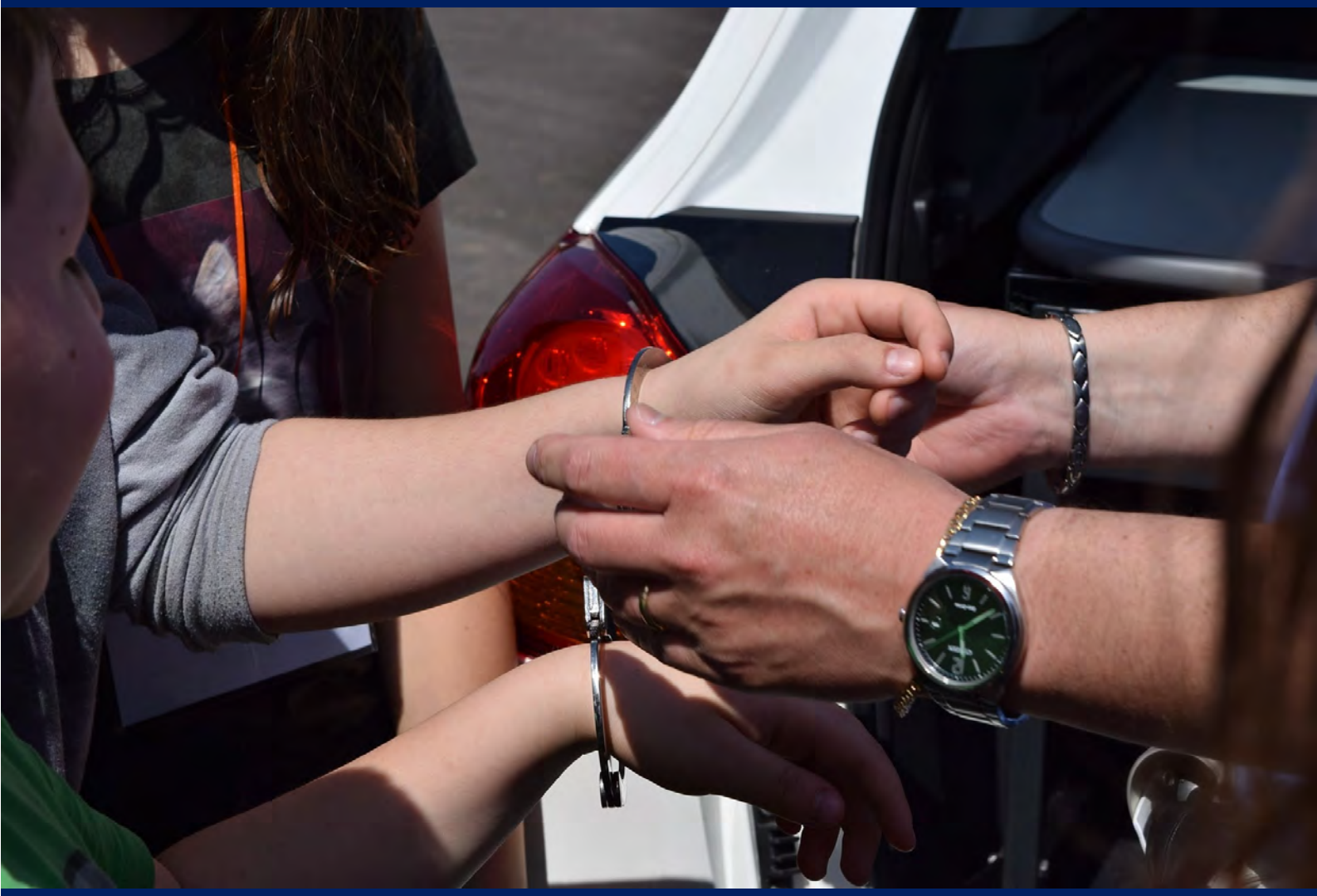
OPSIDIANET

OFFENDERS WITH PSYCHO-SOCIAL AND INTELLECTUAL DISABILITIES: IDENTIFICATION, ASSESSMENT OF NEEDS AND EQUAL TREATMENT



SUSPECTS AND ACCUSED WITH PSYCHOSOCIAL OR INTELLECTUAL DISABILITIES

IDENTIFICATION METHODOLOGIES AND COMMUNICATION FACILITATION TOOLS

This report was funded by the European Union's Justice Programme (2014-2020). The content of this document represents the views of the authors only and is their sole responsibility. The European Commission does not accept any responsibility for use that may be made of the information it contains.

SUSPECTS AND ACCUSED WITH PSYCHOSOCIAL AND INTELLECTUAL DISABILITIES

IDENTIFICATION METHODOLOGIES AND PARTICIPATION FACILITATION TOOLS

Dimitar Markov

Marie Rochol

Center for the Study of Democracy

July 2019

This background paper offers a review of the methodologies for identifying suspects and accused persons with psychosocial and intellectual disabilities and the practical tools for addressing their special needs and facilitating their participation in the proceedings. It was developed within the framework of the project *Offenders with Psycho-Social and Intellectual Disabilities: Identification, Assessment of Needs and Equal Treatment (OPSIDIANET)*, implemented by the Center for the Study of Democracy (Bulgaria), Centre for European Constitutional Law (Greece), Pope John XXIII Community Association (Italy) and Association Droit au Droit (Belgium).

Authors:
Dimitar Markov, Senior Analyst, Center for the Study of Democracy
Marie Rochol, Research Assistant, Center for the Study of Democracy

This report was funded by the European Union's Justice Programme (2014-2020). The content of this handbook represents the views of the authors only and is their sole responsibility. The European Commission does not accept any responsibility for use that may be made of the information it contains.

Cover image: Paolo Ghedini from Pixabay
Published by: Center for the Study of Democracy, 2019
5 Alexander Zhendov Str., 1113 Sofia
Tel.: (+359 2) 971 3000, Fax: (+359 2) 971 2233
www.csd.bg, csd@online.bg

Table of contents

INTRODUCTION

EU criminal law provides suspects and accused with a set of procedural rights aimed to ensure their adequate participation in criminal proceedings. These include, among others, the right of access to a lawyer and to communicate upon arrest (Directive 2013/48/EU), the right to be presumed innocent until proved guilty according to law, to remain silent and to not incriminate oneself (Directive 2016/343/EU), the right to legal aid (Directive 2016/1919/EU), the right to interpretation and translation (Directive 2010/64/EU), and the right to information (Directive 2012/13/EU).

To effectively benefit from the full scope of their procedural rights, suspects and accused need to understand the meaning of these rights, know when and how they can exercise them and be aware of the consequences of their decisions and actions. However, some defendants may not have the capacity to comprehend the information they receive from the authorities due to their age, mental or physical condition or disability. Unless provided with proper assistance, such persons are not able to understand and effectively participate in the criminal proceedings against them.

To encourage Member States to address this issue, in 2013 the European Commission adopted a special *Recommendation on procedural safeguards for vulnerable persons suspected or accused in criminal proceedings*. It suggests a set of measures aimed at strengthening the "procedural rights of all suspects or accused persons who are not able to understand and to effectively participate in criminal proceedings due to age, their mental or physical condition or disabilities ('vulnerable persons')".

As specifically highlighted by the European Commission, a key prerequisite for addressing the special needs of vulnerable suspects and accused persons is the timely and correct assessment of their vulnerability:

"Vulnerable persons should be promptly identified and recognised as such. Member States should ensure that all competent authorities may have recourse to a medical examination by an independent expert to identify vulnerable persons, and to determine the degree of their vulnerability and their specific needs. This expert may give a reasoned opinion on the appropriateness of the measures taken or envisaged against the vulnerable person." (Section 2 of Recommendation on procedural safeguards for vulnerable persons suspected or accused in criminal proceedings)

Unlike age and physical condition, which are easier to identify, psycho-social and intellectual disabilities are not always visible and can, therefore, remain either unnoticed or misinterpreted by the law enforcement and judicial authorities. This is usually due to a lack of knowledge on the part of the authorities of how to recognise the signs of such vulnerabilities, what their impact on the situation of these individuals during the proceedings can be, and what should be done to properly safeguard their rights.

The failure to promptly identify and assess the psychosocial or intellectual problem of a suspect can lead to infringement of their procedural rights, unequal treatment during the proceedings and a violation of the fundamental right to a fair trial.

Against this background, the present paper offers a review of some of the methodologies and practical tools, which law enforcement and judicial authorities use to identify suspects and accused persons with psychosocial and intellectual problems and to address their special needs during a criminal case.

GENERAL OVERVIEW OF EXISTING IDENTIFICATION METHODOLOGIES

Although the situation of offenders with psychosocial or intellectual disabilities is a challenge for many national criminal justice systems, only a few countries have developed and apply specific methodologies for the systematic identification of such impairments. In most countries, law enforcement and judicial authorities perform such identification only if they either notice apparent signs (such as appearance, communication or behaviour) or have obtained other information revealing the specific condition of the person. In some countries, judges, prosecutors and police officers receive training on how to act and react in regards to cases involving persons with intellectual and/or psychosocial disabilities. Most of these training activities, however, are either optional (not mandatory) or are just a small component of a bigger training curriculum.[1]

Specific standardised methodologies for the systematic identification and assessment of psychosocial and intellectual disabilities of offenders (suspects, accused or convicted persons) have been found only in the United Kingdom, Canada and the United States. In addition to these, some methodologies developed by researchers and non-governmental organisations, but not yet applied in practice, were also identified. A total of nine methodologies were selected for further review, the results of which are presented in the following sections.

All methodologies, selected for review, are aimed at first-line practitioners (police officers, prosecutors, judges, prison and probation staff, etc.), who are not experts in the field of psychosocial and intellectual disabilities. This is why their goal is not to diagnose the person, but rather to alert front-line practitioners coming into contact with such a person that there might be a certain problem that would require some special attention.

The majority of selected methodologies are specifically developed for police use, but there are also tools designed for judges, prosecutors, prison and probation staff, social workers and other practitioners (Table 1).

Table 1: Implementing body (who can apply the methodology)

Methodology	Law enforcement	Judges and prosecutors	Other
Authorised Professional Practice: Mental vulnerability and illness	✓		
Autism: a guide for police officers and staff	✓		
Handbook for professionals in the criminal justice system working with offenders with learning disabilities	✓	✓	✓
Checklist: first indications for potential intellectual and/or psychosocial disabilities	✓		

[1] For more information about the identification and assessment mechanisms applied in Austria, Bulgaria, the Czech Republic, Lithuania and Slovenia see Ludwig Boltzmann Institute of Human Rights (2018), Dignity at Trial: Enhancing Procedural Safeguards for Suspects with Intellectual and Psychosocial Disabilities, https://bim.lbg.ac.at/sites/files/bim/attachments/1_handbook_dignity_at_trial.pdf.

Not just another call… police response to people with mental illnesses in Ontario. A practical guide for the frontline officer	✓		
Correctional Mental Health Screen			✓
Brief Jail Mental Health Screen			✓
Sample Policy in Handling the Mentally Ill	✓		
Patient Health Questionnaire 9			✓

In terms of the specific disabilities, which the methodologies are designed to identify, there are two main categories of tools. The first category includes more general methodologies, which are aimed to identify signs of any form of psychosocial or intellectual disability, while the second category includes tools intended to identify specific conditions like autism, learning disability or depression (Table 2).

Table 2: Conditions covered (what can be identified by the methodology)

Methodology	Psychosocial disability	Intellectual disability	Both
Authorised Professional Practice: Mental vulnerability and illness			✓
Autism: a guide for police officers and staff	✓ autism		
Handbook for professionals in the criminal justice system working with offenders with learning disabilities		✓	
Checklist: first indications for potential intellectual and/or psychosocial disabilities			✓
Not just another call… police response to people with mental illnesses in Ontario. A practical guide for the frontline officer	✓ schizophrenia, major depression, bipolar disorder, suicidal behaviour, panic, mute or passive behaviour excited delirium		
Correctional Mental Health Screen	✓		
Brief Jail Mental Health Screen	✓ schizophrenia, bipolar disorders, major depression		
Sample Policy in Handling the Mentally Ill	✓ mental illness, excited delirium		
Patient Health Questionnaire 9	✓ depression		

Each methodology requires the collection of a certain amount of information about the person, to whom it is applied. There are three main methods for gathering this information: observation, questioning of the person and collecting information from other sources. Some of the methodologies use a combination of these methods, while others rely on only one of them (Table 3).

Table 3: Information needed (how is the necessary data collected)

Methodology	Observation	Questioning of the person	Information from other sources
Authorised Professional Practice: Mental vulnerability and illness	✓	✓	✓ (optional if in doubt)
Autism: a guide for police officers and staff	✓	✓	
Handbook for professionals in the criminal justice system working with offenders with learning disabilities		✓	
Checklist: first indications for potential intellectual and/or psychosocial disabilities	✓	✓	✓
Not just another call… police response to people with mental illnesses in Ontario. A practical guide for the frontline officer	✓		
Correctional Mental Health Screen		✓	
Brief Jail Mental Health Screen	✓ (optional)	✓	
Sample Policy in Handling the Mentally Ill	✓		
Patient Health Questionnaire 9			✓

The methodologies that rely on observation as a data collection method include lists of indicators (signs), which the first-line practitioners have to monitor. These might be indicators related to the person's appearance (bizarre clothing or makeup, appearance that is inappropriate to the environment, signs of self-neglect), behaviour (inappropriate, bizarre or irrational behaviour, repetitive or obsessive behaviour, strange posture, mannerisms or bodily movements, unawareness of the surrounding, confusion and disorientation, increased breathing and heartbeat, sweating and shaking, difficulty in concentrating, impulsiveness or hostility, pacing, agitation, hyperactivity, distractibility, short attention span) or communication (difficulty in understanding and/or following conversations or instructions, unresponsiveness, inappropriate responses or emotional reactions, speech difficulties, difficulty in reading or writing, illogical thought, speech that does not make sense to others or repetitions of what has been said before).

The methodologies that rely on the questioning of the person are based on a different and more complex approach. On the one hand, some of the questions included in these

methodologies are aimed to establish the person's current state of mind, which, in many cases, can also be established through observation. Such questions are for example those related to the person's spatial or temporal orientation (where are you, what day is today), memory (how old are you, when is your birthday), etc. On the other hand, there are questions that are aimed to explore the person's mental condition in general rather than in the particular moment. Such questions are, for example, those related to the person's medical history (have you been in a hospital recently, for what reason, do you take any medications), past experiences (have you ever been troubled by repeated thoughts, feeling or nightmare about something, have you ever tried to avoid reminders of or not to think about something, has there ever been a time when you felt so irritable that you found yourself shouting at people or starting fights or arguments), feelings and emotions (do you get annoyed when friends and family complain about their problems or do people complain you are not sympathetic to their problems, do you find that most people will take advantage of you if you let them know too much about you), etc.

The methodologies that use information obtained directly from the person produce more accurate and reliable results. However, it is important to note that the questioning of the person with the purpose of identifying signs of psychosocial or intellectual disability should not be confused with their formal questioning as suspects or accused persons. The questioning to identify signs of disability should be done as soon as possible in order to enable the competent authority to undertake measures to address the person's special needs. The questioning of the person as a suspect and accused, on the other hand, can take place only after informing the person about their rights and undertaking all necessary measures to safeguard them.

Lastly, some methodologies also rely on information collected from other sources such as previous police reports, medical documentation, information obtained from the person's relatives, etc. The main limitation of this method is that, unless the necessary information is immediately available (e.g. by calling the police station or checking an online database), its collection would slow down the process.

AUTHORISED PROFESSIONAL PRACTICE: MENTAL VULNERABILITY AND ILLNESS

Reference

United Kingdom, College of Policing (2018), Authorised Professional Practice: Mental health: Mental vulnerability and illness https://www.app.college.police.uk/app-content/mental-health/mental-vulnerability-and-illness/

Disabilities covered

The Authorised Professional Practice is designed to help police officers recognise 'possible mental health problems, learning disabilities or suicidal intent of people they come into contact with'. It can, therefore, be applied to identify all types of intellectual and/or psychosocial disabilities.

Implementing body

The Authorised Professional Practice is developed and owned by the College of Policing, the professional body for policing in England and Wales. It is designed for police officers and staff, who are expected to apply it when discharging their responsibilities.

Description

The method is designed as a non-exhaustive general guide to help policemen identify indicators of mental health problems and learning disabilities, that does not focus on specific illnesses. These indicators, called 'indicators of general concern', are organised in two different categories.

The first one includes appearance and behavioural indicators such as irrational conversation/behaviour, inappropriate or bizarre behaviour, talking about seeing things or hearing voices which cannot be seen or heard by others, removing clothes for no apparent reason, confusion and disorientation, paranoid beliefs or delusions, self-neglect, hopelessness, impulsiveness as well as obsessional thoughts or compulsive behaviour.

The second category entails aspects of communication such as inappropriate responses to questioning, apparent suggestibility, poor understanding of simple questions, speech difficulties (e.g. poor enunciation, slurring words or difficulty with pronunciation), difficulty reading or writing, unclear concepts of times and places, problems remembering personal details or events, poor ability to cope with interruptions, poor handwriting that is difficult for others to read, difficulty with filling out forms, inability to take down correct information or follow instructions correctly, talking continuously or slowly and ponderously as well as repeating themselves.

It is, however, noted that these signs are not definite proof of mental ill health or learning disabilities but might also be caused by other factors. These include physical illness like a head injury, infection or diabetes, medication that could, for example, affect speech, and other intoxication such as drugs or alcohol.

Furthermore, the guide also states that all indications that a person might experience mental ill health should be treated as genuine, but in case of

doubt other sources of information, as well as mental health professionals, should be consulted and all findings should be recorded.

A second, also not an exhaustive list of indicators includes behaviour that points towards a person's risk of harm to themselves or others. These indicators, referred to as 'risk indicators', include persons putting themselves in danger (e.g. walking into the path of moving traffic or on railway lines), asking for help with their mental health, engaging in threatening behaviour towards others for no obvious reason, threatening or engaging in self-harm, attempting or threatening suicide (e.g. expressing ideas, intentions or plans relating to suicide), a high level of volatility, being unresponsive to others or withdrawn, a tendency to trip, fall over or bump into things, hyperventilating and showing physical signs of severe malnourishment and self-neglect.

Lastly, the Authorised Professional Practice includes a section on recognising mental vulnerability in children and young people, noting that mental health conditions often emerge less easily defined in this demographic group. Instead, signs, as defined by the Youth Justice Board in 2016, can include behavioural problems, emotional difficulties, substance misuse, and self-harm. As mental health professionals may be reluctant to provide a clear diagnosis due to the ongoing evolution of the adolescent brain, police officers should be able to identify when a mental illness could be an underlying cause of behaviour to ensure the person's access to an effective assessment and support pathway. This is said to help reduce the likelihood of mental health problems escalating, improve life chances and prevent crime.

Relevance

The Authorised Professional Practice is designed specifically for police staff and applies to all people who might come to police attention, including suspects and accused persons.

AUTISM: A GUIDE FOR POLICE OFFICERS AND STAFF

Reference

United Kingdom, The National Autism Society (2017), Autism: a guide for police officers and staff
https://www.autism.org.uk/~/media/nas/documents/publications/autism-police-guide-the-national-autistic-society-2017.ashx?la=en-gb

Disabilities covered

The guide covers only autism. It is designed to provide 'background information about autism and aims to help all police officers and staff who may come into contact with autistic children or adults meet their responsibilities'.

Implementing body

The guide has been developed by the National Autism Society and is designed to serve as a general reference for police officers and staff.

Description

To identify whether a person might be autistic, the guide suggests ten characteristics. These question if the person shows unusual/no eye contact, behaves inappropriately, unpredictably or unusually or seems to struggle to understand the police officer. Furthermore, an autistic person might find it difficult to talk to an officer, repeat what someone else says, speak honestly to the point of bluntness or rudeness, seem unusually anxious, agitated or scared of the police officer, display repetitive, obsessional-type behaviour, show sensitivity to sound, light or touch or seem not to realise the consequences of what they may have done.

Additionally, the guide describes a number of dos and don'ts for different situations. Officers should try to keep the situation calm, explain the situation in a simple manner and with the aid of pictures, use the name of the person, be patient with them, non-invasively check them for injuries, avoid sirens/flashing lights, and understand that they might have no understanding of personal space. They should not remove objects for security, try to stop the person from making repetitive movements, raise their voice, use sarcasm/irony, touch the person or expect an immediate response.

According to the guide, when arresting an autistic person physical contact should be kept to a minimum, the situation should be explained, custody agents informed, and the caution should be delivered slowly and clearly. Moreover, officers should check if the person carries any information about their needs. The arrest should not occur rushed, sirens and flashing lights should be avoided if possible, and transport should not happen unaccompanied. When an autistic person is in custody, they should not be overcrowded and loud, and sudden noises should be kept to a minimum. Adequate safety measures to avoid harm should be in place and a suitable appropriate adult, a helper, should be appointed without delay. Possible sensitivities and dietary requirements should be met and the procedure should be properly explained. Officers should ensure that the person understands what is happening while not giving specific timing as that could

be interpreted literally. Since signs of autism may fluctuate depending on levels of anxiety and stress, officers should consider seeking advice from an autism professional.

When interviewing an autistic person, officers should find out the person's particular needs and provide information in advance in clear, accessible formats. They should also consider requesting an intermediary. Procedures should be clear and without sudden changes. No assumptions should be made regarding the person's level of understanding and the optimal way of communication. The interviewer should remain calm and use clear words and no exaggerated facial expressions. Gestures should be minimised to reduce distraction. Should no response be heard, questions should be rephrased to be more direct and literal and to only contain one point. Diagrams and drawings might aid the understanding and frequent breaks should be offered. Additionally, the interviewer should be aware that the level of understanding and expression may be mismatched so frequent checks of understanding are advised. Past tense should be used for events in the past to avoid confusion. Question tags should be avoided as the interviewee might misinterpret the intention of the question and statement questions based on intonation should also not be used.

Relevance

The guide is designed specifically for police staff and applies on all persons who might come into contact with the police, including suspects and accused persons, victims and witnesses. A separate section deals with detainees.

HANDBOOK FOR PROFESSIONALS IN THE CRIMINAL JUSTICE SYSTEM WORKING WITH OFFENDERS WITH LEARNING DISABILITIES

Reference

United Kingdom, Department of Health (2011), Positive Practice, Positive Outcomes. A Handbook for Professionals in the Criminal Justice System working with Offenders with Learning Disabilities
https://www.gov.uk/government/publications/positive-practice-positive-outcomes-a-handbook-for-professionals-in-the-criminal-justice-system-working-with-offenders-with-a-learning-disability

Disabilities covered

The handbook covers learning disabilities that started before adulthood and have lasting effects of impaired intelligence and social functioning. However, much of the advice is also applicable to conditions defined by communication problems such as autism including Asperger Syndrome, ADHD and learning difficulties.

Implementing body

The handbook was developed by the UK Department of Health (Offender Health and Valuing People) and is aimed towards criminal justice staff as well as health and social care staff. It is not meant as a diagnostic manual and provides information regarding the necessary steps if an offender is suspected to have a learning disability or difficulty. There are also chapters aimed towards prison staff and professionals working in or with the Probation Service.

Description

The handbook lists a number of tasks that people with learning disabilities might find difficult: filling in forms, explaining things, following instructions or directions, managing a home and cooking, concentrating for long periods of time, managing their money and bills, telling the time and time awareness, keeping appointments, remembering information, using public transport, reading, writing and comprehension, and understanding social norms.

These difficulties are reflected in a list of questions that can be asked to find out if someone might have a learning disability.

The first three questions are centred around the support a person might receive: can you tell me where or with whom you live; do you have anyone to support you like a social worker, doctor or nurse; and is there anyone who helps you with things like paying your bills, cleaning or cooking?

The second set of question is based on past experiences with support: where did you go to school/did you have extra help at school; what do you usually do in the day; and have you ever been in hospital. If the answer to the last question is yes then there are two follow-ups regarding the time and duration of the stay as well as the hospital's name.

The last set of questions is a more direct test of the person's abilities: do you sometimes find it hard to understand what other people are saying; can

you tell me how old you are/when your birthday is; can you read; can you write; and can you tell me what time it is.

Another section of the handbook explains that a learning disability or similar condition may be hidden by other influences on behaviour such as a form of mental illness, drugs, alcohol, withdrawal symptoms or extreme anxiety brought on by the situation. It also stresses that the criminal justice staff does not have to diagnose possible illnesses or influences but should rather contact an appropriate specialist if they notice the signs mentioned.

Relevance

The handbook is designed to be used on offenders, which includes police suspects and defendants in court.

CHECKLIST: FIRST INDICATIONS FOR POTENTIAL INTELLECTUAL AND/OR PSYCHOSOCIAL DISABILITIES

Reference

Ludwig Boltzmann Institute of Human Rights (2018), Dignity at Trial: Enhancing Procedural Safeguards for Suspects with Intellectual and Psychosocial Disabilities
https://bim.lbg.ac.at/en/project/current-projects-projects-human-dignity-and-public-security-projects-development-cooperation-and-business/dignity-trial-enhancing-procedural-safeguards-suspects-intellectual-and-psychosocial-disabilities

Disabilities covered

The checklist has a broad scope of application and practically covers all forms of intellectual and/or psychosocial disabilities.

Implementing body

The checklist was developed in the framework of an international project implemented by the Ludwig Boltzmann Institute of Human Rights (Austria) in partnership with the Bulgarian Helsinki Committee (Bulgaria), the League of Human Rights (Czech Republic), the Mental Health Perspectives (Lithuania) and the Peace Institute (Slovenia). It is intended for the police, but there is no available information whether it has been applied in practice by any police or law enforcement agency.

Description

The purpose of the checklist is to enable the police to recognise the first indications for a person's potential intellectual and/or psychosocial disabilities. It is organised in the form of a checklist, which the police must complete. The checklist consists of three sets of questions: screening for the police, questions for the suspect and further indications the police might refer to.

The screening for the police includes three questions: is the questioned person able to comprehend complex information and express himself/herself; does the questioned person have temporal and local orientation; and does the questioned person suffer from an obvious thinking disorder (e.g. a person is talking in a confusing manner) or affect disorder (e.g. person reacts in an exaggerated way or shows hardly any emotion). The questions for the suspect includes two questions: does the person get any kind of professional psychosocial support (social work, guardian, supported living, working in a therapy programme) and is it possible to call a person of trust, to get further information about the questioned person. The further indications the police might refer to include: deprivation of liberty in a psychiatric hospital in the past; information about ambulant psychiatric treatment; already existing psychiatric or psychological assessments of other trials; actual medication; drug screening; alcohol screening; reports from police colleagues about previous official actions; information from relatives, close persons or caretakers about the person's disability; and suicide attempts.

For each of the three sets of questions there is a different source of information, which the police can use for collecting the data. The screening for the police is based on the personal perceptions of the police officer for the behaviour of the person, the questions for the suspect are intended to be asked to the questioned person, while the information for the further indications can be collected from various sources (the suspect's criminal record, police registers or databases, medical documentation, witness testimonies, etc.).

The checklist does not include any specific guidelines for the police on how to evaluate the collected information or what measures to undertake if there are positive indications for a potential disability. The handbook, however, includes two documentation sheets about the rights and obligations during a criminal procedure (one for the police and another one for judges), in which the relevant information is presented in easy to read format.

Relevance

The methodology is intended for the police and is specifically designed to be used on suspects and accused.

NOT JUST ANOTHER CALL… POLICE RESPONSE TO PEOPLE WITH MENTAL ILLNESSES IN ONTARIO

Reference

Canada, Centre for Addiction and Mental Health (2004), Not just another call… police response to people with mental illnesses in Ontario. A practical guide for the frontline officer
https://www.publicsafety.gc.ca/lbrr/archives/cnmcs-plcng/cn30152-eng.pdf

Disabilities covered

The guide offers recognition indicators for schizophrenia (including hallucinations and delusions), major depression, bipolar disorder (manic-depressive illness), suicidal behaviour, panic, mute or passive behaviour, and excited delirium.

Implementing body

The guide was developed by the Centre for Addiction and Mental Health in cooperation with St Joseph's Health Care London and the Ontario Police College. It is aimed towards police officers and is recommended as a reference guide for training modules for the police.

Description

The guide offers definitions, recognition indicators and police response strategies for the following specific conditions: schizophrenia (including hallucinations and delusions), major depression, bipolar disorder (manic-depressive illness), suicidal behaviour, panic, mute or passive behaviour, and excited delirium.

According to the guide, schizophrenia can be recognised by the person seeing things that do not exist (hallucinations), holding false personal beliefs (delusions), demonstrating emotions that are inconsistent with speech/thought, jumbled thinking, difficulty sorting out or connecting thoughts and saying things that do not make sense to others.

Signs of hallucinations include faulty sensory perceptions like hearing, seeing, smelling or feeling things that do not exist, talking to oneself, appearing preoccupied and unaware of surroundings, having difficulty following conversations and instructions, having momentary or extended lapses in attention as if listening to something, misinterpreting words and actions of others, isolating oneself and using radio or other sounds to tune out voices. Police response strategies to hallucinations include isolating and containing the person while not invading personal space/touching the person without permission, speaking slowly and quietly using simple concrete language, avoiding verbal confrontation, remembering that it may take the individual longer to process information, instructing them to 'listen to my voice, do not listen to other voices', explaining one's actions, asking questions like 'are you hearing other voices than mine, what are they telling you, what do you see/feel/taste', reducing confusion (bright lights, television or radio), being aware that stress may increase hallucinations, addressing the person by name/asking for how they want to be addressed if the name is not known, and not pretending to experience the

hallucination along with the person. The officer should try to get a sense of how the person feels and how they could help.

Signs of delusions include believing oneself to be someone of importance (i.e. grandeur), excessive religiousness or suspicion, acting violently towards others, avoiding food or medication for fear of poisoning, having sleep difficulties due to fear of being harmed, misinterpreting others' words and actions, appearing afraid and isolating oneself. In cases of delusions officers are advised to respond by keeping distance, positioning themselves on their level if it is safe, avoiding whispering or laughing as this may be misunderstood, remembering that what is on an individual's mind is not always obvious, asking questions what the delusions are about, explaining their intentions before acting, asking if there is anything that would make the person feel more comfortable and assuring them that they are safe, that they are not going to harm them and that the uniform and equipment is to protect them. The officers should not argue that the thoughts are not real, attack delusion, show that they believe in the delusion (instead they could say 'I believe you are telling me this is as you see it'), underestimate the power of the uniform (which can be extremely intimidating for someone suffering from paranoia) or smile/nod when the person is talking (to avoid misunderstandings).

Major depression can be identified by feelings of sadness, helplessness or hopelessness, sad facial expression, teary eyes, sleep and appetite disturbances, lack of interest in everyday activities and relationships like housekeeping, personal hygiene, grooming, social withdrawal, lack of energy, agitation, irritability, poor concentration, and impaired memory. The officers are advised to be patient, convey hope by stating 'With help, you can feel better. You don't have to suffer like this', recognise the pain instead of trying to cheer the person up, assess for suicidal/homicidal behaviour and refer/escort the person to an appropriate mental health service.

Bipolar disorder (manic behaviour) can be recognised by elated, cheerful, playful, high mood, hyperactivity, inflated self-image, inability to sleep, irritability, anger, rage, weight loss, increased activity and too busy to eat, distractibility, short attention span, disorganisation, boundless energy, bizarre dress, accelerated speech that is difficult to interrupt, delusions, poor judgement and uninhibited sexual interest or sexual acting out. The police officers are advised to respond as follows: decrease noise and confusion in the area, if possible remove other people from area, allow pacing if desired, ask short, direct and concrete questions, not engage in long conversation, determine if the person is able to care for themselves, refer/escort to appropriate mental health service.

High risk indicators for suicidal behaviour include being single and divorced, no family ties, history of suicidal behaviour or psychiatric illness, drug addiction/alcohol use, family history of suicide, depressive or psychiatric

illnesses, the elderly and the seasons of spring and summer. It can be recognised through depression, particularly as it is lifting and there is more energy, a preoccupation with death like continually talking and reading about it, giving things away, ending relationships or commitments, words or actions that are end oriented such as checking on insurance policy and tidying up loose ends as well as black and white thinking. The officers are advised to ask questions, be direct and talk about it in a clear language, not be afraid that one is putting the idea into their heads. If the answer to any of the following questions is yes, then that person should not be left alone and should be escorted to the nearest hospital as soon as possible: do you want to kill yourself, how would you do it, when and where are you planning to do it, what preparations have you made, have you ever tried to kill yourself in the past, are voices telling you to kill yourself.

Signs of panic are increased breathing, wide-eyed expression, rapid and pounding heartbeat, sweating and shaking, feeling of impending doom, difficulty communicating and fear of losing it/going crazy/having a heart attack. The officers are advised to speak slowly and calmly, encourage deep regular breathing to facilitate calming, use short simple sentences, assure the person that they are safe, and that they are there to help and take control if needed, explain all action, remove from noise and confusion and refer to crisis service.

Mute and passive behaviour can be recognised by not responding to questions, not appearing aware of surroundings and possibly remaining in one position. Recommended response strategies include approaching like one would a responsive person, not assuming that they do not know what is going on, explaining one's intentions before acting and escorting the person to the nearest hospital.

Lastly, excited delirium includes bizarre/aggressive behaviour, disorientation, acute onset of paranoia, panic, shouting, violence towards others, hallucinations, impaired thinking, unexpected physical strength, apparent ineffectiveness of pepper spray, significantly diminished sense of pain, sweating, fever, heat intolerance and sudden tranquillity after frenzied activity. If these symptoms are observed the person should be brought to the nearest medical facility equipped to deal with this disorder. The person should be escorted by two officers to ensure proper restraints though certain positions are not advised like the individual facing down.

In addition to the response strategies for these specific conditions, the guide offers general guidelines (dos and don'ts) for handling situations involving mentally ill persons. Recommended actions include collecting as much information as possible from all possible sources prior to intervening, taking one's time and eliminating noise and distractions, asking permission first, treating the person with dignity, keeping one's distance and respecting personal space, talking slowly and quietly while identifying oneself and others, explaining one's intentions and actions and acting slowly and with

prior warning. Furthermore, the officers should explain in a firm but gentle voice that they want to help and ask how they can be of assistance. A sense of working together should be developed e.g. 'help me understand what is happening to you', equipment that seems to evoke fear should be explained and choices should be given whenever possible. The officers are advised not to deceive, challenge, tease or belittle the person and not to forget the pain and fear the person might be experiencing. Personal space should not be violated, and the officers should not forget to ask about medication the person requires.

Relevance

The guide is intended to help police officers on the front line in their interactions with people with mental illnesses in the community, including, among others, suspects and accused persons.

CORRECTIONAL MENTAL HEALTH SCREEN

Reference

United States, U.S. Department of Justice, Office of Justice Programs, and National Institute of Justice (2007), Mental Health Screens for Corrections http://www.reidpsychiatry.com/MHCORRECTIONS SCREENS216152.pdf

Disabilities covered

The Correctional Mental Health Screen (CMHS) has a broad scope of application and covers mental health in general. However, it is focused mainly on screening for signs and symptoms of acute psychiatric disturbance and disorder.

Implementing body

The CMHS has been developed by the U.S. Department of Justice (Office of Justice Programs) and the National Institute of Justice and is aimed towards corrections administrators, prison staff and mental health professionals.

Description

The Correctional Mental Health Screen is a gender-specific tool and has different versions of the questionnaire for women and men. The women's version, abbreviated as CMHS-W, includes eight questions in total and if five or more are answered with yes or if there are any other concerns then the woman should be referred for further evaluation. The referral can be urgent in case of any evidence that the person is unable to cope mentally or emotionally or if there is a suicide risk or it can be a routine one if the number of positive answers is reached. The men's version, CMHS-M, includes twelve questions, of which six have to be answered positively for a routine referral, while the conditions for an urgent one are the same.

The yes/no questions for women are: do you get annoyed when friends and family complain about their problems or do people complain you are not sympathetic to their problems; have you ever tried to avoid reminders of, or to not think about, something terrible that you experienced or witnessed; some people find their mood changes frequently as if they spend every day on an emotional rollercoaster like switching from feeling angry to depressed to anxious many times a day – does this sound like you; have there ever been a few weeks when you felt you were useless, sinful, or guilty; has there ever been a time when you felt depressed most of the day for at least 2 weeks; do you find that most people will take advantage of you if you let them know too much about you; have you ever been troubled by repeated thoughts, feelings, or nightmare about something terrible that you experienced or witnessed; and have you ever been in the hospital for non-medical reasons such as a psychiatric hospital.

The men's version includes the following questions: have you ever had worries that you just can't get rid of; some people find their mood changes frequently as if the spend every day on an emotional roller coaster – does this sound like you; do you get annoyed when friends and family complain about their problems or do people complain you are not sympathetic to their problems; have you ever felt like you didn't have any feelings, or felt distant or cut off from other people or from your surroundings; has there ever been a time when you felt so irritable that you found yourself shouting

at people or starting fights or arguments; do you often get in trouble at work or with friends because you act excited at first but then lose interest in projects and don't follow through; do you tend to hold grudges or give people the silent treatment for days at a time; have you ever tried to avoid reminders, or to not think about, something terrible that you experienced or witnessed; has there ever been a time when you felt depressed most of the day for at least 2 weeks; have you ever been troubled by repeated thoughts, feelings, or nightmare about something terrible that you experiences or witnessed; have you ever been in the hospital for non-medical reasons such as a psychiatric hospital; and have you ever felt constantly on guard or watchful even when you didn't need to, or felt jumpy and easily startled.

Relevance

The Correctional Mental Health Screen is designed to be applied to inmates when they first enter an institution. It is mostly used for screening for acute psychiatric disturbance and disorder and identifying those persons that may need closer monitoring and mental health assessment.

BRIEF JAIL MENTAL HEALTH SCREEN

Reference

United States, U.S. Department of Justice, Office of Justice Programs, and National Institute of Justice (2007), Mental Health Screens for Corrections http://www.reidpsychiatry.com/MHCORRECTIONS SCREENS216152.pdf

Disabilities covered

The Brief Jail Mental Health Screen (BJMHS) has a limited scope of application and is aimed to identify recent or acute symptoms associated with any one or more of three mental disorders: schizophrenia, bipolar disorders, and major depression.

Implementing body

The BJMHS has been developed by the U.S. Department of Justice (Office of Justice Programs) and the National Institute of Justice, and is aimed towards corrections administrators, prison staff and mental health professionals.

Description

The Brief Jail Mental Health Screen includes one section of eight questions that the officer has to ask the detainee as well as an optional section for the officer's own comments or impressions. Seven out of the eight questions are focusing on the current state, while one is more general.

The questions include: do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head; do you currently feel that other people know your thoughts and can read your mind; have you currently lost or gained as much as two pounds a week for several weeks without even trying; have you/your family/friends noticed that you are currently much more active than you usually are; do you currently feel like you have to talk or move more slowly than you usually do; have there currently been a few weeks when you felt like you were useless or sinful; and are you currently taking any medication prescribed for you by a physician for any emotional or mental health problems. The final question regards the detainee's medical history and inquires if the persons has ever been in a hospital for emotional or mental health problems. To fill out the form, the officer has to tick a box either yes or no and there is an additional column for general comments regarding each question.

The optional section includes four checkboxes for further impressions as well as a space for other comments. The options are a language barrier, under the influence of drugs/alcohol, non-cooperative, and difficulty understanding questions.

There are also referral instructions, according to which the detainee should be referred for further mental health evaluation if they have answered yes to question 7, or to question 8, or to two or more of the other questions (questions 1 to 6). A referral is also recommended if the officer feels it necessary for any other reason.

The BJMHS was developed in 2002 and validated in 2002-2003, correctly identifying 74 % of the males and 62 % of the females.[2] Four items were added to the BJMHS (BJMHS-R) in an attempt to increase the accuracy of identifying women detainees who needed further mental health interventions in the jail. The re-validation study found improved classification accuracy for the 8-item BJMHS for both males (73 % to 80 %) and females (62 % to 72 %). The 12-item BJMHS-R showed no improvement in classification accuracy for males (72 %) and little improvement for females (66 %) with the added items.[3] Further, Louden and colleagues [3] validated the BJMHS was validated with probationers and the tool correctly identified 77 % of probationers with mental health disorders and performed equally well with males and females.[4] Validation studies have been conducted also in other countries including New Zealand, Australia, the Netherlands and Switzerland.

According to a study, which surveyed 3,124 jails across the U.S., out of the 695 unduplicated jails in the sample ranging in capacity from 5 to over 5,000 614 (88.3 %) jails screen for mental disorder and 180 (29.3 %) use the BJMHS.[5]

Relevance

The Brief Jail Mental Health Screen is designed to be applied to inmates when they first enter an institution and has been validated only among detainees.

[2] Steadman H.J., Scott J.E., Osher F., Agnese T.K. and Robbins P.C. (2005), Validation of the Brief Jail Mental Health Screen, in: Psychiatric Services, 2005: 56; 816-822.
[3] Steadman H.J., Robbins P.C., Islam T. and Osher F.C. (2007), Revalidating the Brief Jail Mental Health Screen to Increase Accuracy for Women, in: Psychiatric Services, 2007: 58; 1598-1601.
[4] Louden J.E., Skeem J.L. and Blevins A. (2013), Comparing the Predictive Utility of Two Screening Tools for Mental Disorder Among Probationers, in Psychological Assessment, 2013: 25, 405-415.
[5] Callahan, L.A. and Noether, C.D. (2018), Brief Jail Mental Health Screen in U.S. Jails, in: J Forensic Med Forecast, 2018: 1(1), 1006.

SAMPLE POLICY IN HANDLING THE MENTALLY ILL

Reference

United States, Georgia Association of Chiefs of Police, Mental Health Ad Hoc Committee to Address Mental Health Issues in Law Enforcement (2008), Mental Health and Law Enforcement Encounters: A Review of Current Problem and Recommendations, Appendix: Resource Guide[6]
https://gachiefs.com/wp-content/uploads/2018/03/Mental-Health-Document_2008.pdf

Disabilities covered

The sample policy offers procedures for the recognition of mental illness and excited delirium. The policy defines mental illness as 'any of various conditions characterised by impairment of an individual's normal cognitive, emotional, or behaviour functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma'. Excited delirium is defined as 'state of extreme mental and physiological excitement, characterised by extreme agitation and hyperactivity, overheating, excessive tearing of the eyes, hostility, superhuman strength, aggression, acute paranoia, and endurance without apparent fatigue'.

Implementing body

The sample policy for handling the mentally ill was developed by the Mental Health Ad Hoc Committee to Address Mental Health Issues in Law Enforcement of the Georgia Association of Chiefs of Police (GACP). Its purpose is to establish guidelines and procedures for law enforcement personnel in the recognition and safe handling of suspected mentally ill persons.

Description

The procedure for the recognition of mental illness lists three categories of indicators: verbal, behavioural and environmental cues. Each category describes possible signs of mental illnesses with examples as to how these could look like. All indicators are based on the observation of the person.

The category of verbal cues includes illogical thought (sharing a combination of unrelated or abstract topics, expressing thoughts of greatness, indicating ideas of being harassed or threatened and exhibiting a preoccupation with death, germs, guilt or other similar ideas), unusual speech patterns (nonsensical speech/chatter, word repetition, pressured speech and extremely slow speaking) and verbal hostility or excitement (talking excitedly or loudly, being argumentative, belligerent, or unreasonable hostile or threatening harm to self or others).

Behavioural cues include the physical appearance (whether it is appropriate to the environment or if the clothing or makeup is bizarre while taking current trends into account), bodily movements (strange postures or mannerisms, lethargic, sluggish movements, pacing and agitation as well as

[6] The full version of the Resource Guide is not available online on the website of the GACP. The procedure for the recognition of mental illness is quoted in Mason, C., Burke, T.W., and Owen, S.S. (2014), Responding to Persons with Mental Illness: Can Screening Checklists Aid Law Enforcement, in: FBI Law Enforcement Bulletin, 4 February 2014, https://leb.fbi.gov/articles/featured-articles/responding-to-persons-with-mental-illness-can-screening-checklists-aid-law-enforcement.

repetitive, ritualistic movements), seeing, smelling or hearing things that cannot be confirmed, confusion about or unawareness of the surroundings, lack of emotional response, causing injury to oneself, nonverbal expressions of sadness or grief, and inappropriate emotional reactions (overreacting to situations in an overly angry or frightening way or reacting with the opposite of the expected emotion).

Lastly, environmental cues include decorations (strange trimmings, misuse of household items), waste matter/trash (accumulation of trash, presence of faeces or urine on the floor or walls) and childish objects.

The procedure for interacting with a person with mental illness includes a list of dos and don'ts. The list of recommended actions includes: remembering that the mentally ill person in a crisis situation is generally afraid; continually assessing the situation for an escalation of risk to all parties; maintaining appropriate distance between the officer and the person; attempting to remain calm and avoid overreacting; giving clear/concise directions; responding to apparent feelings, rather than content (i.e., 'You look/sound scared.'); responding to delusions and hallucinations by addressing the person's feelings rather than what he/she is saying (i.e., 'That sounds frightening,' 'I can see why you are angry.'); trying to help ('What would make you feel safer/calmer, etc.?'); moving slowly; removing distractions, upsetting influence and disruptive people from the scene; obtaining on-scene medical aid when treatment of an injury is needed, or suicidal thoughts are made; being friendly, patient, accepting and encouraging, but remaining firm and professional; being aware that the uniform, gun, handcuffs, etc., may frighten the person, and attempting to reassure him/her that no harm is intended; gathering information from family or bystanders.

Actions that should generally be avoided include: moving suddenly, giving rapid orders or shouting; joining into behaviour related to the person's mental illness (e.g., agreeing/disagreeing with delusions/hallucinations); staring at the person (this may be interpreted as a threat); crowding the person or moving into his/her zone of comfort; giving multiple choices (this generally increases the person's confusion); whispering, joking or laughing (this may increase the person's suspiciousness with potential for violence); expressing anger, impatience or irritation; assuming that a person who does not respond cannot hear; using inflammatory language, such as mental or mental subject; deceiving the subject (being dishonest increases fear and suspicion); minimising concerns (i.e., 'Oh things that can't be that bad,' etc.); touching the person unless essential for safety (although touching can be helpful to some people who are upset, for many it may cause more fear and lead to violence).

The procedure for the recognition of excited delirium includes the following indicators: bizarre or violent behaviour; signs of overheating/profuse sweating; only partially clothed or naked; may be incoherent or speaking in

gibberish; yelling or screaming loudly; seems to be disoriented or hallucinating; may be foaming at the mouth or drooling; may be sweating profusely or the opposite, body temperature soaring and uncooled by perspiration; violence toward/attacking glass; superhuman strength and endurance; unresponsive to pain; disturbances in breathing patterns or loss of consciousness.

The procedure for interacting with a person exhibiting or starting to exhibit any of the indicators for excited delirium recommends that the officer should not attempt to interact with the person without backup and that several officers may be needed to overcome the person's resistance and immunity to pain. If the person's action is not a threat to themselves or others, officers should attempt to stay near the person until he/she tires themselves out to a point where they can become restrained. Once the person is restrained, he/she should be placed on their side for easier breathing, if this can be done without creating an unreasonable risk to others. Upon being restrained, the person should be transported to a hospital by a med unit for medical evaluation since this is considered to be a serious medical emergency.

Relevance

The sample policy in handling the mentally ill was designed to guide law enforcement officers on how to approach and interact with a person who may have mental illness and 'who may be a crime victim, witness or suspect'.

PATIENT HEALTH QUESTIONNAIRE 9

Reference

United States, Pfizer Inc. (2005), Patient Health Questionnaire 9
https://www.phqscreeners.com/

Disabilities covered

The Patient Health Questionnaire 9 (PHQ-9) is specifically designed to assess and monitor depression severity. It is the 9-question depression scale from the Patient Health Questionnaire (PHQ), which is a screening and diagnostic tool for mental health disorders of depression, anxiety, alcohol, eating, and somatoform disorders.

Implementing body

PHQ-9 was developed by researchers from Columbia University with financial support from Pfizer Inc. It has been applied in different settings and among different groups of individuals, including patients in psychiatric clinics, patients with physical impairments, older adults, students, etc. The tool is available in over 30 different languages and is validated for use in different ethnicities.

Description

The questionnaire includes nine questions regarding the person's state of mind in the last two weeks. The problems the person might have encountered include little interest or pleasure in doing things, feeling down, depressed or hopeless, trouble falling or staying asleep or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about oneself or that the person is a failure or have let themselves or their family down, trouble concentrating on things such as reading the newspaper or watching television, moving or speaking so slowly that other people have noticed or the opposite – being so fidgety or restless that the person has been moving around a lot more than usual, and lastly, thoughts that the person would be better off dead or of hurting themselves.

There are four possible answers: not at all, several days, more than half the days and nearly every day. Responses range from 0 (not at all) to 3 (nearly every day). In addition to that, some responses are shaded. A certain number of answers in the shaded section is a sign that the person may suffer from some form of depressive disorder. The total score, on the other hand, is an indication of the severity of the depressive disorder: a score between one and four indicates minimal depression, five to nine mild depression, ten to 14 moderate, 15 to 19 moderately severe and 20 to 27 severe depression.

Since some depressive disorders require additional impairment of social, occupational or other important areas of functioning (major depressive disorder or other depressive disorder), there is an additional tenth question to approximate the severity of the problem: how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? The possible answers are not difficult at all, somewhat difficult, very difficult and extremely difficult. The response to this question is not factored into the final score and serves for obtaining the

person's own opinion on the level of impairment caused by their mental health.

Relevance

The PHQ-9 screener has a very broad scope of application and has been used on various target groups. However, since the questionnaire relies entirely on self-report, it is recommended that all responses should be verified by a clinician, taking into account, among other things, how well the person has understood the questions.

GENERAL OVERVIEW OF COMMUNICATION AND PARTICIPATION FACILITATION TOOLS

When there are indications that a suspect or accused person suffers from psychosocial or intellectual disability, the first thing the competent authority is advised to do is to refer the person to a specialist for a proper assessment of their impairment. Once this is done and reliable information about the person's condition is obtained, measures should be undertaken to address that person's special needs, inform them about their rights in an understandable manner and ensure that they can effectively participate in the proceedings.

Despite the importance of properly addressing the special needs of suspects and accused persons with psychosocial or intellectual disabilities, in most countries medical assistance is the only available support provided in such cases. Nevertheless, several practical tools specifically aimed at facilitating the participation of such persons in the proceedings have been identified, mainly from the United Kingdom.

The identified practical tools can be divided into three categories. The first category is the involvement of a support person. The best example of such a tool is the so-called 'appropriate adult', which is mostly used in the United Kingdom. An appropriate adult is a person, who provides independent support to and advises the suspect so that he/she can understand the procedures. The appropriate adult has to be present when the person is informed about their rights, when a written document has to be signed and when an interview is conducted. When collecting evidence from vulnerable persons (witnesses or defendants), an intermediary can also be called to assist the court by assessing the person's communication needs.

The second category includes guidelines and handbooks for the criminal justice professionals who may come into contact with persons with psychosocial or intellectual disabilities. These tools offer detailed recommendations on what should be done and what should be avoided when such a person is involved. The recommendations address issues such as behaviour, verbal and written communication, interpretation of body language, environment, etc. Some tools are generally applicable in any situation involving a person with psychosocial or intellectual disability, while others are designed for specific actions (arrest, detention, interview, etc.).

The third category of practical tools are easy read leaflets and factsheets. They are aimed at translating information into an accessible language format (e.g. information related to the proceedings or the rights and entitlements of the person). Such easy read leaflets and factsheets are available for persons going to prison (including remand prisoners), arrested persons, persons summoned for an interview or a hearing, etc. There are also general guidelines on how to produce a piece of information into an easy read format.

Finally, in some jurisdictions, there are special courts hearing cases that involve offenders with psychosocial or intellectual disabilities, called mental health courts. The first mental health courts were established in the United States in the early 1980s and since then their number has expanded. At present, mental health courts exist in the United States, Canada and Australia. In the United Kingdom, two pilot mental health courts were introduced in 2009,

but after two years they were closed and no further steps were undertaken to move forward with the plan of introducing such courts.[7]

A mental health court is a specialised court docket for certain defendants with mental illnesses that substitutes a problem-solving model for traditional criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions, nonadherence may be sanctioned, and success or graduation is defined according to predetermined criteria.[8] Mental health courts have both advantages and disadvantages. Those supporting the introduction of such courts argue that they work to reduce reoffending, enhance public safety and improve the well-being of individuals with mental illness.[9] Those criticising the idea claim that mental health courts are coercing defendants with mental illnesses to agree to treatment with the threat of prosecution hanging over their heads and are increasingly becoming a preferential point of entry for persons who have been unable to obtain community-based treatment.[10]

[7] For more information about the results of the pilot study, see Ministry of Justice (2010), Process evaluation of the Mental Health Court pilot, https://www.justice.gov.uk/downloads/publications/research-and-analysis/moj-research/mhc-process-evaluation.pdf.

[8] Council of State Governments Justice Center (2008), Mental Health Courts: A Primer for Policymakers and Practitioners, https://csgjusticecenter.org/wp-content/uploads/2012/12/mhc-primer.pdf. For more information about the mental health courts in the United States, see Almquist, L. and Dodd, E. (2008), Mental Health Courts: A Guide to Research-Informed Policy and Practice, Council of State Governments Justice Center, https://csgjusticecenter.org/wp-content/uploads/2012/12/Mental_Health_Court_Research_Guide.pdf.

[9] Snedker, K.A. (2018), Therapeutic Justice Crime, Treatment Courts and Mental Illness, Palgrave Macmillan.

[10] Mental Health America (2019), Position Statement 53: Mental Health Courts, https://www.mentalhealthamerica.net/positions/mental-health-courts.

DOCUMENTATION SHEETS ABOUT THE RIGHTS AND OBLIGATIONS DURING A CRIMINAL PROCEDURE

Reference

Ludwig Boltzmann Institute of Human Rights (2018), Dignity at Trial: Enhancing Procedural Safeguards for Suspects with Intellectual and Psychosocial Disabilities
https://bim.lbg.ac.at/en/project/current-projects-projects-human-dignity-and-public-security-projects-development-cooperation-and-business/dignity-trial-enhancing-procedural-safeguards-suspects-intellectual-and-psychosocial-disabilities

Disabilities covered

The documentation sheets have a broad scope of application and practically cover all forms of intellectual and/or psychosocial disabilities.

Implementing body

The documentation sheets were developed in the framework of an international project implemented by Ludwig Boltzmann Institute of Human Rights (Austria) in partnership with the Bulgarian Helsinki Committee (Bulgaria), the League of Human Rights (Czech Republic), the Mental Health Perspectives (Lithuania) and the Peace Institute (Slovenia). The first sheet is intended for the police and the second one is intended for judges.

Description

The documentation sheets are designed as questionnaires and the competent authority (the police officer or the judge) needs to go through the questions with the suspect and must also hand out a copy of the document to the suspect.

The documentation sheet for the police includes six items and for each item, there are one or more questions, to which the suspect must answer with 'yes' or 'no'. First, the police have to explain to the person why they have taken them to the police station or arrested them. Second, the police have to explain to the person his/her rights, which include the right to call one person (or ask the police to make the call for them), the right to inform that person about the arrest and the place where they are (but not about the reason for the arrest), the right to call a lawyer, the right not to tell the police anything unless it would be of help, and the right to tell the police if special assistance is needed to understand what is going on (e.g. a translator). Third, the police must ask three questions about the person's medical condition: whether they regularly take medication, whether they have a guardian or a caretaker (or whether they want a family member, a friend, a lawyer or a caretaker to come), and whether they have a disability pass. Fourth, the police must inform the persons about their right to see a doctor and ask them if they want to get a medical examination from a doctor. Fifth, the police must inform the person that after a certain period of time he/she will either be released or moved to a prison. Sixth, the police must explain to the person that their responses can be used against them

in the criminal procedure, then let them read the document, check if they understand it (or if they need further explanations) and ask them to sign it.

The documentation sheet for judges is applied when a judge is interviewing a detainee. It has the same six items as the documentation sheet for the police. The only differences are that the first item refers to the obligation of the judge to explain to the person why they have been detained, while the fifth item refers to the duration of pre-trial detention.

Relevance

The documentation sheets are intended for police officers and judges and are aimed to facilitate the process of informing suspects and accused persons with psychosocial or intellectual disabilities about their rights.

SUPPORT MEASURES FOR VULNERABLE DEFENDANTS IN COURT

Reference

United Kingdom, McConnell, P. and Talbot, J. (2013), Mental health and learning disabilities in the criminal courts. information for magistrates, district judges and court staff, Prison Trust Reform, Rethink Mental Illness http://www.mhldcc.org.uk/media/493/RMI_PRT_MHLDCC_Sept2013.pdf

Disabilities covered

The support measures are applicable to people with mental health conditions or learning disabilities.

Implementing body

The support measures are part of an information resource developed by Prison Trust Reform and Rethink Mental Health. They are specifically designed for judges and court staff, but can also be useful for lawyers and legal advisers.

Description

There are several categories of recommended measures. The first category is measures aimed to assist vulnerable defendants to understand and to participate in the proceedings. These include: arranging for defendants to visit the courtroom before a court hearing or trial so they can familiarise themselves with it; using simple, clear language that the defendants can understand; holding the proceedings in a courtroom in which all participants are on the same, or almost the same level; allowing the defendants to sit with members of their family and/or other supporting adults and in a place where they can easily communicate with their legal representatives; and restricting attendance by members of the public and reporters.

The second category includes measures to support communication and comprehension: using the defendant's name and making sure one has the person's attention before they begin speaking to them; explaining each stage of court proceedings in simple language and short sentences with only one piece of information per sentence; not asking 'do you understand' since a positive response does not necessarily mean the individual does understand (instead the defendant should be asked to tell what they understood); avoiding the use of jargon and technical or legal terminology (or explaining its use if it could not be avoided); allowing the defendant extra thinking time to process information and consider their response before replying; offering support with reading and understanding documents (being able to read a document does not mean understanding the content); providing help to the defendant in making notes of proceedings if they are unable to write very well (the defendant might only be able to either follow proceedings or take notes but not simultaneously); allowing the defendant to sit next to their lawyer, carer or family member (to help reduce the stress of appearing in court and enhance defendants' participation in proceedings); ensuring that the defendant can hear proceedings clearly (glass security screens can impede the defendant's ability to hear); allowing extra breaks and using them as 'explanation time'

(defendants with communication and comprehension difficulties might tire more easily and need such extra breaks).

Judges are also advised to consider some questions such as: what arrangements are in place in the court to ensure that defendants with mental health conditions, learning disabilities, and other support needs are identified in advance of their first appearance in court; what procedures are in place in the if there are concerns about a defendant's ability to understand or to participate in court proceedings; does the court have routine and timely access to liaison and diversion services and do services include access to learning disability and speech and language expertise; how often are special measures and reasonable adjustments used for vulnerable defendants in the court; and is routine information in court available in easy read format.

Judges are also advised to ensure that all possible steps are taken to assist a vulnerable defendant to understand and to participate in court proceedings. If in any doubt about a defendant's ability to understand or to participate effectively in court proceedings, judges should ask for further information and seek advice from a legal adviser. Judges are also advised not to forget that support needs for vulnerable defendants would vary from person to person and, under equality law, reasonable adjustments should be made to assist them, as appropriate.

Relevance

The primary focus of the support measures is adult defendants with mental health conditions or learning disabilities. However, many of them apply also to child defendants and vulnerable witnesses in the criminal court.

MAKING INFORMATION EASIER TO READ

Reference	United Kingdom, Foundation for People with Learning Disabilities (2019), Making information easier to read https://www.mentalhealth.org.uk/learning-disabilities/publications/making-information-easier-read
Disabilities covered	The factsheet is specifically designed to facilitate the provision of information to persons with learning disabilities or learning difficulties.
Implementing body	The factsheet was developed by the Foundation of People with Learning Disabilities and has a broad scope of application. It can be applied by any criminal justice authority coming into contact with people with learning disabilities or difficulties.
Description	The factsheet is designed to facilitate the provision of written information to people who may need help with completing forms or understanding and following instructions. It offers a list of recommendations on how to make written information easier to understand. These include: using short sentences that only include one idea each, using a large font size with 14pt as the minimum; using easy words and explaining complicated terms if they have to be used; using A4 pages and avoiding smaller page sizes; using a plain font and avoiding fancy fonts and italics; and using images (photos or drawings) to aid understanding (an image should represent each sentence if possible and should be placed on the left side and the text should be the right side). The factsheet also gives an example of information presented in easy read format (a notification for an upcoming appointment with a probation officer) and a list of other recommended resources.
Relevance	The target group of the factsheet are criminal justice authorities providing information in writing (forms, instructions, information about rights, etc.). It is fully applicable to any written information provided to suspects and accused persons with learning disabilities or learning difficulties.

HANDBOOK FOR PROFESSIONALS IN THE CRIMINAL JUSTICE SYSTEM WORKING WITH OFFENDERS WITH LEARNING DISABILITIES

Reference

United Kingdom, Department of Health (2011), Positive Practice, Positive Outcomes. A handbook for professionals in the criminal justice system working with offenders with learning disabilities
https://www.gov.uk/government/publications/positive-practice-positive-outcomes-a-handbook-for-professionals-in-the-criminal-justice-system-working-with-offenders-with-a-learning-disability

Disabilities covered

The handbook provides information, practical advice, sign-posting and best practice examples for criminal justice professionals working with offenders with learning disabilities and learning difficulties.

Implementing body

The handbook was developed by the UK Department of Health (Offender Health and Valuing People) and is aimed towards a broad target audience, including criminal justice professionals.

Description

According to the handbook, the first action for criminal justice professionals, if they are concerned about a person's ability to cope, should always be to contact a specialist, obtain a full assessment of the person's condition and follow the approach recommended by the assessment report.

In addition to that, the handbook offers a number of communication recommendations. The first group of recommendations are practical recommendations for communicating with the person. These include: using the person's name when addressing them at the start of a question or comment; always explaining to the person concerned exactly why they are in a new situation, what they should expect and when; preparing the person for each stage of the communication ('David, I will now ask you some simple questions' or 'David, I will now explain what we are going to do next'); emphasising important words; avoiding using acronyms, abbreviations, sarcasm and metaphors; being patient and calm whilst communicating, not rushing the person (they are likely to need longer to process the questions and think about their answers); using concrete terms not abstract references ('at breakfast time' rather than 'early on'); breaking large chunks of information into smaller chunks, with short breaks; using visual aids when asking questions, for example photos or drawings to illustrate a point; asking questions in the chronological order in which they happened (a calendar and spoken prompts can be used, for example, 'Was it the day after you went to the doctors?'); keeping the questions precise and not vague ('Where were you yesterday afternoon?' rather than 'Where have you been recently?'); avoiding double-negative and unclear questions ('Were you in the shop?' instead of 'You were not in the shop, were you?'); being aware that repeating questions may suggest to the person that they

have given the wrong answer the first time; not making the person feel pressured into a response (many people are more suggestible or they may be eager to give what they think is the 'desired' answer); checking that the person understands what has been said (they can be asked to repeat the question or message in their own words, or they could be questioned further).

The second group are practical recommendations for the planning of interviews, hearings or meetings. These include: seeking assistance from a health or social care professional or someone else who knows the person; ensuring the information, which is sent out beforehand, is easy to understand (the person may need assistance to organise attending, for example, with travel arrangements or with understanding and remembering the time and date); if possible, conducting several short interviews or sessions instead of one long session (this will help with the person's concentration levels and to reduce anxiety); having sessions in a familiar environment and avoiding changing the room each time (ensuring the environment is free from distracting noises and as calm and familiar as possible will help reduce anxiety).

The third group are tips for understanding the person's body language, such as: not assuming that a lack of eye-contact means the person is not listening; not assuming that nodding means understanding and checking that they understand by asking other questions; remembering that the person may not understand social rules, such as taking it in turns to speak and giving people their personal space; considering having a break if the person appears agitated, restless or distracted (this is likely to be because of their condition and the stress of the situation); remembering that the person may not understand the meaning behind other peoples' gestures or facial expressions.

The fourth group are practical tips and techniques for making written communication more accessible. They include: using a simple, well-shaped font (such as Comic Sans, Arial or Helvetica); using a minimum font size of 14 (especially for those with a learning disability, visual impairment or poor literacy skills); increasing the line spacing to spread the text lines; limiting the use of italics, underline, or bold; using bullet point lists, rather than long written paragraphs and using text boxes to summarise points; avoiding using BLOCK CAPITALS as the word loses its shape; keeping sentences short and simple; not using documents with hand-written text as this would be too hard to read; keeping the layout simple and including plenty of blank space; avoiding shiny paper with black text (the contrast causes difficulty for people with visual stress); using off-white or pastel shades of paper (these are easier to read, particularly for people with dyslexia, but it is always advisable to ask the person what they prefer); using pictures (line drawings, photos, diagrams, maps, flow-charts and specialist cartoons and symbols) to make a document more accessible to someone with a reading

problem (any pictures used should give clues about the meaning behind the text).

In addition to the general communication recommendations, the handbook offers special tips for the police service, the court service, the prison service and the probation service.

The tips for the police service are: explaining who the officer is to the detainee and what their role is (additional explanation may be needed for plain-clothed police); explaining all jargon and terms used (such as 'arrested', 'suspected' or a police 'caution'); checking that the detainee understands what their rights are (going through the rights and asking the detainee to communicate these back rather than them just answering 'yes, I understand'); ensuring that the detainee understands the consequences of a confession (there have been cases where a detainee with learning disabilities has confessed to a crime so they can 'leave earlier' or to try to please the person asking the questions); and not misinterpreting behaviour such as a poor memory or the person being easily distracted as suspicious, without further investigation (these are common features of having a learning disability).

The tips for the court service include: making sure, where possible, that written material presented to the defendant is easy to understand; keeping spoken language at a level the defendant can understand; ensuring that the court proceedings, and what the defendant can expect, are fully explained beforehand, using terms that they can understand; and checking throughout the trial that the defendant understands what is happening and what has been said by other people involved in the process. In addition to these, there is a list of recommendations for making the court environment less intimidating for vulnerable defendants such as: arranging for the defendant to visit the courtroom before the trial or hearing, so they can familiarise themselves with it; enlisting the support of the police to ensure that the defendant is not, when attending court, exposed to intimidation, criticism or abuse; holding the proceedings in a courtroom in which all participants are on the same, or almost the same, height level; allowing the defendant to sit with members of their family and/or other supporting adults, and in a place where they can easily communicate with their legal representatives; conducting the trial according to a timetable that takes into account a vulnerable defendant's ability to concentrate, which may mean allowing regular and frequent breaks; staff removing robes; restricting attendance to the court proceedings by members of the public and reporters.

Relevance

The handbook is targeted at all criminal justice professionals who may come into contact with persons with learning disabilities or learning difficulties and has additional recommendations for the police service and the courts.

AUTISM: A GUIDE FOR POLICE OFFICERS AND STAFF

Reference

United Kingdom, National Autism Society (2017), Autism: a guide for police officers and staff
https://www.autism.org.uk/~/media/nas/documents/publications/autism-police-guide-the-national-autistic-society-2017.ashx?la=en-gb

Disabilities covered

The guide provides background information about autism and aims to help all police officers and staff who may come into contact with autistic children or adults meet their responsibilities.

Implementing body

The guide was developed by the National Autism Society and is specifically designed for police officers and staff.

Description

The guide offers recommendations for arresting an autistic suspect and managing them in custody, for interviewing autistic suspects, and for involving Appropriate Adults and intermediaries.

When arresting an autistic suspect, the police are recommended to keep physical contact to a minimum, avoiding the use of handcuffs or other restraints, if possible; to check whether the person carries any information about their needs, read it and follow it; to explain simply and calmly where the person is taken and why, and what they should expect on arrival to the custody suite; to call ahead to warn the custody staff if the person appears to be distressed and ask if arrangements can be made to avoid having to wait in a busy reception area; to tell the custody sergeant that the detainee is autistic and explain any related concerns; and to deliver the caution slowly and clearly. The police are not advised to rush into making an arrest unless it is the only option; raise voice or rush the person, unless absolutely necessary; use sirens and flashing lights, if it can be avoided; detain or transport the person unaccompanied in the back of a police van (they could become distressed and require immediate attention or first aid); attempt to stop the person from rocking or making other repetitive movements (these are self-calming mechanisms and likely to be beyond their control); remove 'comfort' items, such as pieces of string or other small items, unless essential (this may raise anxiety).

When an autistic suspect is in custody the police are recommended to remain alert to the possibility of undisclosed autism; detain the person in the quietest area possible and try to be reassuring; respond to any sensitivity that the person may have to particular textures such as police blankets or clothing; make sure the adequate safety measures are in place to minimise risk of self-harm and other injury; bear in mind that the signs of autism may fluctuate depending on levels of anxiety and stress; let the person retain any comfort item they may have if it's not causing harm; identify and appoint a suitable Appropriate Adult without delay; consider seeking the advice of an autism professional if unable to appoint an

Appropriate Adult who understands the person's particular needs and difficulties; make sure the person understands why they are in custody, for how long and what they can expect to happen; avoid being specific about timings ('I will be with you in a minute' could be interpreted literally and cause anxiety if no one appears a minute later); identify and meet any dietary requirements; avoid overcrowding the person (they may respond better to dealing with as few police officers and staff members as possible) and making loud, sudden noises (if an autistic person is kept in a cell, the noise of the door banging could be very distressing or shouting of other prisoners very frightening).

When preparing for interviewing an autistic suspect the police are advised to find out about the person's particular needs, including what causes them particular stress and sensory issues, from them and those closest to them; consider requesting an intermediary to help with communication; make preparations for an interview environment that takes into account their sensory needs; and provide information in advance in clear and accessible formats. At the same time the police are not advised to leave the person unclear or confused about what will happen and when; make sudden changes to the procedure; assume they know best how to communicate with them, or make assumptions about their level of understanding.

During the interview, the police are recommended to consider the use of drawings and diagrams; offer frequent breaks and 'time out' if needed; tailor language to the individual; start sentences with the person's name where appropriate; be aware of what the person understands as well as what the person can say themselves; frequently check understanding and summarise answers; ask one point per question ('Was the shopkeeper on the phone when you arrived?'), and avoid stacked and multi-part questions ('Was the shopkeeper on the phone when you arrived and did he hang up?'); use the past tense for events that have already happened ('Think about when you were in the shop. Did you speak to Simon?'); ask direct, literal questions ('Did you know at that time that Simon was running late?'), and avoid questions or statements that use insinuation or that require inference or deduction ('You knew he was late but you still went to the shop in the morning?'). Actions that police is advised to avoid include: trying to stop repetitive behaviours as they may be a coping mechanism; take away comfort items; misinterpreting echolalia (repeating what you say) or silence for insolence or evasion of questions; moving too quickly and not allowing enough time to process questions and verbalise an answer; using questions that are statements ('You went to the shop?'), or using intonation to indicate a question; using 'tag' questions ('You went to the shop, didn't you?'), or encouraging tags ('That's correct.'); using questions posed in the present tense ('So, now are you in the shop and talking to Simon?').

The section on Appropriate Adults and intermediaries explain the role of these persons and their involvement in the proceedings. In the UK, an Appropriate Adult (AA) acts as a safeguard and provides independent

support to a vulnerable suspect and must be called to the police station. Their appointment should be based upon a person's vulnerability and not on their perceived intellect as the fluency of their speech might not reflect their communication skills in stressful situations.

The Appropriate Adult's role is to support, advise and assist the detainee and to ensure that they understand what is happening during the interview and investigative stages. Appropriate Adults facilitate communication between the detainee and the police while making sure the former's rights are respected. They must be present when the custody officer informs the detainee of their rights and entitlements when any documents are to be signed by the detainee and during the caution. If these have taken place before the Appropriate Adult's arrival they must be repeated. The Appropriate Adult is also present during interviews and might intervene if they think the communication could be improved when a break is needed, and they can recommend the detainee to seek legal advice.

An intermediary, on the other hand, is an impartial expert in communication who assists the police and the court in obtaining evidence from vulnerable witnesses and defendants. They are tasked with assessing a person's communication needs and providing person-specific recommendation about: the most effective and appropriate way of communicating information and questions; the best way of communicating while preparing the person for the various stages of the criminal justice process; how to monitor and manage anxiety associated with giving evidence when it impacts communication; and how to appropriately use communication aids to support communication.

Relevance

The guide is specifically designed for police officers and staff who may come in contact with an autistic suspect, victim or witness.

YOU HAVE BEEN ARRESTED – THIS WILL TELL YOU WHAT WILL HAPPEN (EASY READ)

Reference

United Kingdom, The Criminal Justice Liaison Team, 5 Boroughs Partnership NHS Foundation Trust in partnership with Greater Manchester Police (2014), You have been arrested – this will tell you what will happen
http://library.college.police.uk/docs/APPREF/HC-Easy-read.pdf

Disabilities covered

The easy read information leaflet is specifically designed to help the police when providing information to arrested persons with learning disabilities or learning difficulties.

Implementing body

The leaflet was developed by the Criminal Justice Liaison Team, 5 Boroughs Partnership NHS Foundation Trust in partnership with Greater Manchester Police and is intended for police officers and police staff.

Description

This leaflet informs suspects and accused persons with learning disabilities about the steps after being arrested. The information is in an accessible easy read format using simple sentences and images. It starts with the statement that the police think the person has done something wrong and that the part of the police station the person is in is called a custody suite. Then it explains the difference between court bail and remand to court, which both mean that the person is charged with a crime. Alternatively, the person might be sent home, might be cautioned or be released on police bail. It is then explained that the person has to give their belongings to the officer for the duration of their stay, which might include having to change clothes. Some items might be kept as evidence, but this is only done after informing the person and usually, the items will be returned once the person leaves.

The explanation for the procedure at the station is as follows: the police officer explains the detainee's rights to them, the person might call someone to be there (e.g. a family member, partner, friend, colleague, nurse or doctor) and might get checked by a healthcare professional if unwell. The role of the Appropriate Adult, who is supposed to assist the person's understanding, is also explained and the detainee is instructed to tell the police if they need a break, that questions do not have to be answered, that everyone in the room must sign the interview form and that they may have to return to their cell after the interview. The police may contact a solicitor for the person, who helps with legal information and fair treatment free of charge.

The rules at the police station are also explained: the detainee has to stay in a locked cell, where they can sit or lie down, use the toilet and press a button if assistance is needed. There may be a camera in the cell and the detainee is given food and drinks. The police take a picture and fingerprints using a machine. Additionally, DNA samples are collected orally before the interview. The police can record the interview as well.

A longer easy read version of the rights and entitlements upon arrest was published by the Hertfordshire Constabulary. The Rights and Entitlements Easy Read Booklet explains what happens after a person has been arrested, what rights does that person have and what help can people give them.[11]

Relevance

The target group of the leaflet are police officers and police staff. The leaflet was specifically designed for the UK police service and might need some adaptation if used in other countries.

[11] Hertfordshire Constabulary (2018), Rights and Entitlements Easy Read Booklet, https://www.herts.police.uk/assets/Information-and-services/About-us/rights-and-entitlements-booklet.pdf.

PRISON – GOING IN (EASY READ)

Reference

United Kingdom, Rethink Mental Illness (2017), Prison – Going in https://www.rethink.org/advice-information/rights-restrictions/police-courts-and-prison/prisons-going-into-prison/

Disabilities covered

The easy read factsheet is specifically designed persons with a mental illness going into prison.

Implementing body

The factsheet was developed by Rethink Mental Illness and is intended for the prison service and prison staff.

Description

The factsheet covers the different categories of prisons and prisoners in England and explains, in an easy read format, what a person can expect when going to prison.

It starts with a description of the four categories of prisons for men (high security, category B, C and D) and for women (category A, restricted status, closed conditions and open conditions) and the two types of prisoners: remand prisoners, who are held in prison until their next court appearance and enjoy a less restrictive stay than other prisoners, and sentenced prisoners, who can serve a suspended (14 days to two years), determinate (fixed length of time), extended (up to eight years because of significant risk to the public due to certain violent or sexual offences) or a life sentence (at least 15 years). There are also separate prisons for juvenile offenders under the age of 21.

The next part explains what happens when someone arrives in prison. The detainee's belongings are checked and stored, and medication and health are documented. If a person is found to be mentally ill, they might be transferred if the prison cannot provide the right care. Each prisoner is assigned a personal officer to answer questions and listen to their problems. Other prison officers manage the prison and the behaviour of the inmates while further staff provides meals, education and spiritual support. Most prisons also have an induction wing, where new inmates are acclimated to prison life, other wings might include prisoners on remand, sentenced prisoners, lifers and healthcare. Many prisons also have a Listener scheme, which provides emotional support when needed.

The factsheet also includes a section for people whose friend or relative is going to prison, which lists resources that can help them deal with this situation.

Relevance

The target group of the leaflet are persons with mental illnesses, who are going to prison. It is intended not only for convicted prisoners but also for inmates in pre-trial detention (remand prisoners), whose criminal proceedings have not finished yet.

www.opsidianet.eu