GENERAL PRINCIPLES WHEN QUESTIONING WITNESSES AND DEFENDANTS WITH MENTAL DISORDER

Toolkit 12

10 July 2014

The Advocate's Gateway toolkits aim to support the early identification of vulnerability in witnesses and defendants and the making of reasonable adjustments so that the justice system is fair.

*Effective communication is essential in the legal process. The handling and questioning of vulnerable witnesses and defendants is a specialist skill (*Raising the Bar: the Handling of Vulnerable Witnesses, Victims and Defendants in Court *2011). Advocates must ensure that they are suitably trained and that they adhere to their professional conduct rules.*

*The court must take every reasonable step to facilitate the participation of any person, including the defendant (Rule 3.8(4)(a) and (b), Criminal Procedure Rules 2013). Courts are expected to make reasonable adjustments to remove barriers for people with disabilities (*Equal Treatment Benchbook 2013*, giving effect to the Equality Act 2010).*

These toolkits draw on the expertise of a wide range of professionals and represent best practice guidance; they are not legal advice and should not be construed as such.

This toolkit brings together policy, research and guidance relating to:
1. definitions;
2. identification;
3. areas of difficulty affecting communication;
4. case management;
5. framing your questions both before and at court.

The term 'mental disorder' covers a wide spectrum of mental health conditions but, for the purposes of this toolkit, learning disabilities are excluded from consideration since a separate toolkit already exists which provides guidance for dealing with such vulnerability (Toolkit 4). Similarly, there is a toolkit which gives guidance in relation to screening individuals for various vulnerabilities (Toolkit 10) which should be read in conjunction with this toolkit as well as a toolkit dealing with a person giving evidence by means of remote video link (Toolkit 9).

Information about an individual's specific capabilities or condition is essential and, if not supplied, must be requested. This toolkit contains general guidance and is not a replacement for a Registered Intermediary's or psychiatrist's assessment which would provide advice specific to the individual. It is intended that in due course there will be toolkits for specific diagnoses of mental disorder as each disorder can raise radically different issues.

A Registered Intermediary should be considered if the person is unlikely to be able to

recognise when they do not understand something, or to tell the questioner that they have not understood, or has some other communication difficulty; this is necessary even where no intermediary was used at a previous investigative interview stage because giving evidence in court is qualitatively different from the experience of an Achieving Best Evidence interview. The intermediary's report will advise about the most effective means of communication tailored to the individual's needs and the vocabulary required by the case.

> Advocates should not take it upon themselves to decide what the communications needs are of any of their potentially vulnerable witnesses. (Professional Practice Committee of the Bar Council)

KEY POINTS ABOUT QUESTIONING

- Tailor questions to the individual's needs and abilities.
- Demonstrate empathy and understanding especially if the person seems particularly angry or agitated.
- Use a calm and reassuring tone.
- Use responsive body language.
- Eye contact can be threatening.
- Signpost the subject and explain when the subject is about to be changed.
- Ask short, simple questions, one idea at a time.
- Whilst the use of 'open' questions may be appropriate to begin with (e.g. *'Tell me about ...'*, *'Describe ...'*) if the individual is confused then 'closed' questions (i.e. those seeking a 'yes' or 'no' response) ought to be introduced.
- 'Yes/no' *or '*Did' questions can be followed up using a 'wh' question i.e what/where/when/who. Why is complex as high levels of language for thought and reasoning are required. It can be interpreted as accusative.
- Use common words, unambiguous language and avoid figures of speech as idioms such as *'Does that ring a bell?'* can cause confusion because processing under stress, particularly with mental health difficulties, becomes very literal. It may cause images/thoughts of 'bells' to emerge.
- Speak slowly and allow the person enough thinking time to give a full answer.
- Repeat names, places and objects often. Use these names rather than pronouns such as 'he/she'.
- Follow a logical, chronological order. Use a timeline/symbols/pictures.
- Reflect back information and summarise issues to show you have been listening, e.g. answer *'I live at 14 Acacia Avenue'*; follow-up question *'How long have you lived at 14 Acacia Avenue?'*
- Some question types carry a high risk of being misunderstood or producing unreliable answers. Such problematic question types should be discussed at a ground rules

hearing. These include questions:

- with `tag' endings (i.e. a statement followed by an invitation to confirm its truth);
- in the form of a statement asserting that something is a fact, which may not be recognised as a question;
- asking *'Do you remember ...?'* particularly where the question concerns what the witness told someone else;
- forced choice questions (i.e. those that limit the potential responses or include inappropriate comparators);
- those containing one or more negatives;
- repeated questions because these suggest the witness is lying or confused.

1. DEFINITIONS

1.1 '**Mental Disorder**' is defined in the Mental Health Act 1983 (section 1 as amended by the 2007 Act) as 'any disorder or disability of the mind'.

1.2 Population research consistently finds that one in four people will suffer from some form of mental health issue during their lifetime. There is a similar definition in Code C of the Police and Criminal Evidence Act 1984 Codes of Practice with 'mentally vulnerable' meaning 'any detainee who because of their mental state or capacity may not understand the significance of what is said, of questions or of their replies'.

1.3 Clinical diagnoses of mental disorders are made in the UK mainly by using the ICD-10 (International Classification of Diseases) although some clinicians use the DSM-5 (the *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association 2013).

1.4 Some of the most common types of mental disorder include:

- schizophrenia;
- bipolar affective disorder;
- personality disorder;
- post-traumatic stress disorder;
- dementia.

1.5 For more information about recognising/identifying each disorder, please look at the appendix where key symptoms of each are set out.

1.6 The definition of a 'vulnerable witness' (section 16(1)(b) Youth Justice and Criminal Evidence Act 1999) includes those whose quality of evidence is likely to be diminished because they suffer from a mental disorder within the meaning of the Mental Health Act

1983 (section 16(2)(a)(i)) or otherwise has a significant impairment of intelligence and social functioning (section 16(2)(a)(ii)). When determining whether an individual's quality of evidence is likely to be diminished, the court must consider its likely 'completeness, coherence and accuracy' (section 16(5)).

> 'Courts are accordingly expected to make reasonable adjustments to remove barriers for people with disabilities, including mental disorder' (section 6.2 Judicial College, *Equal Treatment Benchbook 2013*, giving effect to the Equality Act 2010).

2. IDENTIFICATION

2.1 Both police officers and Victim Support professionals have said that they do not feel adequately trained and equipped to support victims of crime with mental health problems. They were concerned about doing the wrong thing and exacerbating any distress the victim was feeling. It is hoped that the introduction of the Liaison and Diversion Scheme in custody suites will promote a more joined-up approach between the agencies supporting suspects with mental health needs.

2.2 Court staff, legal representatives and the judiciary often work, however, on the assumption that the police, social workers or others are responsible for and would have identified whether the court user has a mental disorder. This is a dangerous assumption and there is a definite need to identify where a mental disorder may be present so that proper assessment can be undertaken and thereby prevent a 'revolving door' situation whereby an individual's mental health needs are not identified and dealt with as early as possible. Research in 2006 found that the official recognition of potentially vulnerable witnesses by police and the Crown Prosecution Service was much below that identified by the researchers i.e. an official figure of 9% versus 24% in the research findings with the researchers using a 'very conservative estimate'. The largest groups that were not identified in the official figures were the mentally disordered and learning disabled. The findings suggest that there still remains a huge unmet need among vulnerable witnesses with regard to identification and implementation of the special measures (Burton et al 2006).

2.3 There should not be an over-reliance upon self-reporting as many individuals may conclude that questions as to whether they have any 'special needs' refer solely to physical as opposed to mental health difficulties they may have. Someone with a mental disorder may also be unaware that their condition amounts to a mental disorder or disability so will not reveal it. Others may choose not to disclose their mental disorder due to the stigma associated around mental health or because of shyness, uncertainty or embarrassment. Many fear that their condition will have an adverse impact on their credibility, or the case as a whole and this appears to be backed up by anecdotal reports:

'In reality ... you tend to find people with mental health or learning disabilities etc. tend to be written off as witnesses before you even get anywhere' [Barrister, North East].(Mcleod et al 2010a)

2.4 It is therefore important to be open to the possibility of these conditions being present and the following factors can assist in carrying out this screening to determine whether expert assessment is required although many individuals may deny or exaggerate symptoms. It is also important to recognise that not all individuals with a mental disorder will present with all of the factors listed. Also please note that The Advocate's Gateway has another toolkit focused specifically on screening for vulnerabilities (Toolkit 10).

FACTORS WHICH CAN BE INDICATIVE OF A POTENTIAL MENTAL DISORDER

2.4 Factors relating to the individual

THEIR LIFE

- Exposure to trauma or stress in their past;
- victim of bullying;
- inappropriate coping strategies such as substance misuse;
- inappropriate emotional responses e.g. laughing to themselves;
- chronic physical health problems or any illness that has an organic effect on the brain;
- in receipt of Personal Independence Allowance or Disability Living Allowance;
- resident at a group home or institution or employed in a sheltered workplace;
- in possession of certain prescription medicine or receiving injected medicine;
- receiving support from a carer/social worker/community psychiatric nurse;

TASKS

- Communication difficulties and developmental delay, e.g. lack of reading and writing ability;
- an inability to handle personal affairs, e.g. debt, and tied to this may be some form of capacity assessment.

TYPES OF CRIME

- Being arrested for certain types of crime, e.g. arson is said to have the strongest relationship with mental disorders followed by assaults of all kinds;
- risk-taking behaviour that is out of character.

PRESENTATION

- Being overly suggestible or eager to please;
- distracted;
- shaking or with a tremor;
- unkempt dress;
- has no speech or limited speech or is difficult to understand, using signs and gestures to communicate;

- appears to have some difficulty in understanding questions;
- responds inappropriately or inconsistently to questions or does not answer questions succinctly;
- alternatively, may speak very quickly jumping from topic to topic without having been asked a question;
- seems to focus on what could be deemed irrelevant small points rather than important issues;
- appears to have a short attention span or is distracted;
- has difficulty in remembering their date of birth, age, address, telephone number, the day of the week, where they are and whom they are talking to;
- Continually repeats what is said to them;
- Appears over-excited/exuberant/restless, e.g rocking back and forth;
- appears uninterested/lethargic;
- appears overly emotional;
- talks very negatively about themselves;
- appears confused by what is said or happening;
- is physically withdrawn, e.g. hiding their face or shutting their eyes;
- is violent;
- expresses strange ideas;
- does not understand common everyday expressions;
- odd angling of the head/eyes for viewing;
- a failure to search visually for people, but instead looks around the room;
- hesitant in movement/reluctant to move in unfamiliar environment;
- uncontrollable muscular movements;
- little awareness of personal space.

2.5 Factors associated with their family

- Hostile or rejecting relationships – emotional abuse or inconsistent parenting;
- emotional, physical and/or sexual abuse;
- family history of mental illness, particularly amongst parents or siblings;
- family's reaction to stress and their strategies to problem-solving will impact on the individual;
- family dysfunction and breakdown.

2.6 Social factors

- Economic deprivation;
- discrimination of any kind;
- delinquent peer groups;
- social isolation and poor/no support networks.

2.7 Environmental factors

- Poor housing;
- Unemployment;
- Poor health care;
- Previous history of criminality.

Dual diagnosis/co-morbidity

2.8 Some individuals may also have a dual diagnosis –mental health and substance abuse problems – or co-morbidity – in that they have more than one co-existing mental health and/or learning disability issue.

2.10 Many court users with co-morbidity of both mental disorder and a learning disability were more prepared to disclose the learning disability than the mental disorder:

> 'Because people with disabilities have rights' [Male, criminal case, learning disabilities and mental health condition, North]. (Mcleod et al 2010a)

2.11 Potential questions for an expert assessment

1. Does the individual have symptoms indicative of a potential mental disorder, co-morbidity or dual diagnosis?
2. If so, how might the nature or extent of the person's mental health condition affect their ability to give evidence, particularly with reference to their:
   a. response to questioning;
   b. concentration and attention;
   c. ability to communicate and
   d. interaction with other people.
3. Are there any measures which can be taken to support the witness to give their best evidence and ensure questioning does not cause further distress and/or exacerbate their condition?

3. AREAS OF DIFFICULTY AFFECTING COMMUNICATION BOTH BEFORE AND AFTER COURT

> Speech, language and/or hearing can be impaired in individuals with a diagnosis of mental illness. Difficulties in these areas can result in the reduced intelligibility of messages, or in deficient listening skills. This imposes limitations on the communication of thoughts and feelings. It frequently engenders messages of intolerance, ridicule and rejection by society. This can encourage feelings of isolation, hostility and anger in those affected, which are frequently accompanied by feelings of low self esteem, a lack of confidence, and worthlessness and uselessness. (France 2001:15)

3.1 Mental illness has nothing to do with a person's intelligence level so do not assume

they also have learning disability. Some individuals may have a co-morbidity of mental disorder and learning difficulties (Toolkit 4) in which case you should refer to both toolkits for advice. Nor does a mental disorder automatically infer that a person's evidence is lacking in credibility or reliability, which some people may assume.

3.2 Recounting the experience of events may reawaken or intensify feelings of fear and distress.

3.3 If they are experiencing events like hallucinations (which can involve any of the senses), be aware that the hallucinations or the delusions they experience are their reality. You will not be able to talk them out of their reality. They may experience the hallucinations or delusional thoughts as real and be motivated by them.

3.4 People with disordered thinking find it hard to keep a logical order to their ideas and their thoughts and speech may be jumbled and disconnected, giving the impression that they are talking nonsense.

3.5 Good practice example The vulnerable defendant struggled with concepts of time, so the defendant (who gave evidence from the live link room) was allowed to take an agreed timeline into the live link room to assist cross-examination. The advocates had a duplicate copy and indicated certain points on the timeline when putting questions to the defendant.

3.6 Memory problems can become more acute when people feel under pressure or anxious and may affect the consistency of testimony. But there is a difference between recalling details and the underlying reliability of an account. For example, people may have difficulty remembering precise dates and times, but this does not necessarily call the whole account into question. Memory problems may just affect the level of detail or precision, not the reliability or credibility of the testimony as a whole. e.g.

> 'I didn't give an absolutely accurate description [of the perpetrator]. Because I have lapses of memory, short-term memory, I have schizophrenia and I'm not sure it's a symptom [...] I couldn't explain to them.' [Interviewee – 40, male, victim of assault and burglary] (Pettitt et al 2013)

3.7 Psychiatric medication has a number of potential side-effects, all of which may impact on the person's ability to communicate:

- blurred vision;
- dizziness;
- drowsiness;
- loss of mental sharpness;
- memory problems;
- muscle stiffness;

- poor concentration;
- rapid heartbeat;
- shaking or muscle spasms;
- sleep disturbance;
- slowed thinking;
- slurred speech;
- abnormal movement of jaw, lips and tongue.

3.8 As well as memory problems, the onset of dementia can itself create communication barriers including:

- problems finding the right words;
- using the same words repeatedly;
- not appearing to understand what is said;
- saying very little;
- using phrases lacking in meaning or coherence;
- an inability to stay on topic.

3.9 Interpreting events relies on a person's ability to put experiences into a wider context. If a person is experiencing thought disorder, paranoia or delusions they might find it difficult to interpret events because they will be experiencing a reality which is different to that of other people. Other symptoms such as low motivation, agitation and racing thoughts might also have an impact on the ability to interpret events. Again these symptoms will vary in severity and are likely to fluctuate over time.

3.10 Difficulty with concentration is a common symptom of many mental health conditions. However, there is a difference between finding it difficult to concentrate and being unable to concentrate, and it should not be assumed that difficulties preclude a person's ability to give evidence. If someone is experiencing obsessive thoughts or hallucinations then it can be very challenging to concentrate on anything beyond these experiences. Other symptoms such as lack of energy or feelings of despair can make it difficult to pay full attention to situations and may also have an impact on the clarity or tone of responses.

3.11 Good practice example The witness was taking a significant amount of medication to control psychiatric symptoms. Her ability to give evidence was much improved in the afternoon when her medication had the chance to start working and her mental state was most stable. It was scheduled so that she gave her testimony only in the afternoons.

3.12 Feelings of anxiety and low self-esteem may be exacerbated by questioning and individuals may become agitated or distressed finding it difficult to speak in public. Anxious witnesses may also be eager to please and/or willing the experience to be over, so give quick

answers that they believe the questioner wishes to hear. It may be difficult for people to remain focused and give a measured response if they are experiencing some of the symptoms associated with schizophrenia and psychosis, such as hearing voices – this can be very distracting, like listening to two conversations at once.

3.13 Because an individual may be struggling to comprehend information they have been given, they are likely to begin to feel more confused, which in turn increases anxiety levels. This increased anxiety interferes with the person's ability to comprehend, to think rationally and to actively engage in deductive reasoning.

3.14 Someone with an undiagnosed mental disorder may be overlooked and research suggests that depression and anxiety are not viewed as requiring the same level of empathy and support as other conditions. At first glance, people with these conditions do not appear as vulnerable as someone with generalised learning disabilities.

3.15 Many people with a mental disorder are prone to stress reactions when their coping strategies break down which can lead to feelings of panic and mental overload causing a total shutdown or the urge to provide any answer at all to bring the questioning to an end. The person may have difficulty with taking in the new information and it is common for there to be a delay between the person hearing something and understanding it and in working out how to respond.

3.16 Depressive disorders may lead to individuals being quick to admit failings or fault due to abnormal feelings of guilt or because they may actually believe that they have carried out an act.

3.17 Hypomania may mean that the person lacks an appreciation of the significance of questions and may also lead them to make exaggerated statements or false claims because of elation or ebullience. They may also underplay the seriousness of an allegation.

3.18 Individuals may present differently at different times due to their condition being in remission or as a result of either intoxication or withdrawal from substances or, with post-traumatic stress disorder, if reliving the original trauma. Therefore their communication skills from one day to another may be very different and measures that were appropriate at one time may not be appropriate on another date. Accordingly, even where someone may present as having no communication problems when assessed, there is an argument that they should still have an intermediary at court based on the history of their illness. Psychiatrists may also be able to give more guidance as to how long particular symptoms may last which may assist with the scheduling of hearings.

3.19 There are three key inter-related risks linked to the individual's vulnerability which

need to be avoided when they are being questioned:

1. suggestibility – whereby people accept messages from formal questioning which affects their subsequent behaviour;
2. compliance – occurs due to the individual being eager to please and to avoid conflict;
3. acquiescence – occurs when a person simply answers yes to all questions regardless of what is asked.

4. CASE MANAGEMENT

4.1 Mental distress can fluctuate – people may have periods where they experience no symptoms at all or particularly difficult days or times of day which if possible ought to be avoided. Impromptu and frequent breaks may also be needed to help calm a person's anxieties or lower their stress levels.

4.2 Assessment by an intermediary will help ensure that the most effective means of communication is developed, tailored to the individual's needs and the vocabulary required by the case, but their role is not to deal with issues of competency or capacity.

4.3 Communication is closely linked to emotional containment. The intermediary will need to assess the need for the use a strategies which assist emotional containment. Without this underpinning, effective communication and participation can break down.

4.4 The Intermediary may recommend using some form of stress ball or fidget object. Many people find doodling containing. Some may need to rock or move in order to think and remain in the trial process. The judge will need to explain this to the jury.

4.5 In cases of dissociation and high anxiety, it will be necessary to ascertain from the person whether there are specific strategies which help avoid fragmentation of their personality. Likewise, when a person is distressed and uncontained, it is important to find out what can help them to reintegrate and return to calmness.

4.6 Some people need certain sensory stimuli (such as aromas, e.g. lavender or a touch on the arm/shoulder, or calling their name) to help them return to a contained level so that communication can take place. It is vital these strategies are assessed by the intermediary and recommended if appropriate, as being touched unexpectedly may equally heighten distress.

4.7 Breathing techniques are often helpful in managing high levels of stress. It may be necessary to have breaks to use these or for the intermediary to employ them during questioning.

Witnesses with a mental disorder are eligible for an intermediary where the use of

an intermediary would maximise the quality of their evidence. (paragraph 3.79 Ministry of Justice 2011a)

4.8 Pre-trial visits and receiving information in an 'easy-read' format is likely to help to reduce anxiety and put a person more at ease.

If I'd have known beforehand there was definitely going to be a screen, I wouldn't have to face him, I wouldn't have to look at him – I'd have been a little bit more confident about going in the courtroom.' [Female court user, mental health condition, criminal case, South] (McLeod et al 2010a)

4.9 Help on the day of a hearing from the Witness Service or prison staff at court will be appreciated, as will access to special measures (such as screens or giving evidence by video link) when they give evidence.

'[Special measures were] immensely [helpful]. She [the participant's daughter] found it much better because she don't have the fear of him looking at you. And the fact that she had been self-harming and feeling very low that was one of the reasons she got it, for her mental state.' [Interviewee 45, mother of the victim of sexual violence] (Pettitt et al 2013)

- Video-recorded evidence or live link can be useful for people who find interaction with other people challenging or who are unable to speak up in public due to chronic low self-esteem.
- Screens can help people to focus and concentrate on cross-examination, particularly where they may experience obsessive thoughts or hallucinations.
- Removing wigs and gowns may reduce the risk of a person becoming anxious, distressed or experiencing feelings of paranoia or panic, particularly where people have difficulties with authority figures or unfamiliar procedures and environments.
- The use of written or predetermined questions may also help those people who experience disordered, obsessive or intrusive thoughts which make following the thread of conversation difficult. The judge is likely to expect these to have been drafted in advance and be checked with both the intermediary and themselves. The use of picture symbols can be very useful as reading ability may also be severely affected.
- You can anticipate that the judge will be willing to intervene in a supportive manner during cross-examination, where appropriate. The following are common triggers which can exacerbate a person's mental distress:
    - noise;
    - interruptions;
    - room environment and unfamiliar surroundings;
    - too many people or conversations;
    - over-stimulation or sensory overload;
    - being given lots of (new) information;

- being asked to concentrate – including reading, writing and talking (especially for long periods);
- time pressures, demands and deadlines;
- long sessions (interviews, meetings and court sittings);
- unfamiliar dress and unknown rules;
- presence of technology such as closed circuit television that may provoke mistrust or paranoia;
- change of arrangements such as the location of the court or personnel;
- authority figures and official procedures;
- questioning or interrogation;
- feeling trapped;
- feelings of not being listened to or believed;
- loss of control or choices, feeling excluded from decision-making;
- feeling of being pushed, rushed or hushed;
- shocks and sudden changes;
- having personal or psychiatric history made public.

4.10 People with mental distress have also told the charity Mind that the following reasonable adjustments may be helpful, in addition to special measures, although which might be appropriate in a particular case would always need to be checked with the individual themselves:

- interviews and hearings taking place in rooms with natural light;
- shorter sittings and/or the opportunity to take regular comfort breaks;
- staying seated while giving evidence and during cross-examination;
- permission to get up and walk around if this reduces discomfort, as some medication can cause restlessness.;
- allowing a supporter or carer to accompany the person at all times – including to stand alongside the witness box, where possible;
- ensuring witnesses are comfortable with court procedures and environment, such as explaining why there are closed circuit television cameras present or switching them off;
- asking police officers to remove hats and helmets to reduce distress caused by unfamiliarity or authority figures (as with wigs and gowns);
- requesting the judiciary, clerks and defence to address the witness directly and display patience and sensitivity when explanation is necessary or distress becomes acute;
- requests to clear the courtroom where sensitive medical information is raised for the first time and relevance needs to be determined.

5. FRAMING YOUR QUESTIONS[1]

5.1 There is a great deal of negative stigma surrounding people with mental health issues and a person's mental state is going to have an enormous impact upon their ability to communicate. Accordingly, be respectful to the person with the mental disorder because if they feel respected and heard they are more likely to return respect and consider what is being said to them. **Empathy and understanding** to build rapport are therefore key from the outset. Acknowledge how the person is feeling but rather than labelling the emotion, consider providing supportive statements instead, e.g. *'It can be really stressful to be in court.'*

5.2 Feeling that they have been heard is similarly important and these positive feelings of being appreciated, understood, accepted and valued can actually help the cognitive functioning return to normal.

5.3 Seek to avoid the potential triggers of mental distress listed above.

5.4 Apply the ABC of communication: **A**void confrontation, **B**e practical, **C**larify the person's feelings and offer comfort.

5.5 When dealing with hallucinations never seek to suggest that you experience their reality too.

5.6 Never appear to lie to them as it will usually break any rapport you might want to establish, especially if they are suffering with paranoia.

5.7 If needed, set limits with the person as you might to others. For example: *'I only have five minutes to talk to you.*' or *'If you scream, I will not be able to talk to you.'*

5.8 Also if you don't understand what they have said, say so and ask them to repeat what they have said. A card with a symbol/words *'Don't understand'* can also be used for the vulnerable person to point to if words escape them.

5.9 To enable good communication with the witness/defendant and to ensure you get the evidence the court needs, you should adopt the following best practice.

- Establish and maintain eye contact in a natural way but be careful of staring at the person for too long or equally of not looking at them at all. Generally, people will be able to inform the intermediary during their assessment how they feel about eye contact and what helps them best. Some people need to look away to think.

[1] See also Toolkit 2(a) General principles from research.

- Allow plenty of time for their response, repeating questions if necessary, and explain further if the witness is confused or distressed.

  'When I'm talking I'll go all round the houses to get to the (point) [...] I think it would have been helpful if they realised that yes, alright, I can tell you about the situation and what happened but it will take me longer.' [Interview 28, female, antisocial behaviour and assault] (Pettitt et al 2013)

- Use plain language and avoid jargon and legal terminology.
- Ask straightforward questions in a logical time-sequence such as *'What happened first?'*, *'What did you do next?'*, *'What was the last thing you remember?'* rather than compound questions like *'Before the man ran away, did you notice anything?'* Some people will have problems with sequential thought with the additional possibility of intrusive thoughts interrupting them.
- Where a witness is accompanied by a carer, mental health advocate or intermediary, address remarks to the witness/defendant rather than to the person accompanying them.
- Repeat names, places and objects using the witness's/defendant preferred name at the start of questions (making sure you have found out what the person wants to be called including any title, e.g. Mr or Ms).
- Ask short, simple questions, one idea at a time. Someone with a mental disorder may have a limited working memory and therefore be unable to remember all of a multi-part question in order to respond accurately.
- Follow a logical, chronological order, avoiding questions that jump around in time or appear to be unconnected as this will only exacerbate difficulties if someone is suffering with a thought disorder.
- Consider using a visual timeline or similar device, as advised by an intermediary, if the person is likely to have difficulty in responding to questions about times, dates or separate events or locations.
- Drawing can be a very useful communication tool. Likewise using figurines.
- Signpost the subject and explain when the subject is about to be changed. This gives the person transition time to focus on the next subject. It can also be helpful to schedule breaks at a change of subject.
- Check directly on understanding, using simple words. It is good practice to ask someone to say when they do not understand a question, but do not assume that they will be able to do so. Some people with a mental disorder will have difficulty recognising when they do not understand something and, even if they do realise this, are likely to be reluctant to say so. Never simply ask '*Do you understand?'* as the person will invariably state that they do. It is helpful to ask them to repeat in their own words what has been said.
- Having a selection of symbols for *'I don't understand', 'Go slower'*, *'Stop', 'Ok', 'Now',*

'Toilet', and so on will offer a safe communication system for *showing* if telling becomes difficult.

- Be flexible. Good practice example A young woman with mental health problems, language disorder and autism was allowed to give her evidence with her back to the video screen because she couldn't bear any sort of direct communication if she could actually see the person. The Registered Intermediary then repeated the whispered answers. Some of these answers were quite aggressive, insulting and dismissive and she also ran out of the room many times. With patience, understanding and support, however, she was able to give clear and lengthy evidence.

5.10 Some question types carry a high risk of being misunderstood or producing unreliable answers including:

- `tag' questions which make a statement then add a short question inviting confirmation – these are powerfully suggestive and linguistically complex (sections 5.2–7 Toolkit 6);
- other forms of assertion, including questions in the form of statements, which may not be understood as questions;
- forced choice questions which create opportunities for error when the correct alternative may be missing;
- *'Do you remember...?'* questions requiring complex processing, particularly when the person is asked, not about the event, but about what they told someone else;
- questions containing one or more negatives (actual, such as 'not', or implicit, such as 'without') make it harder to decipher the underlying meaning. Questions containing negatives increase complexity and the risk of unreliable responses.

5.11 The repetition of questions (consecutively or interspersed with others) by one or more authority figures (advocates and judges) risks reducing the overall accuracy of the responses of some people with a mental disorder, who may conclude that their first answer is wrong or unsatisfactory if someone in authority repeats the question, or it may prompt anger, irritation or some other form of mental distress.

APPENDIX

Schizophrenia is a type of psychosis (a loss of contact with reality) often characterised by hallucinations, thought disorder, paranoia and/or delusions.
Key symptoms include:

- **delusions** – fixed false beliefs held despite evidence to the contrary and that are out of keeping with the individual's social and cultural context;
- **hallucinatory experiences** – including voices and visions and false, persistent, perceptions in other sensory modalities including smell, touch and taste;
- **changes in the clarity and fluency of thoughts** – making conversation sometimes

difficult to follow;

- **perceived interference with thoughts** – hearing your own thoughts spoken out aloud or believing others can place thoughts into or withdraw thoughts from you or can control your thoughts/actions;
- **significant and consistent change in the overall quality of some aspects of personal behaviour –** e.g. overexcitement, irritability, disinhibition, laughing inappropriately and aggressive/acting-out behaviours. Alternatively, there can be the opposite with a loss of interest, apathy, lack of emotion, social withdrawal, poor self-care and aimlessness.

Bipolar affective disorder is another psychotic condition involving extreme changes in mood, from severe lows (depression) to severe highs (mania) with regular moods in between.

Key symptoms include:

- increased self-esteem;
- impaired concentration;
- low threshold for irritability;
- talking rapidly;
- delusions;
- hallucinations;
- acting irrationally.

Personality disorder is where an individual's personal characteristics or traits cause regular and long-term problems in the way they cope with life, interact with others or how they respond to events emotionally. These characteristics are present from adolescence and young adulthood and persist in different settings. There are several different types of personality disorder.

Key features include:

- not trusting other people;
- lack of emotion;
- extreme fear of rejection;
- reckless and impulsive behaviour;
- being overly dramatic and striving to always be the centre of attention which can include self-harm;
- perfectionism;
- an inability to see the bigger picture;
- pseudo-hallucinations, such as hearing voices.

Depression is where the individual suffers with low mood which is so severe that it impacts on everyday activities.

Key symptoms include:

- persistent low mood;
- irritability;
- altered sleep pattern (early morning wakening/insomnia/over-sleeping);
- appetite disturbance (either decreased appetite or overeating);
- loss of libido;
- feelings of hopelessness, helplessness, worthlessness or guilt;
- loss of self-esteem;
- lack of enjoyment in life;
- withdrawal and isolation – from family and peers;
- suicidal ideation/self-harming behaviour (including high-risk offending, substance abuse, promiscuity or eating disorders);
- sometimes delusional thoughts.

Post-traumatic stress disorder is related to other forms of anxiety disorder.
Key features include:

- **exposure to a traumatic event** – that lies outside normal experience and that would clearly cause suffering in almost anyone;
- **persistent re-experiencing** – recurrent flashbacks, nightmares and reliving of the episode and/or psychological distress and bodily anxiety responses to cues that symbolise or resemble the trauma;
- **persistent avoidance of places** – activities or cues specifically related to the trauma which may not be obvious to an outsider;
- **symptoms of hyper-arousal –** e.g. hyper-vigilance, startle responses, sleep disturbance and dramatic outbursts of fear, panic or aggression;
- **psychosocial impairment –** an impact on everyday living.

Dementia is a progressive deterioration in functioning including memory, personality, behaviour and ability to do everyday activities such as dressing, washing and household tasks.
Key symptoms include:

- memory impairment especially of simple words and of time and place;
- changes in personality;
- very passive behaviour;
- impaired reasoning.

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