisions were put in place. These provisions will be discussed as part of an evaluation of the effectiveness of this model of treatment.

Group Information

The Deaf SOTP was delivered to four group members. Three experienced and BSL trained facilitators delivered the programme, working on a rotational basis with two being present in each session. There was a team of four BSL interpreters, also working on a rotational basis with two interpreters per session. There were two supervisors to ensure availability given the additional needs of the client group.

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Treatment Format

The SOTP used was a pilot of the new Becoming New Me (BNM) programme. BNM is designed for offenders with Intellectual Disabilities (ID). The deaf offenders attending the programme did not have ID but they communicated using BSL. BSL differs from English in that it has a separate grammar, syntax and social context. Therefore, it cannot be assumed that deaf offenders can read English. The group members had varying literacy skills but none could write more than a few words of English. One advantage of the BNM programme is that it does not rely on written English but uses a variety of methods of communication. It has a pictorial basis with visual prompts displayed around the room. It also uses more interactive techniques, which particularly helps offenders with sequencing problems. This is important when working with deaf offenders. When communicating in BSL, the topic and context have to be set up in BSL in order for communication to make sense. The interactive techniques used help to focus offenders at a point in time thereby setting the time and context for them.

A further advantage of BNM is that it uses limited vocabulary. Although deaf offenders may not have ID, they may be considered language-deprived because BSL has a limited vocabulary. There are simply not as many signs compared to English words. The BNM programme also relies on more concrete concepts compared with other SOTPs which often use abstract concepts. One challenge of working with deaf offenders is that they have limited abstract reasoning[17]. Therefore, the use of concrete concepts in BNM works better with this client group. Deaf offenders also have limited inner dialogue and introspection and may also have difficulties with perspective taking[18]. The BNM programme does not focus on these skills so is deemed a more appropriate form of treatment. The pace of the BNM programme is much slower compared with other SOTPs. It was expected that this would work well with deaf offenders as the interpretation process creates a slower pace throughout treatment. Finally, the pilot of the new BNM programme incorporates aspects of the Adapted Better Lives Booster programme (ABLB). Given the amount of the funding needed for interpreters, it was unlikely that the group members would be able to access further treatment following this programme. The combination of BNM and ABLB in the programme meant that offenders accessed secondary relapse prevention treatment as well.

Interpreters

There is some debate about the use of interpreters in a therapeutic setting. As stated earlier, it has been suggested that the triadic relationship between offenders, interpreters and facilitators might be detrimental to the treatment process[19]. This involves offenders having to disclose personal details with many people in the room which could impact on their ability to be open and honest. However, because of the lack of facilitators with sufficient BSL qualifications (level six), it

15. O'Rourke, S., & Grewer, G. (2005). Assessment of deaf people in forensic mental health settings: A risky business! *Journal of Forensic Psychiatry & Psychology*, 16, 4: 671–684.
16. Iqbal, S., Dolan, M., & Monterio, B. (2004). Characteristics of deaf sexual offenders referred to a specialist mental health unit in the UK. *Journal of Forensic Psychiatry & Psychology*, 15, 3: 494–510.
17. BSL interpreters, personal communication, 2012.
18. Ibid.
19. Marshall et al (1998) see n.8.

was decided at HMP Whatton to use interpreters. There were a number of challenges involved in this. It was not possible to simply translate material into BSL because it is such a different language to English[20]. There was a greater need to prepare sessions in advance with interpreters to ensure exercises were placed in the correct context and set up correctly with the aims of the session in mind. Much of the material had to be adapted further to take into account deaf culture and work responsively with the group members. There was also a need for facilitators and interpreters to debrief together after each session. This ensured interpreters had an opportunity to discuss concerns and seek support with any difficulties brought about by working with sexual offenders. It also allowed communication about how well learning points had been understood by group members and what further changes might be needed. Despite the challenges, the use of interpreters brought great treatment gains. It ensured that information was translated accurately and reduced misunderstandings and misinterpretations. The risks of such confusions are clear given the treatment subject. The interpreters also provided a wealth of knowledge regarding deaf culture. This was important when considering treatment needs. For example, whether a deaf offender had a treatment need relating to anger or simply communication frustration given the limited opportunities to communicate in a prison setting. Deaf people often have to rely on external agencies to support them with daily living issues in a hearing world. This could be deemed a treatment need in terms of poor problem solving or another aspect of their culture.

Despite the challenges, the use of interpreters brought great treatment gains.

Challenges

All group members were inexperienced in group environments. They had received varying levels of schooling and this was reflected in their processing of the group environment. As their focus was on the interpreters they would often sign over each other which had to be managed by facilitators. Some group members had residual hearing which caused them to be easily distracted by background noise. Each distraction necessitated a conversation about what the noise was, which resulted in frequent loss of focus in session.

Deaf offenders experience a high degree of isolation in prison caused by difficulties with communication. They lack knowledge about the prison regime, probation and programmes information and are not privy to general prison gossip. They also cannot access much of the prison literature because it is written in English. This isolation impacted on treatment in two main ways. First, the group members would not challenge each other regarding their offending and permission-giving thought patterns. This is because challenging each other risked being exiled from the small deaf community in prison. As they have no one else with whom they can communicate, no one would risk losing that. The second impact of isolation was misuse of group time. The first 15 minutes of a group programme is dedicated to group members discussing any current issues they have which may impact on their participation during session. Previously deaf group members had not had this forum where they could talk easily with staff through interpreters. This resulted in them wanting to use this time to discuss a range of issues including letters they had received but could not read, problems on the wing and at home, feeling unwell, concerns about their future, probation etc. As they were not privy to overhearing others talking, they were often unaware that other people also experienced such problems. They appeared to be quite self-centred because they would talk at length about their problems but show little empathy to the problems of others. It generally seemed they were following the conversation not to show support, but to gauge when they would be able to join the conversation and discuss their own issues. However, given the lack of empathy and emotional support deaf people often grow up with[21] resulting from the difficulties with communication, it is perhaps understandable they have difficulty with those skills themselves.

The process of translation was a further challenge when working with this client group. Since BSL does not have the range of vocabulary of English, many of the social niceties of conversation are lost. BSL translates the meaning of what is said rather than each word which results in BSL appearing much more direct. This impacts on the ability to build a therapeutic alliance. For example, translating the comment: 'That's a really good point and thanks for raising it. It's something that we'll be discussing in the next section so hold on to that because its important and we'll come back to it then'; becomes: 'Stop. Remember it. Talk later'. Issues with translation were apparent throughout the programme. Another example is that, risk factors had to be reworded, so the item 'preferring sex to include violence or force' was

20. For example, this group had no knowledge of the word 'prefer' as this is based on an English concept not a BSL concept. Therefore, the risk factor 'preferring sex with children' had to be changed to 'fancy children'.
21. BSL interpreters, personal communication, 2012.

changed to 'feel sexy — hit, punch, kick, hold'. In BSL there is no sign for violence as an all encompassing term, so individual actions are used. Furthermore, some signs are based on English concepts and so require knowledge of the hearing world which deaf offenders might not have. An example of this is this concept of responsibility. The deaf offenders had no concept of this in terms of taking responsibility for themselves and their behaviour. They only understood it within the context of other people having a responsibility to look after them, such as doctors, social workers, the Royal National Institute for the Deaf (RNID) and their local council.

Facilitator experience of delivering Deaf SOTP

Facilitators enjoyed the opportunity to deliver this unique programme and recognised the pioneering nature of the work. However, the experience also had a number of less positive aspects. The pace of sessions could be extremely slow because everything went through the translation process. This required a greater degree of patience than other SOTPs. There were many misunderstandings, frequent need for repetition and confusion because of facilitators' lack of experience of the deaf world and group members' lack of experience of the hearing world. Although all facilitators were trained to at least BSL level two, the need for translation left facilitators feeling deskilled because they did not know exactly how their words were being translated. The subtle meaning of carefully selected statements designed for maximum impact was often lost in translation.

Group members' learning was more easily recognised by this point and they were very proud of their achievements, particularly because they did not feel they had achieved much in other aspects of their lives.

Facilitators noticed some difficulty building a therapeutic alliance with group members. Much of this resulted from the triadic relationship highlighted by Marshall et al[22] which made the process feel disjointed. The directness of BSL meant much of the language used to build a therapeutic relationship is lost in translation. Deaf group members were unaware of tone of voice or specific words facilitators used so facial expression was emphasised to build warmth instead. However, this was often missed by group members because they were watching interpreters. The result was a lack of rapport compared with hearing groups, which is of particular concern given that research has highlighted the power of the therapeutic alliance in promoting change[23].

Facilitators also found it difficult to manage their feelings regarding the lack of empathy displayed by the group. Although this is not uncommon on this type of work, it is rare for an entire group to show this degree of lack of empathy. This is a consequence of having such a small group, because facilitators are unable to look to other group members to recognise change or the impact their work is having. However, it would not be feasible to deliver deaf SOTP to a larger group given the responsivity needs of this client group.

These aspects of facilitating on the programme had a negative effect on the resilience of facilitators, resulting in them questioning their abilities and finding it hard to empathise with their group members. This lack of empathy was compounded by the use of interpreters, which reduced rapport and added distance when working with offenders. In addition, group members' preoccupation with their own problems also contributed to this drop in empathy for facilitators. As this was a pilot programme, facilitators did not have a clear end date for the programme. There were also only two facilitators delivering at key parts of the programme, which impacted on their individual workloads. These factors worked in combination to lower resilience at points during the programme.

However, the ending of the programme was extremely positive for facilitators and group members alike. Group members' learning was more easily recognised by this point and they were very proud of their achievements, particularly because they did not feel they had achieved much in other aspects of their lives. There were many positives to delivering this programme, such as the ability to be creative, learning new skills to be responsive, working with interpreters, learning to manage difficult group dynamics and learning new communication skills.

Treatment effect

- In order to evaluate the effectiveness of the programme, research was conducted to answer two specific questions:

22. See n.8.
23. Prescott, D. (2012). Therapeutic Communication: Motivation, Feedback and Beyond. Paper presented at Sexual Offender: Essential Therapy – Coercive Therapy? 12th Conference of the International association for the Treatment of Sexual Offenders (IATSO), Berlin, Germany. Lengerich, Germany: PABST Science Publishers.

- ❒ Has the intervention enabled group members to develop insight into their risk and develop strategies for risk management?
- ❒ Has the intervention enabled group members to develop protective factors to offending through treatment?

Four measures of change were used for the three group members who completed the Deaf SOTP. These measures included:

Psychometric assessments

The DSOTP used the Reduced Adapted NOTA 1, including: Self esteem questionnaire, Impulsivity scale, Ruminations scale, Relationship style questionnaire, openness to women scale/openness to men scale, sex offender opinion test and my private interests measure. These measures have been adapted to suit lower functioning individuals and as such, use simplified language. These psychometric assessments use dynamic items and are therefore able to detect post treatment change.

Offence accounts

The pre and post course offence accounts were completed by the facilitators in order to explore whether group members could describe their offending, explain why they offended and take responsibility for it. These were compared pre and post course.

Treatment needs and protective factors

The treatment needs and protective factors[24] for each group member were included with a treatment needs analysis grid (TNA). These grids identify risk areas which are relevant to offending. These were compared pre and post course which helped to determine any changes in risk areas post treatment.

Results

Has the intervention enabled group members to develop insight into their risk and develop strategies for risk management?

Insight into offending

The DSOTP treatment programme has proven effective in developing the group member's understanding and awareness of their offending.

In contrast to the opinion that exploring offence accounts with deaf sexual offenders can result in a lack of information about emotions and thoughts, because of the largely verbal component[25], this was not found to be the case with this group. This might have been the result of the treatment using pictures rather than words, which allowed the group members to explore their offending in a more visual way. As noted by O'Rourke and Grewer[26] BSL involves a large visual component, suggesting that the visual element of the deaf SOTP helped group members to explore their offending.

Targeting risk areas

Findings from the treatment needs analysis grids (TNA) suggest that the appropriate risk areas have been identified in treatment to a large extent. In some instances, other relevant risk areas remained untreated. This was particularly relevant to Participant three where risk relating to sexual interests had not been explored. There are several possible explanations for this. First, exploring offending with deaf individuals is vulnerable to inaccuracies because of the limitations of vocabulary[27]. This conclusion supports research by Steinberg[28] who proposed that when using interpreters the pace of therapy with a deaf client is much slower given the nature of the communication and interpreting languages. Second, each group member had a high number of dynamic risk factors with varying sexual interests, and this was a piloted programme, so insufficient time was allowed to explore all areas of risk. However is also noted that hearing offenders with high dynamic risk would usually complete more extensive treatment to address specific risk areas. Forthcoming programmes for hearing offenders will adopt a rolling method by which additional modules are included for higher risk offenders in need of more specific work — such as exploring attitudes, or sexually deviant behaviours. In line with this method, the Deaf SOTP would benefit from the inclusion of core elements of treatment that are mandatory for all group members,

24. Protective factors are considered to be individual characteristics or environmental conditions that could help to counteract the risks to which the individual is exposed (Richman & Fraser, 2001). These are introduced into treatment in order to focus on the positive aspects of an individual's life and to prevent treatment from being deficit-focused.
25. Brennan, M., & Brown, G. (1997). *Equality before the law: Deaf people's access to justice*. Durham, UK: Deaf studies Research Unit.
26. O'Rourke & Grewer (2005) See n.14.
27. Hoyt, M. F., Siegalman, E. Y., & Schlesinger, H. S. (1981). Special issues regarding psychotherapy with the deaf. *American Journal of Psychiatry*, 138, 807 – 811.
28. Steinberg, A. (1991). Issues in providing mental health services to hearing impaired persons. *Hospital and Community Psychiatry,* 42, 380 – 389.

with optional elements personalised to those individuals in need of more extensive work.

Rationalising offending

One of the questions raised by the research is whether deaf sexual offenders rationalise their offending in the same way as hearing offenders[29]. Although Dennis and Baker[30] propose that they blame their deafness for the offending, the group members in the Whatton pilot project did not follow this trend. They were able to identify lifestyle factors and thoughts they experienced during their offending. An interesting finding relates to the level of responsibility that group members took for their offending. While they did not blame their deafness for the offending, responsibility was placed on the victim by all three group members. Dolnick,[31] proposed that the deaf community's attitude can influence offending by supporting denial or minimization. Given three group members formed their own community within the prison, it is possible that minimisation is being reinforced by the group. Possible challenges to this minimisation could risk an individual being isolated from the community. Another possible explanation is that deaf offenders are no different in this type of minimisation than hearing offenders who are completing treatment for the first time. Schneider and Wright[32] argue that a high proportion of sexual offenders deny or minimise their offences.

Has the intervention enabled group members to develop protective factors to offending through treatment?

Developing protective factors

Findings from the treatment needs analysis grids suggest all three group members developed protective factors through treatment. In particular, areas relating to getting on with other people and being a responsible member of society improved. It is possible that the experience of being able to communicate in a group setting via an interpreter has improved relationships with professionals. This is supported by Schneider and Sales[33], who found that developing social contacts is difficult for deaf offenders due to obvious language barriers. This can lead to frustrations because of the amount of time it takes to write information back and forth to individuals such as Offender Managers if telephone devices to support deaf offenders are not available. There was also evidence that group members had started to establish a more active life in prison. The development of this protective factor in particular is encouraging given all group members had treatment needs relating to self management.

Future research

Interpreters

The use of interpreters has widely been acknowledged as the appropriate way to work with deaf offenders[34]. However, as previously discussed, this triadic relationship can impact on the therapeutic relationship between group members and facilitators[35].

The use of interpreters might have influenced the pace of the programme. This suggests future research would benefit from exploring the experiences of individuals involved in this treatment. This could be completed by interviewing these individuals. Such investigation could also identify other difficulties that have been observed with using interpreters, such as ensuring professional objectivity and boundaries[36].

Conclusion

What has been established from the research is that in order to work effectively with deaf offenders, treatment techniques need to be modified. The research goal was to evaluate the effectiveness of the pilot Deaf Sex Offender Treatment Programme based on changes in dynamic risk. All three group members who engaged in the treatment were high risk. Measures identified noticeable shifts in identifying and developing insight into risk areas. Less impact was found with regards to more specific areas such as sexually deviant behaviour. However, as it is unlikely that one treatment programme will ever be developed to address all treatment areas, progress in risk areas that were addressed have been comparable with mainstream treatment for hearing offenders. The Deaf SOTP would benefit from additional modules being included within its design. This would allow the option for high risk deaf sex offenders with more specific needs to complete mandatory modules, followed by additional modules. This would replicate forthcoming treatment programmes currently being developed for hearing offenders.

29. O'Rourke & Grewer (2005) see n.14
30. Dennis, M. J. P., & Baker, K. A. (1998). Evaluation and treatment of deaf sexual offenders. A multicultural perspective . In W. L. Marshall, Y. M. Fernandez, S. M, Hudson., & T. Ward, (Eds), *Sourcebook of treatment programmes for sexual offenders*. New York: Plenum Press.
31. Dolnick, E. (1993), Deaf as culture. *The Atlantic*, 3, 37.
32. Schneider. S., & Wright, R. (2004). Understanding denial in sexual offenders. *Trauma, Violence and Abuse*, 5, 1: 3–20.
33. Schneider, N. R., & Sales, B. D. (2004). Deaf or hard of hearing inmates in prison. *Disability & Society*, 19, 1: 77– 89.
34. Bramley. (2007). see n.9.
35. Marshall, et al (1998) see n.8.
36. Dennis & Baker(1998) see n.29.