Criminal Justice Practitioners' Perceptions of Eyewitnesses with Anxiety and Depression

Abstract

In the UK, witnesses with a mental health disorder are considered 'vulnerable' by the Criminal Justice System and consequently eligible for support within the Achieving Best Evidence guidance (recommendations produced in England and Wales to assist criminal justice practitioners in supporting vulnerable, intimidated, and significant witnesses during the criminal justice process). However, it is unclear how the evidence and credibility of such witnesses, especially those with anxiety and depression, are perceived by criminal justice practitioners. The present study aimed to explore how practitioners in England and Wales perceive witnesses with anxiety and depression, and the current guidance and training on mental health. One hundred and five practitioners including police officers (32), court staff (60), and registered intermediaries (13) completed an online questionnaire which examined their personal perceptions of, and attitudes towards, witnesses with anxiety and depression as well as the level and effectiveness of current guidance and training. Based on previous literature, it was anticipated that practitioners may hold biased perceptions of witnesses with anxiety and depression, and current guidance and training on mental health may be insufficient. The findings revealed that practitioners frequently encountered such witnesses and prior knowledge of mental health issues influenced their perceptions with many reporting that such knowledge caused them to question the reliability of their evidence. Additionally, practitioners perceived the Achieving Best Evidence guidance including the use of special measures to be appropriate. However, they perceived that training around mental health required improvement. The implications of these findings are discussed.

Keywords: mental health; eyewitnesses; practitioners; perceptions

Criminal Justice Practitioners' Perceptions of Eyewitnesses with Anxiety and Depression

Mental health is a growing public health concern (Mental Health Foundation, 2021a) and many individuals with a mental health disorder witness crime (Mind, 2013). This suggests that the frequency of contact between criminal justice (CJ) practitioners and such individuals is likely to be significant. In 2015, it was estimated that between 20 and 40 per cent of police time in the UK involved a mental health concern and demand appears to be increasing (College of Policing, 2015). The current official guidance, Achieving Best Evidence (ABE) in Criminal Proceedings (Ministry of Justice, 2011), is a set of recommendations that was produced in England and Wales to "assist those responsible for conducting video-recorded interviews with vulnerable, intimidated and significant witnesses, as well as those tasked with preparing and supporting witnesses during the criminal justice process" (Ministry of Justice, 2011, p. 1). Whilst this guidance is advisory rather than mandatory, there must be a strong justification put forward at court if its recommendations are not followed (Davies & Westcott, 2018). The guidance considers witnesses with a mental health disorder to be 'vulnerable' within the judicial system (Ministry of Justice, 2011). However, due to research on their capabilities as eyewitnesses being extremely sparse, CJ practitioners working with this group have limited knowledge of their ability to provide accurate and reliable witness testimonies (Reavey et al., 2016). The UK's Crown Prosecution Service outlines that witnesses with a mental health disorder have the same right to access to justice as any other witness and prosecutors should make their decisions free from assumptions or stereotypes (Crown Prosecution Service, 2009). Until now, however, it has been unclear whether the attitudes and perceptions of CJ practitioners are impartial. This is particularly important regarding witnesses with anxiety and depression because these are the two most prevalent mental health disorders within the community (Mental Health Foundation, 2021b). Hence, it stands to reason that many individuals may be experiencing anxiety and depression when they witness a crime (Mind, 2013).

With regard to mental health in general, research has found that individuals with a mental health disorder are at a greater risk of witnessing crime compared to individuals without a mental health disorder (Dinisman & Moroz, 2019). Despite this, very little is known about their eyewitness capabilities. Regarding anxiety and depression specifically, very few studies have explored this and of those that have, the findings are

inconsistent (e.g., Mitte, 2008; Ridley, 2003; Rounding et al., 2014; Rutherford et al., 2007). There has been more research conducted on general memory and mental health but again the findings are mixed. Although studies have found that anxiety and depression can have a detrimental impact on general memory performance (e.g., McDermott & Ebmeier, 2009; Plana et al., 2014), there are studies that have shown the opposite (e.g., Grant et al., 2001; Kizilbash et al., 2002). As a result, there is a lack of clear research not only on the general memory capabilities associated with anxiety and depression, but also on the specific eyewitness capabilities of individuals with such disorders. This means that CJ practitioners are likely to have a limited understanding of their capabilities as witnesses which may affect the interactions that they have with such individuals (Ritter, Teller, Munetz & Bonfine, 2010). They may for example view them and/or their evidence with bias, particularly given that there is a strong social stigma attached to mental health (Mental Health Foundation, 2021c). Approximately, nine out of ten people with a mental health disorder report that stigma and discrimination have a negative effect on their lives. This is because society in general has stereotyped views about mental health and how it affects individuals. Many people believe that individuals with a mental health disorder are violent and dangerous when in fact they are more at risk of being attacked than harming others (Mental Health Foundation, 2021c). Previous research has found that many witnesses of crime have a fear of not being believed or being blamed by CJ practitioners as a result of their mental health disorder (Koskela, Pettitt & Drennan, 2016).

Within the literature, there has been some effort to explore CJ practitioners' perceptions of vulnerable witnesses. Watson et al. (2004) revealed that police officers perceive witnesses with a mental health disorder to be inherently less credible compared to witnesses without a mental health disorder. Further research exploring the experiences of witnesses with a mental health disorder who have come into contact with the police has revealed the following negative experiences: perceived lack of empathy and respect, perception of being blamed, and a feeling that they were disbelieved and discredited (Koskela et al., 2016). Many witnesses reported the feeling of being disbelieved and discredited as being directly related to having a mental health problem and the prejudiced attitudes held by police officers (Koskela et al., 2016). However, previous research has tended to focus on more severe mental health disorders such as schizophrenia, restricting the extent to which its findings can be applied to other mental health disorders such as anxiety and depression. It has also tended to focus solely on police officers, most likely because police officers are often the first responders to emergency calls involving individuals with a mental health disorder (Compton et al., 2014). This means that other CJ practitioner groups with whom witnesses also interact during the investigative process have been overlooked. Consequently, it is

important that the perceptions of further CJ practitioners are understood. Additionally, much of the literature has examined perceptions of the suspect rather than the witness (e.g., Teplin & Pruett, 1992). As the role of a witness is different to that of a suspect within an investigation, it is crucial that we also understand how witnesses are perceived. In terms of recent research, the most relevant study to date was conducted by Reavey et al. (2016). In their research, police officers, judges, magistrates, and detectives took part in a semi-structured interview in which their knowledge and experience of working with witnesses with a mental health disorder were explored. The findings revealed that such CJ practitioners were not equipped with adequate knowledge about mental health and how to deal with mental health disorders, particularly with regard to the production of witness statements. It was also revealed that the level of their knowledge was too basic and practitioners were reluctant to address mental health concerns because they preferred to be personally and socially detached from the issue. Not knowing how to engage with mental health issues was a concern for a number of practitioners in relation to obtaining accurate and reliable witness evidence (Reavey et al., 2016). Such findings provided an initial insight into CJ practitioners' perceptions but also highlighted the need for further research. The use of semi-structured interviews limited the study's capacity to collect a large dataset: across all professional groups, data were collected from only 20 participants. The present study used an online questionnaire, allowing for a larger and more representative sample.

As well as enhancing our knowledge and understanding of how CJ practitioners perceive witnesses with a mental health disorder, it was also important to understand the level and effectiveness of current training regarding mental health. In 2014, the chair of the Police Federation described police mental health training as inadequate (Dodds, 2014). This was supported by research demonstrating that only 22 per cent of Metropolitan Police Service response officers thought that their training on mental health was sufficient (Adebowale, 2013). Further research has shown that officers usually receive little training on mental health even though they want more training (Compton et al., 2014). More recently, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) assessed the effectiveness of forces at protecting and helping those with mental health problems. It was found that whilst forces are investing in mental health training, the quality of training is inconsistent (HMICFRS, 2018). This led to a recommendation that all forces in the UK should review their mental health training programmes. However, there has been less of a focus on mental health training for CJ practitioners who are not on the frontline. Consequently, further investigation was required with practitioners working at various stages of the CJ process in England and Wales. Furthermore, the ABE guidance advises a

number of measures to protect vulnerable witnesses when giving evidence (Ministry of Justice, 2011), yet very little is known about the awareness and effectiveness of these measures with regard to their use in current practice in relation to mental health. Therefore, further investigation into perceptions of the current guidance was also necessary. The findings of the present study will enable us to better understand practitioners' perceptions, not only of the witness and their evidence, but also of the current training and guidance surrounding mental health. This will allow for any necessary changes to be made, inevitably enhancing the provision of best evidence.

The Present Study

The aims of the present study were to 1) examine CJ practitioners' experiences, attitudes, and perceptions of witnesses with anxiety and depression and 2) explore their perceptions of the current guidance and training on mental health within their professions. The practitioners included: police officers, barristers (qualified legal professionals who offer specialist advice when representing, advocating, and defending clients in court), judges, solicitor-advocates (qualified to represent clients as advocates in court), and registered intermediaries (communication specialists who help vulnerable witnesses to give evidence to the police and to the court). The study explored perceptions of the prevalence and identification of witnesses with anxiety and depression, their capabilities, the current interview procedures and support used with such witnesses, the current mental health training available to practitioners, and the legal process involving such witnesses. Based on previous literature, it was anticipated that practitioners may hold biased perceptions of witnesses with anxiety and depression in terms of how they perceive the accuracy and reliability of their evidence. As there is currently a lack of research on the eyewitness capabilities of such witnesses, it was predicted that practitioners may report not having sufficient knowledge of mental health disorders and their implications for witnesses. Based on previous research, it was also expected that the current guidance and training on mental health may not be perceived by practitioners to fully meet their needs.

Method

Participants

In order to allow CJ practitioners from a range of geographical locations across England and Wales to complete the questionnaire, the study was administered online. A total of 113 CJ practitioners completed the questionnaire but eight respondents could not be classified into one of the three groups used for the data analysis. They were not therefore included in the analysis. For the purpose of the analysis, barristers, judges, and solicitor-advocates were grouped together to form one group labelled 'court staff'. 'Police officers' and 'registered intermediaries' remained as two separate groups. The use of these three groups allowed for comparisons to be made between practitioners working at different stages of the CJ process (investigation stage: police officers; trial stage: court staff; support across both stages: registered intermediaries). Of the 105 remaining CJ practitioners, 32 were police officers, 60 were court staff, and 13 were registered intermediaries. There were 48 females and 57 males (minimum age range = 18-24; maximum age range = 55-60). The age ranges and number of participants in each range were: 18-24 *(1)*, 25-34 *(26)*, 35-44 *(34)*, 45-54 *(28)*, and 55-60 *(16)*. Participants completed the questionnaire voluntarily. They were recruited via e-mail, telephone, or social media from five police forces and one police organisation, law firms, criminal courts, and professional organisations located across England and Wales. They did not receive compensation for their participation. The police officers comprised Police Constables, Detective Constables, and Detective Sergeants. They worked in various areas of policing (Uniform General Patrol, General CID, Public Protection, Child Abuse Investigation, Crime Prevention and Problem Solving, Major Crime, Priority Crime, Serious Crime, and Specialist Operations). The barristers, judges, and solicitor-advocates also worked in various areas of practice (Crime, Personal Injury/Clinical Negligence, Family, Employment, Civil, Housing, Planning and Environment, Commercial, Education Law, Immigration, and Regulatory).

Materials and Procedure

Data were collected using a web-based software (Qualtrics). The questionnaire was based on previous research (Crossland et al., 2018) and modified slightly following practitioner feedback from a police officer, barrister, and registered intermediary (who did not complete the questionnaire). This was to ensure that the questions were clear and appropriate. It took approximately 15-20 minutes to complete and comprised a total of 61 close-ended and scaled-response questions. The questions measured personal perceptions, attitudes, and experiences about 1) prevalence and identification of witnesses with anxiety and depression, 2) capabilities of such witnesses and the influence of prior knowledge, 3) interview procedures used with such witnesses, 4) ABE

guidance in terms of its appropriateness and the suitability of special measures, 5) support and training in terms of current support for witnesses with anxiety and depression and training available for practitioners, and 6) the legal process with regard to whether the process could be improved for such witnesses. Regarding the scaled-response questions, a higher score indicated a more positive response. For example, when asked about the accuracy of evidence provided by witnesses with anxiety and depression, the following scale was used: 1 = I don't know, 2 = not accurate at all, 3 = slightly accurate, 4 = moderately accurate, and 5 = entirely accurate. The length of the scale varied between questions. The questions with shorter scales were based on previously published research looking at mock juror perceptions of witnesses (e.g., Henry et al., 2011). The questions with longer scales were developed for the purpose of this research; the use of a longer scale provided a more sensitive examination. The questionnaire was presented in the same format for all participants. However, some questions were omitted depending upon the individual participant as these questions were dependent on the response given to the previous question. For example, if a participant answered 'yes' to the following question: 'Are there occasions when you suspect that a witness has got a mental health problem, even if you have not been informed of a formal diagnosis?', they were then asked: 'How often do you suspect that a witness is experiencing a mental health problem?' If they answered 'no' then the latter question would not be presented. The minimum length of the questionnaire was 45 questions and the maximum possible length was 61 questions. Potential participants were provided with an online link to the questionnaire. First, they were given an information sheet providing briefing information about the study to help them decide if they wanted to take part prior to asking for their consent via a consent form. After giving consent, they provided demographic details and were asked to complete the questionnaire. At the end of the questionnaire, participants were debriefed and thanked for their time.

Results

Prevalence and identification of eyewitnesses with anxiety and depression

Respondents were asked of their experiences relating to the prevalence and identification of eyewitnesses with anxiety and depression. They were asked on a scale between 1 and 5 how often they came into contact with such witnesses in a typical month (1 = never, 2 = rarely, 3 = sometimes, 4 = often, and 5 = very often). Witnesses with anxiety were encountered more often (M = 3.8, SD = 1.0) compared to witnesses

with depression (*M* = 3.6, *SD* = 1.0). This finding was consistent across CJ practitioner groups. Respondents were also asked on a scale between 1 and 8 how easy/difficult it was to identify such witnesses (1 = I don't know, 2 = extremely difficult, 3 = moderately difficult, 4 = slightly difficult, 5 = neither easy not difficult, 6 = slightly easy, 7 = moderately easy, and 8 = extremely easy). Witnesses with anxiety were reported to be easier to identify (*M* = 5.6, *SD* = 1.7) compared to witnesses with depression (*M* = 4.6, *SD* = 1.9). Again, this finding was consistent across groups. In practice, practitioners may be informed of a witness's formal mental health diagnosis if an assessment of their medical needs has been conducted by a mental health professional (College of Policing, 2016). When respondents were asked if there were occasions when they suspected that a witness had a mental health disorder even if they had not been informed of a formal diagnosis, 94% of police officers, 97% of court staff, and 100% of registered intermediaries reported *yes*.

Perceptions of the capabilities of eyewitnesses with anxiety and depression

(Insert Table 1 here)

Respondents were asked a range of questions relating to the capabilities of witnesses with anxiety and depression. The means and SDs for the responses to these questions are presented in Table 1. When asked on a scale between 1 and 5 how capable witnesses were of providing evidence when no additional support was available (1 = I don't know, 2 = not capable at all, 3 = slightly capable, 4 = moderately capable, and 5 = entirely capable), the means were very similar for both witness types (see Table 1). However, a univariate Analysis of Variance (ANOVA)[1] revealed that there was a significant effect of group on perceptions of witnesses with anxiety, $F(2, 104) = 10.42$, $p = .000$, $\eta p^2 = .17$. A further univariate ANOVA also revealed that there was a significant effect of group on perceptions of witnesses with depression, $F(2, 104) = 8.20$, $p = .000$, $\eta p^2 = .14$. Regarding anxiety, post hoc comparisons indicated that there was a significant difference ($p = .02$) between court staff (*M* = 3.5, *SD* = 0.9) and police officers (*M* = 2.9, *SD* = 1.1) and a significant difference (p = .000) between court staff and registered intermediaries (*M* = 2.2, *SD* = 1.0). There was no significant difference (*p* =

[1] Although the sample sizes were unequal, this is not necessarily a problem when using a univariate Analysis of Variance if the variances are equal (Field, 2018). Levene's test was conducted in all analyses and the results were not significant in all cases which suggests equal variances between groups.

.09) between police officers and registered intermediaries. Regarding depression, there was a significant difference (p = .02) between police officers (M = 3.1, SD = 1.2) and registered intermediaries (M = 2.1, SD = 1.3) and a significant difference (p = .000) between court staff (M = 3.5, SD = 1.1) and registered intermediaries. There was no significant difference (p = .28) between police officers and court staff.

When asked on a scale between 1 and 5 how able such witnesses were of giving evidence in court with no additional support (1 = I don't know, 2 = not able at all, 3 = slightly able, 4 = moderately able, and 5 = entirely able), the means were very similar for both witness types (see Table 1). A univariate ANOVA revealed that there was a significant effect of group on perceptions of witnesses with anxiety, $F(2, 104) = 14.01$, p = .000, ηp^2 = .22. A further univariate ANOVA revealed that there was a significant effect of group on perceptions of witnesses with depression, $F(2, 104) = 12.24$, p = .000, ηp^2 = .19. Post hoc comparisons indicated that there was a significant difference (p = .001) between court staff (M = 3.4, SD = 0.9) and police officers (M = 2.6, SD = 1.3) and a significant difference (p = .000) between court staff and registered intermediaries (M = 2.0, SD = 0.9). However, there was no significant difference (p = .26) between police officers (M = 2.6, SD = 1.3) and registered intermediaries (M = 2.0, SD = 0.9). With regard to depression, there was a significant difference (p = .002) between court staff (M = 3.4, SD = 1.1) and police officers (M = 2.6, SD = 1.3) and a significant difference (p = .000) between court staff and registered intermediaries (M = 1.9, SD = 1.0). However, there was no significant difference (p = .23) between police officers (M = 2.6, SD = 1.3) and registered intermediaries (M = 1.9, SD = 1.0). Regarding accuracy and credibility, these were measured using the same scale as above and there were no differences between groups on these variables (see the means in Table 1). In general, respondents considered witnesses with anxiety and depression to be moderately accurate and credible.

Respondents were then asked whether prior knowledge of a witness's mental health disorder influenced how they perceived their evidence and, if so, how. It was found that 44% of police officers, 48% of court staff, and 39% of registered intermediaries reported such knowledge to have had an impact. The most common response across all groups was *caused one to question evidence reliability*.

Interviewing eyewitnesses with anxiety and depression

Respondents were asked about the interview procedures used with witnesses with anxiety and/or depression. These questions were answered only by police officers, registered intermediaries, and one of the sub-groups of court staff (solicitor-advocates). This was because these groups are involved at the interview stage

of the criminal justice process whereas barristers and judges are not. Questions about interview procedures were not therefore relevant to the latter two groups. Respondents were asked if the standard procedures for interviewing witnesses with anxiety and/or depression were the same as, or different from, typical witnesses with no mental health disorders. It was found that 56% of police officers, 55% of solicitor-advocates, and 46% of registered intermediaries reported the procedures to be different.

Respondents were then asked on a scale between 1 and 6 how effective the interview procedures were at obtaining useful information from such witnesses (1 = I don't know, 2 = not effective at all, 3 = slightly effective, 4 = moderately effective, 5 = very effective, and 6 = extremely effective). A univariate ANOVA revealed that there was a significant effect of group on perceptions of the effectiveness of interview procedures, $F(2, 60) = 6.05$, $p = .004$, $\eta p^2 = .17$. Post hoc comparisons indicated that there was a significant difference ($p = .02$) between police officers ($M = 4.1$, $SD = 1.3$) and registered intermediaries ($M = 2.9$, $SD = 1.9$) and a significant difference ($p = .003$) between solicitor-advocates ($M = 4.6$, $SD = 0.9$) and registered intermediaries. There was no significant difference ($p = .53$) between police officers and solicitor-advocates. When asked if they would make any changes to how such witnesses were interviewed, 31% of police officers, 55% of solicitor-advocates, and 85% of registered intermediaries responded *yes*. The most common suggestion for improvement across all groups was *better mental health awareness training for practitioners.*

Appropriateness and effectiveness of ABE guidance

In order to understand how the ABE guidance was regarded, respondents were asked on a scale between 1 and 8 how appropriate it was for eliciting evidence from witnesses with anxiety and/or depression (1 = I don't know, 2 = extremely inappropriate, 3 = moderately inappropriate, 4 = slightly inappropriate, 5 = neither appropriate nor inappropriate, 6 = slightly appropriate, 7 = moderately appropriate, and 8 = extremely appropriate). A univariate ANOVA revealed that there was a significant effect of group on perceptions of its appropriateness, $F(2, 104) = 4.23$, $p = .02$, $\eta p^2 = .08$. Post hoc comparisons indicated that there was a significant difference ($p = .01$) between police officers ($M = 6.9$, $SD = 1.5$) and court staff ($M = 5.7$, $SD = 2.2$). There was no significant difference ($p = .80$) between police officers and registered intermediaries ($M = 6.4$, $SD = 1.9$) and no significant difference ($p = .50$) between registered intermediaries and court staff.

Respondents were also asked on a scale between 1 and 6 how effective special measures were at supporting such witnesses to give their best evidence (1 = I don't know, 2 = not effective at all, 3 = slightly

effective, 4 = moderately effective, 5 = very effective, and 6 = extremely effective). A univariate ANOVA revealed that there was a significant effect of group on perceptions of their effectiveness, $F(2, 104) = 3.76$, $p = .03$, $\eta p^2 = .07$. Post hoc comparisons indicated that there was a significant difference ($p = .03$) between registered intermediaries ($M = 4.6$, $SD = 0.8$) and court staff ($M = 3.8$, $SD = 1.2$). There was no significant difference ($p = .64$) between registered intermediaries and police officers ($M = 4.3$, $SD = 1.0$) and no significant difference ($p = .18$) between police officers and court staff. The most effective measure reported was *video-recorded interview* by police officers, *live link* by court staff, and *examination of the witness through an intermediary* by registered intermediaries.

Perceptions of support and training

Respondents were asked if they would make any changes to how witnesses with anxiety and/or depression were supported. It was found that 38% of police officers, 55% of court staff, and 92% of registered intermediaries reported *yes.* The most common suggestion for improvement across all groups was *better support services*.

Regarding training, respondents were asked if there was mental health awareness training within their profession for managing such witnesses. It was found that 53% of police officers, 33% of court staff, and 46% of registered intermediaries reported *yes* and 71% of police officers, 40% of court staff, and 83% of registered intermediaries had completed the training. Respondents were asked on a scale between 1 and 5 how effective the training was (1 = not effective at all, 2 = slightly effective, 3 = moderately effective, 4 = very effective, and 5 = extremely effective) and all groups reported it to be effective. A univariate ANOVA revealed that there was no significant effect of group on perceptions of its effectiveness, $F(2, 24) = 2.38$, $p = .12$. Respondents were also asked, using the same scale as above, how relevant the training was and all groups reported it to be relevant. A univariate ANOVA revealed that there was no significant effect of group on perceptions of its relevance, $F(2, 24) = .09$, $p = .91$.

All respondents were then asked if they had knowledge of anxiety and/or depression aside from any training and 75% of police officers, 94% of court staff, and 93% of registered intermediaries responded *yes.* The most common source from which they had received this knowledge was *professional experience.* Subsequently, respondents were asked on a scale between 1 and 5 to what extent this knowledge affected their perceptions of witnesses with anxiety and/or depression (1 = not at all, 2 = a little, 3 = a moderate amount, 4 = a lot, and 5 = a

great deal). A univariate ANOVA revealed that there was a significant effect of group on the extent to which such knowledge affected perceptions, $F(2, 91) = 7.90$, $p = .001$, $\eta p^2 = .15$. Post hoc comparisons indicated that there was a significant difference ($p = .04$) between police officers ($M = 2.5$, $SD = 1.0$) and court staff ($M = 2.0$, $SD = 0.9$), a significant difference ($p = .000$) between police officers and registered intermediaries ($M = 1.3$, $SD = 0.5$), and a significant difference ($p = .03$) between court staff and registered intermediaries.

Perceptions of the legal process involving eyewitnesses with anxiety and depression

When asked which (if any) aspect(s) of the legal process could be improved for witnesses with anxiety and/or depression, the most common response provided was *specific training relating to individual mental health conditions* by police officers and registered intermediaries, and *general training about mental health* by court staff.

Discussion

This is the first study to explore how CJ practitioners in England and Wales perceive witnesses with anxiety and depression including 1) the prevalence and identification of such witnesses, 2) their eyewitness capabilities and the influence of prior knowledge, 3) the interview procedures used with such witnesses, 4) the ABE guidance and special measures, 5) the available support and training, and 6) the legal process involving such witnesses. Data were collected from several legal professions (police officers, court staff, and registered intermediaries). This was because previous research has largely looked at police officers only (e.g., Koskela et al., 2016; Watson et al., 2004).

The results revealed that practitioners across all groups encountered witnesses with anxiety and depression. This is supported by research showing an increase in police officers encountering individuals with a mental health disorder due to a rise in mental health related issues within the community (Lamb et al., 2002; Reavey et al., 2016). Research has shown that, in 2007, more than 50% of witnesses who provided statements were deemed vulnerable (Smith & Tilney, 2007) and this is likely to be higher today for the reason above. In light of this, the present findings are somewhat unsurprising but do extend the existing literature as data were obtained from a range of CJ practitioners, not just frontline staff.

Regarding perceptions of witness capabilities, practitioners across all groups perceived both witness types to be credible which challenges previous research (Koskela et al., 2016; Watson et al., 2004). However,

previous studies have focused on different disorders such as schizophrenia and the perceptions of suspects rather than witnesses. This makes it difficult to draw comparisons between the sets of findings. In terms of the witness's capability to provide evidence when no additional support was available, there was no significant difference revealed between anxiety and depression. However, regarding anxiety, court staff perceived such witnesses to be significantly more capable compared to police officers and registered intermediaries. Also, regarding depression, both police officers and court staff perceived such witnesses to be significantly more capable compared to registered intermediaries. When practitioners were asked how able such witnesses were of providing evidence in court with no additional support, again there was no significant difference revealed between anxiety and depression. Yet, court staff perceived both witness types to be significantly more able compared to police officers and registered intermediaries. This could be due to the latter groups having less exposure to the provision of evidence in court. It seems from the findings of both variables that registered intermediaries hold the most negative perceptions of both witness types regarding their capabilities when no additional support is provided. This finding may have emerged as registered intermediaries are likely to have expertise in various disabilities. They may therefore have knowledge about the nature of anxiety and depression. Also, the role of an intermediary is to support the witness and consequently this group may have believed that such support was necessary to improve capabilities. Indeed, the use of intermediaries with vulnerable witnesses has been advised in order to achieve best evidence (Mind, 2013; Ministry of Justice, 2011).

Moreover, practitioners across all groups reported that prior knowledge of anxiety and depression, emanating mainly from professional experience, influenced their perceptions of witnesses with these disorders. This is important as practitioners' understanding of anxiety and depression may not be accurate which could affect how a witness's evidence is perceived. Indeed, a further finding demonstrates this. When asked how such knowledge influenced their perceptions, practitioners believed that it caused them to question the reliability of the evidence. This was particularly true of police officers. This has also been found in previous research that has demonstrated that police officers' responses to the knowledge of a witness having a mental health disorder include a lack of empathy and understanding, and attitudes indicating prejudice such as perceiving the witness to be unreliable (Koskela et al., 2016; Mind, 2013).

Furthermore, practitioners across all groups suspected that a witness had a mental health disorder even if they had not been informed of a formal diagnosis. This is perhaps unsurprising given that a witness's vulnerability may not be disclosed until later in the investigative process, if at all (Reavey et al., 2016).

Nevertheless, it is a concern as such perceptions could affect how the witness and their evidence is managed during the investigative process. Although research has suggested that mental health can impact memory (e.g., McDermott & Ebmeier, 2009; Plana et al., 2014), there is literature demonstrating that mental health disorders do not necessarily lead to problems with memory and potential testimony (e.g., Mitte, 2008; Ridley, 2003; Rutherford et al., 2007). Consequently, it is essential that practitioners are equipped with appropriate knowledge and understanding of mental health and its effect on memory. Despite the fact that all practitioners in the present study who had previously received mental health awareness training reported it to be effective and relevant, thus contradicting previous literature (e.g., Borum, 2000; Dodds, 2014), many did not know about such training. In addition, when asked which aspect(s) of the legal process could be improved for witnesses with anxiety and/or depression, the most common response was a need for more training about mental health which supports previous research (e.g., Adebowale, 2013). This poses the question of whether more effort should be made to ensure that practitioners receive adequate evidence-based training (HMICFRS, 2018; Mind, 2013).

Regarding the ABE guidance, most practitioners reported it to be appropriate for witnesses with anxiety and depression. However, police officers reported it to be significantly more appropriate compared to court staff. This could be because it is not uncommon for the mental health problems of witnesses to become known to the prosecution or the court staff only on the first day of the trial (Dinisman & Moroz, 2019) and police officers may have more exposure to the guidance due to its strong focus on interviewing procedures. In addition, special measures were held in relatively high regard. Specifically, registered intermediaries reported such measures to be significantly more effective compared to court staff which may be because intermediaries represent one of these measures. Nevertheless, very few cases involving witnesses with a mental health disorder involve special measures. Previous research suggests that this may be due to difficulties in identifying the needs of such witnesses because of the perception that support needs might not be readily detectable and the witness themselves might not be willing to disclose any issues (Charles, 2012). It is possible therefore that the practitioners in the present study had not experienced these measures regularly in practice which may have influenced the findings. Further, practitioners across all groups expressed a need for better support services for witnesses with anxiety and/or depression. This indicates that the current support is not entirely appropriate. With regard to interviewing, only 50% (approximately) of police officers, registered intermediaries, and solicitor-advocates reported the interview procedures used with witnesses with anxiety and/or depression to be different to those used with typical witnesses. Registered intermediaries in particular perceived the procedures to be

ineffective at obtaining useful information with many stating that they would make changes to how witnesses with anxiety and/or depression were interviewed. This raises the question of whether such witnesses are being interviewed in the most appropriate way given their vulnerability and further reinforces the need for better support for vulnerable witnesses.

Whilst the findings of the present study suggest that in England and Wales witnesses with anxiety and depression are a common occurrence which warrants further investigation, there are limitations that should be considered. There were only two groups that included respondents located in Wales (barristers and registered intermediaries). Consequently, the sample may not be representative of the perceptions and experiences of police officers, solicitor-advocates, and judges in Wales. Future research should aim to gather a more even distribution of responses from practitioners working across both countries. Additionally, the group sizes were unequal which may affect interpretations of the data and one may argue cause difficulties when making comparisons between the groups. However, having unequal sample sizes is not necessarily problematic when analysing the data using a univariate ANOVA if the variances are equal (Field, 2018). This was tested using Levene's Test of Homogeneity of Variance and, in all analyses, this test was not significant which suggests equal variances between groups. Furthermore, even though the overall sample size was larger than that of previous studies (e.g., Reavey et al., 2016), the present findings are based on perceptions rather than evidence from archival records. The practitioners' responses therefore are only as reliable as their recall. This should be considered before drawing conclusions on the actual eyewitness capabilities of adults with anxiety and depression.

Conclusion

To conclude, the findings of the present study provide support for previous research. This is because the majority of CJ practitioners believed that prior knowledge of a mental health disorder caused them to question the reliability of witness evidence. As a large proportion of practitioners reported that they suspected a witness of having a mental health disorder even if they had not been informed of a formal diagnosis, this could have significant implications for the CJS. Witnesses and their evidence may be being perceived with bias which may be restricting the provision of best evidence. Consequently, it is essential that the actual effects of mental health on eyewitness memory are researched. This will provide a greater understanding of the true influence of anxiety and depression, and the reliability of a witness that has these mental health disorders. This is supported

by a further finding that practitioners need more training about mental health. To date, there are no empirical studies exploring the specific psychological functioning in witnesses with a mental health disorder during the investigative process. This means that practitioners are unlikely to be well informed about their eyewitness capabilities. Having access to robust evidence as well as sufficient training will allow practitioners to understand the needs of such witnesses and enable them to provide the correct support, as required, at an appropriate stage of the investigation. This will help to enable witnesses with a mental health disorder to give their best evidence.

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Conflicts of interest/Competing interests

The authors have no conflicts of interest to declare that are relevant to the content of this article.

Availability of data and material

Not applicable.

Code availability

Not applicable.

Ethics approval

The questionnaire and methodology for this study was approved by the Human Research Ethics Committee at the University of Winchester.

Consent to participate

Informed consent was obtained from all individual participants included in the study.

Consent for publication

The authors affirm that all individual participants provided informed consent for publication of the study.

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