Department of Justice
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Mind Wise
A NEW VISION FOR MENTAL HEALTH

Mental Health & Wellbeing and Personality Disorders:

a guide for criminal justice professionals

Accessing Fair Justice and Improving Mental Health Outcomes

Contents

How this guide can help you

This guide has been commissioned by the Department of Justice (Northern Ireland), and developed by MindWise, to assist criminal justice professionals to support people who are vulnerable by virtue of mental or emotional ill-health to access fair justice and improve their mental health outcomes.

This guide is one of a series of guides being developed by the Department of Justice to provide information on issues that might make someone vulnerable in the CJS.

Who is the guide for?

The guide is for criminal justice professionals in all parts of the criminal justice system (CJS). This includes police officers, advocacy and support workers, solicitors, barristers, prosecutors, magistrates, the judiciary and courts and probation, prison, youth justice and Department of Justice staff.

Who is the guide about?

The guide is about all children, young people and adults with mental health conditions or issues, or personality disorders, who come into contact with the CJS. You may be in contact with them as victims, witnesses, suspects, defendants and or individuals who have been convicted of an offence and are serving sentences either in prison or the community. Your colleagues or people that you work with may also have mental health conditions or issues.

How can the guide help me?

The guide can help you to:

- Be aware that there can be a link between being regularly involved in offending or becoming a victim and experiencing mental health issues;
- Be aware of and understand the range of mental health conditions, mental health issues and personality disorders;
- Recognise when an individual might be experiencing mental health distress;
- Develop confidence and competence in working with an individual who is experiencing mental health distress;
- Be aware of and access the support available.

How should I use this guide?

This guide is designed to be used by as a regular reference point and each section can be used individually.

Section 1

provides information on why you are likely to come across people with mental health conditions and issues in the CJS and how to recognise when someone might be experiencing mental health distress.

Section 2

provides a three step guide to working with and supporting someone who you think may be experiencing mental health distress.

Section 3

provides information on the support available for mentally vulnerable people in different parts of the CJS.

Section 4

provides more detailed information on the main range of mental health conditions, mental health issues and personality disorders.

This guide is not intended to equip professionals to diagnose someone as having a mental health condition or issue, or a personality disorder. The guide does not replace existing guidance and protocols within your organisation, but should be used in conjunction with local policy and protocols.

TERMINOLOGY

The term 'Mental Health Condition' is used where the text relates to severe and enduring mental illness which affects every day life (e.g. Schizophrenia, Bi-polar Disorder, Clinical Depression and Obsessive Compulsive Disorder). 'Mental Health Issues' is used to indicate less severe and enduring symptoms of poor mental health, such as anxiety-related disorders, stress and depression. Where a person with a mental health condition or issue is experiencing adverse symptoms, this has been referred to as 'Mental Health Distress'. All the information provided relates to both diagnosed and undiagnosed mental health conditions or issues, and personality disorders.

MINDWISE

MindWise is a leading mental health charity in Northern Ireland delivering 30+ services run by 110 professional staff and 100+ volunteers. With the backing of our 330 members we raise awareness and help more than 1000 people each day affected by mental health issues to tackle their problems. For more information please visit our website www.mindwisenv.org

In the UK

- 25% of adults in the **general population** experience at least one diagnosable **mental health problem** in any one year [1]
- 70% of adult prisoners suffer from two or more mental health problems [2]
- 95% of young **prisoners** aged 15 to 21 suffer from at least one **mental health problem** [3]
- 64% of male- and 50% of female **prisoners** have a **personality disorder**; 12 and 14 times the level in the **general population** respectively [4]
- People with **mental health conditions** are five times more likely to be a victim of assault, and three times more likely to be a victim of a household crime by someone they know than anyone in the **general population** [5]

1) Singleton, N. et al, Psychiatric Morbidity among Adults living in Private Households, 2000, Office of National Statistics (2001)
2) Criminal Justice Inspection Northern Ireland, Not a Marginal Issue: Mental health and the criminal justice system in Northern Ireland – A follow-up review of inspection recommendations, CJINI (March 2012)
3) Ibid.
4) Ibid.
5) Victim Support, Mind, King's College London and Kingston University, At Risk, Yet Dismissed – The Criminalisation of People with Mental Health Problems, Victim Support and Mind (2013)

Minister's foreword

In the course of their work, criminal justice professionals regularly come into contact with children, young people and adults with a variety of mental health issues.

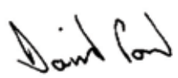
For someone vulnerable by virtue of mental or emotional ill health, contact with the criminal justice system can be a further source of anxiety and distress.

I want to ensure access to justice for all and to protect the welfare of everyone we come into contact with. This means ensuring that those who need extra support receive it.

This is why, in partnership with Mindwise, my Department has developed this new guide to improve awareness of mental health issues among criminal justice professionals and to provide some practical advice on recognising, working with, and supporting people who are experiencing mental health distress.

Everyone working in the criminal justice sphere can play a role in supporting people with mental health issues, by treating them with respect and consideration, ensuring they are treated fairly in criminal justice processes, and helping to connect them with the care they need.

I am also committed, through my Department's diversity programme, to supporting all those within the workforce who have mental health issues or who care for those with mental health issues.



David Ford MLA
Minister of Justice

Section 1

PEOPLE WITH MENTAL HEALTH CONDITIONS AND ISSUES IN CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

Each year significant numbers of children, young people and adults with mental health issues come into contact with the CJS in Northern Ireland as victims, witnesses, suspects, defendants and serving sentences in the community or in custody.

The high rates of mental ill health among suspects, defendants and those serving sentences will come as no surprise to criminal justice practitioners. In many cases, these individuals will not be accessing the services they need in the community because they are not aware of their condition, do not know where to seek help, have a chaotic lifestyle or experience other barriers to getting the support they need. It is less well known that those who are mentally vulnerable are more likely to become victims of crime and experience more difficulties in achieving access to justice. Feeling overwhelmed, distressed or confused or fear of a negative response stops many vulnerable victims from reporting the crime in the first place or following through with their complaint.

Some of the issues and barriers that people might face in the CJS as a result of their mental health issues include:

- Particular vulnerability to fear, stress and anxiety and a likely subsequent deterioration of their mental health and wellbeing
- Fear of and actual discrimination, stereotyping and stigma regarding their conditions or issues
- Their problems not being taken seriously as they have no formal diagnosis
- Difficulties in understanding and being understood, especially when unwell
- Fear of disruption to medication, support and recovery
- Lack of or fluctuating capacity to make decisions about themselves

Everyone working the CJS can play a role in supporting these individuals, by treating them with consideration, helping to connect them with the care and support that they need and, ensuring that they are treated fairly in the criminal justice processes.

WHAT DO MENTAL HEALTH CONDITIONS AND ISSUES LOOK LIKE IN PRACTICE?

A number of factors can impact on how an individual with a mental health condition or issue will present at a given time including:

The stability of their condition

It is important to understand the difference between the medical symptoms of a certain mental health issue and how a person might present at a particular time. When you come into contact with them, a person with a mental health condition or issue might be stable, very unwell or somewhere in between. For example, someone with a diagnosed mental health condition like schizophrenia or bipolar disorder could be stable, either permanently or for long periods of time. Others could regularly become unwell and experience negative symptoms.

Whether or not they have a diagnosis, are taking their medications and are aware of their symptoms

Not all conditions will be diagnosed and not everyone will be accepting of their diagnosis, taking their medication or be aware of their symptoms. For example, someone with a mental health condition who is experiencing positive hallucinations or a mania might feel exceptionally positive and might not be aware or accept that they are becoming unwell and need help.

Whether or not they are under the influence of alcohol or drugs

An individual experiencing mental ill-health might have taken alcohol or illegal drugs for recreational use when you come into contact with them, which can mask symptoms of mental ill-health. It is also quite common for people with mental health conditions or issues to use alcohol and drugs to deal with the more severe symptoms of their condition or the side effects of their prescribed medications.

Whether or not they are willing to disclose their condition

People might mask their symptoms out of embarrassment, due to internalised stigma, to avoid showing weakness or because of the paranoia they are experiencing. For example, those who regularly hear voices or see people that are not there have sometimes learned how not to acknowledge these experiences in front of other people. This type of masking is very stressful and exhausting and can also make any mental deterioration worse in the long run.

HOW CAN CONTACT WITH THE CRIMINAL JUSTICE SYSTEM AFFECT SOMEONE'S MENTAL HEALTH CONDITION OR ISSUE?

For people with pre-existing mental health conditions or issues, being a victim of crime or being involved in crime and being detained can make it difficult to maintain the healthy balance necessary to stay mentally well. Deterioration in someone's mental wellbeing can happen over a number of weeks or even months, for example, by the time a case reaches court, or as rapidly as in a couple of hours while being interviewed by the police. It is therefore essential not to assume that the level of wellness of a person you come into contact with will stay the same throughout their journey through the CJS or even during their contact with you or your organisation.

There are a number of essential elements to achieving recovery and staying mentally well for any person with a mental health condition or issue.

These elements can be easily disrupted by contact with the CJS. For example, unfamiliar criminal justice processes may give rise to fear and anxiety. Having no or delayed access to medication, not being able to take medication on time or missing a medical appointment may add further to distress. The physical environment may also have an adverse impact on wellbeing. Police custody suites are often noisy and busy places, which can add to the stress experienced and result in immediate deterioration of symptoms.

Some people with mental health conditions are also very sensitive to bright lights and touch by others, especially when already unwell or stressed and exposure to these can lead to stress and deterioration. The same applies to people with Obsessive Compulsive Disorders who are unable to complete rituals or other compulsive behaviours leading to additional stress.

HOW CAN I RECOGNISE WHEN SOMEONE MIGHT BE EXPERIENCING MENTAL HEALTH DISTRESS?

The following are common signs and behaviours displayed by people experiencing mental health distress (i.e. a deterioration of their mental health). Being aware of these signs can help you to recognise when there might be a problem. These common signs are easier to pick up if you know the individual or work with them over a longer period as part of their contact with the CJS. You will then get to know their usual behaviour. However, even if this is the first time you have met them; one or more of these behaviours can indicate possible issues relating to mental health and wellbeing.

More details on the symptoms of specific mental health conditions or issues are provided later in this guide, but the following are common symptoms of mental health distress:

- Seeming anxious / distressed / fearful
- Seeming irritated / agitated / aggressive
- Expressing despair / guilt / feelings of worthlessness
- Displaying extreme tearfulness and not being able to stop crying
- Having difficulty focussing / lack of concentration / appearing distracted
- Appearing apathetic / emotionally flat / dazed / lacking in energy / appearing un-interested
- Seeming over-excited / laughing for no clear reason / not being able to stop laughing
- Expressing obsessive or irrational thoughts
- Displaying compulsive behaviours like constant hand washing or touching objects a set number of times
- Asking for constant reassurance about the same minor issues
- Talking to self of others who are not there / hearing voices
- Seeing people of things that are not there
- Having delusional thoughts / paranoia
- Having grandiose ideas / unrealistic ideas or levels of optimism
- Acting inappropriately for the current situation / being inappropriately personal or sexual / invading personal space
- Dressing flamboyantly / wearing clothes that are dirty or inappropriate for the weather
- Talking very rapidly or very slowly / having difficulty taking things in / interrupting constantly
- Showing recent evidence of self-harm like cuts on the arms or recovering from an overdose
- Sweating /shaking / appearing to have trouble breathing of swallowing
- Trying to cover ears or eyes / complaining about noise or light levels
- Giving indicators when speaking like “My brain is on fire,” “My head is foggy” or “I am feeling really down”

Section 2

WORKING WITH AND SUPPORTING SOMEONE EXPERIENCING MENTAL HEALTH DISTRESS

When working with someone who you recognise may be experiencing mental health difficulties or distress, try to follow these three steps:

STEP 1 – CREATE THE RIGHT ENVIRONMENT

Make a positive statement about mental health and recovery in your working environment

Many people do not share information about their mental health condition or issues because they are afraid they might get a negative reaction or might not be taken seriously. It is likely that they have previously heard derogatory comments and jokes about people with mental health issues. They may also have direct experience of negative reactions as a result of others being told or finding out about their illness.

Consider putting a couple of posters on the wall in your working environment which share positive messages about mental health and about recovery. (These types of posters are available from MindWise) You could also mention your organisation’s commitment to supporting people experiencing mental health difficulties when you introduce yourself. You should not assume that people know that they are in a safe environment in which to share information about their mental health: instead spell this out clearly.

Engage effectively

Make eye contact, when appropriate

Always make eye contact while asking any questions about mental health. This is especially important when you need to ask a range of questions requiring you enter information on a computer or on a form. Avoiding eye contact might imply that you are embarrassed about asking these questions, which could reinforce stigma, or that you are not really interested in the answers. Remember not to stare or hold people’s gaze for too long. Where the person actively tries to avoid your eye contact, you might want to get around making them feel uncomfortable by not looking at them while asking your questions. Explain this to them first by saying something like:

> *“I am making eye contact with you when I speak. I feel that is making you feel uncomfortable. Instead I can look at my paper work here. Would you prefer that?”*

Engage in a calm, private space

To engage effectively you should ensure that there is no one in earshot of your conversation unless completely unavoidable due to your organisation's policy and procedures. An individual will be more likely to share information in a calm, private space.

Use straightforward language and allow time to respond

Keep in mind that people who are mentally unwell may find it difficult to concentrate because their thought processes have slowed down or speeded up as a result of becoming unwell or taking prescribed medications. Use simple, literal language. Introduce yourself and explain what your role is within the CJS. Start each question with their name and allow sufficient time for them to answer even if this involves a short period of silence.

You might also need to allow for time for you to help them stay focussed or repeat what has been said. If possible do not make the interview longer than 20 or 30 minutes at the most before allowing for a ten minute break. Where a Registered Intermediary has been engaged, they can advise on the length of breaks. (See Section 3 for further information)

Make any adjustments to put the person at ease

People experiencing mental distress may be able to tell you if there are adjustments you can make to make things easier for them. To find out, you can ask simple questions like:

- *"Is there anything I can do to make this conversation more manageable for you?"*
- *"Do you need some time alone before I speak to you?"*
- *"You seem uncomfortable: Would you like a drink of water?"*

STEP 2 – FIND OUT MORE ABOUT THE INDIVIDUAL'S MENTAL HEALTH AND CURRENT WELLBEING

Do not make assumptions about previous contact

Even if you have met the mentally vulnerable person before, even in the last number of hours, do not make assumptions about previous contact. You could for example start the conversation with: "(Name of Person), as you know, my name is..." etc. Do not assume that the individual will have retained all of the information you provided last time, especially if they were unwell.

This approach provides a new opportunity for the person to share relevant information with you now they have met you more than once. It also allows for any changes to their mental wellbeing to be identified and recorded by you as deteriorations can occur at any time and sometime very rapidly.

Potential Adjustments

People experiencing mental distress might benefit from being moved away from areas that are noisy and crowded. What might appear to you to be reasonable noise or light levels might make a mentally vulnerable person who is unwell or anxious, manic or even psychotic. Where possible try to offer the mentally vulnerable person the option of going into a separate room where it is quiet and where the lights can be turned down.

Some people experiencing mental distress will struggle with physical contact, especially where it is unexpected as this over-stimulates them. It is therefore important that you do not touch the person you are interviewing even if you are just trying to reassure them. Also avoid, for example, holding their shoulder or touching their backs, unless it is unavoidable as part of risk management. If this is the case, give an advance warning of what you are going do.

Mentally vulnerable people might benefit from a delay in being interviewed, even if this is for a couple of hours only. It might be helpful to lie down in a quiet place for a time, like a cell, where the lights can be switched off or a blanket can be provided to put over their eyes. Where possible you might want to consider delaying for a number of days as this will allow for any emotional distress to reduce.

For people taking medication for their mental health condition, it might be useful to have interviews in the afternoon rather than the morning as the side effects might cause drowsiness and tiredness after waking. Some medications, especially anti-depressants, can also cause people to have very dry mouths making it difficult to talk for a longer time without a drink of water.

Be clear about why you are asking questions about mental health

Before you begin asking questions about mental health, let the person know why you are asking for this information. You should also mention what you plan to do with the information you are asking for, who you have to or might want to share it with, where it will be recorded and how you intend to keep them informed of what is going on. If you are unable in your role to provide follow-on support, point this out to avoid raising false expectations. You could, however, let them know that you can advise them on other services they can access.

Use appropriate, sensitive questions to find out more about someone's mental health and wellbeing

It is important that you use the right questions to start a conversation about mental health as many individuals, especially young people, will still have an issue with the term 'mental illness" or any associated terms. Instead you could focus on what you have observed by saying for example:

- *"How are you feeling at the moment?"*
- *"You seem really anxious / restless / distracted / hyper (etc.). Are you ok?"*
- *"You said you were feeling down / stressed / like your brain was on fire (etc.) What did you mean by that?"*
- *"Is there anything you would like to tell me about yourself right now?"*

This approach allows for a person to answer directly by sharing that they have a mental health diagnosis, or indirectly by confirming what you have observed and thereby opening further conversation. Remember to leave an opening for the person to answer even if this means a short period of silence. If this does not work or there are no real symptoms you can pick up, you could continue the conversation by saying for example:

- *"Are you taking any medication at the moment to help you with your feelings?"*
- *"Are you getting any support or help from anyone to talk about your problems? Would you mind sharing with me what you talk about?"*
- *"Are you seeing your GP at the moment for anything? Would you like to tell me a bit more about that?"*
- *"Do you have a Community Mental Health Nurse, Key Worker (e.g. in a supported housing setting), Social Worker or MindWise Community Bridge Builder? How do they help you?"*

Even if the response is negative, this still might open up a conversation about mental health and wellbeing. Otherwise consider the following questions:

- *"Would it be easier for you to talk to someone else? (For example a man rather than a woman or vice versa / a person who speaks their first language / an independent mental health advocate)*
- *"Would you like to see our Doctor / Nurse / mental health person?"*
- *"Shall I get back to you in half an hour so once you had a cup of tea / a lie down / time on your own (etc.)?"*

STEP 3 – TAKE FURTHER ACTION

Assess immediate risk to the person themselves, to you and to others

*This section should be read in conjunction with your organisation's policy and procedures in relation to risk management.

Risk to themselves

The risk that a mentally vulnerable individual who is unwell might pose to themselves is a risk of suicide or severe self-harming. You should establish how immediate and severe this risk is so that you can take the necessary steps to keep them safe. For example, has the individual been planning suicide in the immediate future and have they put plans in place for this? Has the individual recently engaged in severe self-harm or are they planning to carry out severe self-harming in the near future? The following questions can be used to assess risk:

- *"Are you feeling safe right now?"*
- *"Are you having any thoughts about harming yourself at the moment?"*
- *"Have you done anything to yourself today that might cause you harm?*
- *"Is there any medication you should have taken or need to take soon?"*
- *"I am concerned about your safety. Is there anything I should know?"*

If the risk is immediate and severe, this might mean stopping the conversation at this point or continuing the conversation in a different track (e.g. using Safe Talk, Applied Suicide Intervention Skills or other suicide first aid techniques.) You should follow your organisation's policies to keep the individual safe. Other suicidal ideation, thoughts of self-harming or minor recent incidents of self-harming should be recorded, but can be dealt with after the conversation has finished.

Remember that self-harming can also involve previous behaviours which you might not have observed or noticed, for example: having taken an overdose of prescribed or illegal drugs; banging of the head against a wall; or, recent cutting or burning of skin which is now hidden but which requires immediate treatment. (For more information on suicidal risk or self-harming, please see the relevant headings later in this guide.)

A mentally vulnerable person can also be a risk to themselves if they have not taken their medication as prescribed, as their condition can deteriorate rapidly. There are many reasons why someone might not take their medication. People who are mentally unwell, for example, can have difficulties remembering when to take their medication. Alternatively, they may try to avoid taking it because it has bad side effects or takes away what might be pleasant feelings of euphoria. Alcohol and drug use and a chaotic lifestyle may also be a factor.

People who have become a victim of crime might also have missed any medication prescribed because they were, for example, admitted to hospital with injuries, could not get access to their medication because of a domestic abuse incident or simply forgot due to the stress of their experience.

Risk to yourself or others

If you are feeling scared or at risk yourself, or the person to whom you are talking threatens you, trust your own instincts and take any necessary precautions or leave the room. However, it is important to remember that the overwhelming majority of people with mental health conditions who are acutely unwell are a risk to themselves only.

If you suspect that the person you are talking to might be a risk to others, you can ask the following questions:

- *"Are you having any thoughts about harming others at the moment?"*
- *"How real are these thoughts?"*
- *"Can you control them?"*

Some people who are very unwell might have thoughts of harming others but manage not to act on them. Others might become aggressive towards others because of the extreme anxiety and paranoia they are experiencing. You should follow your organisation's policies to keep yourself and others safe.

Consider and explain what support is available now or later in the criminal justice process

There are a number of support services available for people who are mentally vulnerable and in contact with the CJS. These are described in detail at Section 3. You should take the opportunity to let the vulnerable person know about the support that might be available in the future at other parts of the CJS process. This is likely to reduce their stress considerably and therefore reduce the risk of deterioration in their mental health.

Explain what you are going to do next and why

You should take time to explain to the individual what you are going to do next and why. This should cover any information you will be recording and sharing and any referrals you plan to make. Be clear about how much follow–on support you or others can provide to avoid raising false expectations. Taking time to provide this information can reduce any stress the individual is experiencing and allow them to ask questions for clarification.

Any information that you are required to share as part of your organisation's policy and procedures or as part of risk management should have been highlighted to the individual as part of Step 2. You should repeat what you are going to do with this information and how recording and sharing it can assist their current journey or future contact. However, it might be useful to remind them not to assume that every CJS professional who they come into contact with now will be up to date with their background. They might have to repeat some of the information in future or remind other professionals to check their files.

Outside of this, you need to seek the individual's agreement to share this information with others in your organisation, in the CJS or with their own GP as appropriate. Do not assume that the information someone has shared with you about their mental health can be shared with your colleagues. The same applies to using this information as evidence during a police interview or in court as part of a defence strategy or to support the Victim Personal Statement. Many people who are detained prefer not to have their mental vulnerability made known and used as a redeeming feature.

Record and share information internally and externally in line with protocols

Record what you have observed and any information that the individual has shared about their mental health. If you are not sure if the information was correct or if the individual was telling the truth, record it anyway. (This includes any individual saying that they do not have any mental health problems, where you suspect they do.) If the individual did not have a diagnosis or did not share this with you, you can still record the behaviour you

observed and your suspicions of mental ill-health.

Next, share information internally and externally in line with your organisation's protocols. This will assist criminal justice professionals at other stages in the system in beginning conversations about mental health and identifying symptoms and risk.

Personal Experience

K. is a 27 year old female with a diagnosis of Bi-polar Disorder with rapid changes between moods. She had been stable for over two years with her condition being managed with medication and avoidance of triggers. One evening she attended a house party with her boyfriend and after having a couple of drinks, she went into a bedroom and fell asleep. She was awoken by a man she had never seen before who was pinning her down to the bed and touching her inappropriately. The assault only lasted a couple of minutes and she had managed to push him away when other people entered the room hearing her shouting.

K's boyfriend took her to the police station to report the assault. However, due to the shock of the incident and the delay in her statement being taken, K. had cycled from a stable mood to a manic mood. Her speech had become very rapid and difficult to follow. She also found it difficult to concentrate on the questions being asked by the police officer and started acting in a way which was likely to be interpreted as inappropriate. As well as laughing and joking with the police officers, she referred to herself as "Sexy K.". She had not told the police officers that she had Bi-polar Disorder as she did not want her boyfriend to find out. Furthermore, K. was not really aware of the inappropriateness of her behaviour until well after the interview.

In all the circumstances, the PPS made a decision not to prosecute the case, even though K's boyfriend knew the man who had attacked her. Had the interview been held a number of days later, the outcome may have been different.

Personal Experience

M. is a 20 year old man who was arrested about six months ago for burglary and attempted burglary and interviewed at a Belfast PSNI station. He was assessed by the Forensic Medical Officer after he disclosed as part of the PACE risk assessment that he had previously engaged in self-harming and he was deemed fit for interview. A MindWise Appropriate Adult (AA) Worker was called in as he was classed as a 'mentally vulnerable adult' due to that disclosure. The AA Worker noted that there was no other information recorded on the custody record regarding suffering from any mental health problems or depression. M. had disclosed alcohol dependency but was not under the influence of alcohol during the time of arrest.

During the time that the AA spent with M. to prepare for the interviews and providing samples, M. divulged that he had been feeling very depressed over the last number of months and that he was using alcohol and self-harming (cutting) to feel better. He also explained that he had been put in secure accommodation when he was sixteen because of his self-harming but had not been given any support since. M. was bailed and offered a referral to the MindWise Linked-In Project, which supports young people (aged 13 to 21) leaving police custody for a period of up to six months.

The Linked-In Officer met with M. the next day and identified a number of health and other support issues including: no GP registration; not engaged with Community Mental Health Services; previous suicide attempts and recent suicidal thoughts; regular cannabis and alcohol use leading to anger and depression; recent rejection by his biological father; insecure housing; difficulty accessing benefits; and, offending behaviour. The Officer also noted that M. seemed undernourished, dishevelled and very anxious.

M. was helped to develop and implement a personal action plan including support to secure GP registration, GP referral to Community Mental Health Services, psychiatric assessment and referral to counselling support. He was also helped to address a range of stressors for mental health problems including support in accessing housing and benefits and meeting the requirements set by the CJS.

Section 3

SUPPORT FOR MENTALLY VULNERABLE PEOPLE IN THE CJS

This section provides further information on the support available for mentally vulnerable people in different parts of the CJS.

VICTIMS AND WITNESSES

The Department of Justice has published a Victim Charter to provide information on the standard of service they can expect to receive when in contact with the criminal justice system. The Charter is one of the commitments in the five-year strategy *'Making a Difference to Victims and Witnesses of Crime – Improving Access to Justice, Services and Support'.* Download from: www.nidirect.gov.uk/victimcharter

The following services are available to vulnerable victims and witnesses:

- **Registered Intermediaries** (RIs) can assist people with significant communication difficulties arising from a mental health condition or issue, or a personality disorder at the investigative stage carried out by the police and at the trial. Through the Scheme, a professionally qualified RI assists the vulnerable victim by assessing their level of communication ability and needs, providing reports to both the investigating police officer and the court about communication strategies and being present at the police interview and at the trial to facilitate communication.
- **The Victim and Witness Care Unit**, a partnership between the Public Prosecution Service and the PSNI, will ensure that victims and witnesses of crime are kept informed of progress in court cases they are involved in. This could lead to reduced levels of anxiety and stress among victims and witnesses who are vulnerable due to having a mental health condition or issue.
- **'Special Measures'** can be put in place to help young and vulnerable victims and witnesses to give their best evidence possible. An application for these needs to be made by the Prosecutor to the Public Prosecution Service. Special Measures include a screen around the witness box, giving evidence by TV link, giving evidence in private without members of the public and press, judges and barristers removing their wigs and gowns, using previously recorded statements to the police as evidence and, having an interpreter.
- The **NSPCC Young Witness Service** provides support to children and young people under the age of 18 who have to attend court as witnesses. NSPCC workers provide information and advice to children and their families before during and after the trial.
- **Victim Support NI** supports victims aged 18 and over, who need to attend court, with emotional support and practical information. Victim Support NI also provides community services involving emotional support, information and practical help to people who have experienced from any type of crime.

Victims of Disability Hate Crime

People living with a severe mental health condition can become victims of a Hate Crime. The agreed definition of a disability hate crime is any criminal offence which is perceived, by the victim or any other person, to be motivated by hostility or prejudice based on a person's disability or perceived disability. Disability hate crimes can also be committed by family members or carers. Both Victim Support NI and the Leonard Cheshire Disability NI can provide information, practical help and emotional support in relation to reporting a disability hate crime, improving access to the CJS and engaging other relevant services.

Role of the Custody Sergeant

People arrested for an offence and taken to custody are risk assessed in accordance with the Police & Criminal Evidence Order (1989) NI and Codes of Practice, commonly known as PACE. A Custody Sergeant will carry out a NICHE assessment with every person being booked in which includes questions about their mental health. They will then arrange for a Forensic Medical Officer (FMO) in attendance at the police station to assess the detained person's suitability for interview where it is deemed that they might be vulnerable. Young people under the age of 18 are often seen by the FMO as a matter of routine as they are vulnerable due to their age. Any concerns you have regarding the detained person's mental health and wellbeing should be reported to the Custody Sergeant, even if you are not employed by the PSNI but are attending in another professional capacity.

Place of Safety

People detained by the police under the Mental Health (NI) Order 1986 as they are so unwell that they are a danger to themselves or others are taken to a 'Place of Safety' which is usually the Accident and Emergency Department at the local hospital. The hospital can then arrange for an assessment, treatment and, when required, transfer to a secure unit. On some occasions a police cell is still used as a Place of Safety.

POLICE CUSTODY AND DIVERSION

The following services are available to mentally vulnerable individuals during or on release from custody:

- **Parents, partners, carers or key workers** can support a vulnerable person during police interview.
- The MindWise NI **Appropriate Adult Scheme** (NIAAS) can support vulnerable adults and young people in the police station including during police interview where no parent, partner, carer or key worker is available, willing or suitable.
- **Registered Intermediaries** (RI) can assist people with significant communication difficulties arising from a mental health condition or issue, or a personality disorder at the investigative stage. RIs assess levels of communication ability and needs, provide reports to both the investigating police officer and the court about communication strategies and are present at the interview and trial to facilitate communication
- **Interpreters** can provide advice on cultural differences when discussing mental health and wellbeing
- You may be able to identify **solicitors who specialise in supporting mentally vulnerable people**.
- The Mindwise NI **Linked-In Pilot Project** supports children and young people aged 10 to 21 after release from police custody to screen for mental health issues and access services to meet their individual needs (Currently in pilot areas only).
- **Youth Engagement Clinics** facilitated by the Youth Justice Agency support children and young people aged 10 to 17 by diverting them away from court and access support services that they might need

THE COURT PROCESS

The following services are available to vulnerable individuals during the court process:

- MindWise's **Linked-In Pilot Project** Officers will bring mentally vulnerable children and young people to their Youth Conference, support them while they are there and help them meet the requirements set as part of their Youth Conferencing Plan or Order. (Currently in pilot areas only)
- The **Probation Board for Northern Ireland** provides mental health assessments as part of any pre-sentence report requested by the judge.
- If medical expertise is required while an individual is detained in court custody, this is secured by the Prisoner Escort and Court Custody Service (PECCS) manager, or other escort service, either through an FMO or by contacting emergency services.

Role of Prosecutors

Prosecutors make a decision for prosecution using the 2 stage test for prosecution: firstly, they must decide if the evidential test met, and if so; secondly, if it is in the public interest to prosecute. In addition to prosecuting a case at court, prosecutors have some diversionary options available in appropriate circumstances.

Prosecutors will need to know if a suspect has a mental health issue that has affected their behaviour in committing the alleged offence, and their mental state at the time or during a trial. Police should pass on information to the Public Prosecution Service (PPS) about the suspect's condition if known. This can then be taken into account, along with all the other information and evidence provided by police to PPS, in making a decision whether or not to prosecute a case.

In some circumstances a suspect's mental health condition may have an impact on their ability to form an intention to commit an offence. The suspect's legal representative may raise issues and expert evidence may be sought. Further, a suspect's mental health condition may be a factor affecting the public interest in prosecuting a case. More information on how the PPS takes prosecution decisions is set out in their Code for Prosecutors and other policy documents available on their website: www.ppsni.gov.uk

There are 2 distinct legal concepts relating to a suspect with a mental illness,"Unfitness to Plead" and "Insanity":

- the defence of insanity requires consideration of the accused's mental state at the time of committing the offence, whereas
- unfitness to plead relates to accused's mental state at the time of, or during the criminal trial.

Role of PBNI's Psychology Department

The core function of the PBNI Psychology Department is to enhance the existing work of Probation Officers. This includes supporting the work of Probation Officers at both the Pre Sentence and case management stages, including, for example, providing specialist psychological opinion within case consultations and, depending upon the issues, by facilitating preliminary or comprehensive psychological assessments with clients.

The role of the Department also includes working at the interface between health and criminal justice including, for example, liaising General Practitioners and with the various Community Mental Health Teams (and Community Forensic Mental Health Teams.) The PBNI Psychology Department also supports the work of Probation Officers assessing or supervising clients who have confirmed or suspected mental health problems and in certain cases facilitate time-limited interventions with such clients as part of their supervision in the community.

- **Registered Intermediaries** (RI) can assist people with significant communication difficulties arising from a mental health condition or issue, or a personality disorder at trial. RIs assess levels of communication ability and needs, provide reports to both the investigating police officer and the court about communication strategies and are present at the interview and trial to facilitate communication. The decision to involve a Registered Intermediary is ultimately a matter for the presiding Judge.
- MindWise's **Court Defendant Support Pilot Project** can provide mentally vulnerable defendants with support during a Crown Court trial where the Judge has agreed to this. (This support can be in addition to the engagement of a RI during examination and cross-examination.)

SUPERVISION IN THE COMMUNITY

- Children, young people and adults being supervised in the community either on release from custody or as part of a community sentence access mainstream health and social care services. The **Probation Board for Northern Ireland** and the **Youth Justice Agency** have an important role to play in supporting them to do so.
- **Community Forensic Mental Health Teams** are multi-disciplinary teams who have links with the local criminal justice system including prison, police, courts and the Probation Board for Northern Ireland, and access to housing and social services.
- **Child and Adolescent Mental Health Services** aim to promote emotional well-being and deliver care, treatment and preventative mental health services to children and young people aged 0 – 18 years of age who experience significant mental health difficulties

WOODLANDS JUVENILE JUSTICE CENTRE

- Health care within Woodlands Juvenile Justice Centre is provided by health care staff employed by the Youth Justice Agency. The current health care team consists of a part-time **Psychiatrist**, a **Forensic Psychologist** and 4.5 **nurses**, with usually only one member of nursing staff working each day.
- The **Adolescents Leaving the Justice System** (ADJUST) project, delivered by Start 360, provides support to young people (aged 16 to 21) six weeks pre-lease and up to six months afterwards in the community. This support includes addressing risk factors for developing mental health issues as these are often the same as those for reoffending behaviours.

PRISON CUSTODY

- Healthcare services for prisoners are provided by the **Southern Health and Social Care Trust** in each of the three prison establishments: Maghaberry Prison, Magilligan Prison and Hydebank Wood Prison and Young Offenders Centre. This includes the provision of psychology and psychiatric services and transfers to secure forensic mental health services where appropriate.

- A number of **private and voluntary services** offer further support including the Samaritans, Cruse Bereavement and Relate NI.
- **Adolescents Leaving the Justice System** (ADJUST), a project delivered by Start 360, provides support to young adults (aged 16 to 21 only) for six weeks pre-lease and up to six months following release in the community.
- The **Probation Board for Northern Ireland's Psychology Department** supports the work of Probation Officers in assessing and supervising clients who have confirmed or suspected mental health problems. The Psychology Department can refer clients to the appropriate services within Community Mental Health Teams or Community Forensic Mental Health Teams where appropriate.

SECURE FORENSIC MENTAL HEALTH SERVICES

- The **Shannon Clinic** is the medium secure forensic unit for Northern Ireland which detains adults who have committed a crime but who are mentally too unwell to be detained on remand or in prison. As well as having its own specialist mental health team, the Clinic also provides a MindWise **Patient's Advocate** and a CAUSE **Carer's Advocate**.
- Equivalent facilities are not currently available in Northern Ireland for young people or for adults requiring a high secure forensic unit. People in need of these types of facilities are usually transferred to England.

Section 4

INTRODUCTION TO MENTAL HEALTH CONDITIONS, ISSUES AND PERSONALITY DISORDERS

This section provides an introduction to the range of mental health conditions, mental health issues, indicators of mental distress and personality disorders. The first section includes information specific to children and young people.

CHILDREN AND YOUNG PEOPLE

There are number of issues in relation to mental illness and mental health conditions that are specific to children and young people. Those under the age of 18 will still have developing brains and personalities and are less likely to have received a mental health diagnosis. This can be for a number of reasons including going through the already emotionally turbulent time of adolescence when mental health distress might be masked, lacking an awareness of own mental health distress symptoms and a reluctance by medical health professionals to provide a formal diagnosis to those who are not yet adults. In addition the abuse of alcohol, illegal drugs and 'legal highs' can both mask symptoms of mental ill-health and cause them to develop. Children and young people might also be more likely to be adversely impacted by the stigma still associated with a mental health condition.

Attachment issues

Children can develop difficulties forming appropriate and secure attachments with others for a number of reasons. Typically, this occurs when a child's experience of care-giving by parents or other carers has been negative including, for example, the parents or caregivers being emotionally absent or otherwise unavailable to meet the child's needs. The child might also experience physical, emotional and/or sexual abuse by parents of caregivers. A common reason why a parent might not be able to meet the emotional needs of their child is because they themselves have a severe mental health condition or, are addicted to alcohol or drugs. Children who develop attachment issues are more likely to be involved in anti-social or offending behaviour.

Self-harming

Mid-adolescence is a peak time for engaging in self-harming behaviour. Self-harming is primarily an inappropriate coping strategy. For this reason both young people involved in offending and those who have become victims might be engaged in it.

Previous experience of abuse, trauma or bereavement

Recent research by MindWise into the profile of young people supported by the Linked-In Project – Supporting Young People Leaving Police Custody showed that at least a quarter of those young people who engaged with the project had previous experience of abuse, trauma or bereavement. An estimated ten per cent had experience of living with a parent of carer who had a mental health condition themselves. Young people with experience of trauma, and in particular childhood abuse or neglect, are more likely to display the following behaviours:

- Difficulties in tolerating and controlling negative emotions
- The development of maladaptive or self-endangering behaviours
- The use of avoidance strategies especially emotional avoidance
- A mild to severe disassociation from reality (rather than a loss of reality like when experiencing psychosis)
- Substance abuse and self-harm
- Impulsive aggression
- Suicidal ideation

Conduct disorder

Psychiatrists will not diagnose anyone under the age of 18 with personality disorder as their personalities are still developing. A diagnosis of a 'Conduct Disorder' or an emerging 'Anti-social Personality Disorder' is sometimes made based on a history of behaviour before the age of 15 which involved bullying, physical violence, lying, stealing, vandalism or cruelty to animals etc.

Co-morbidity and Dual Diagnosis

You should be aware that most mentally vulnerable people will present with a range of issues rather than fitting neatly into a single category.

Co-morbidity means that someone has more than one mental health condition or issue, development disorder or disability. Anyone can experience mental health issues or develop a mental health condition.

Dual diagnosis is used to describe someone with a mental health condition or issue who also has a substance abuse issue. Many people with a mental health condition use drugs and alcohol to help them deal with the symptoms of their condition.

MENTAL HEALTH CONDITIONS

SCHIZOPHRENIA

What is Schizophrenia?

Schizophrenia is a severe mental health condition in which thinking and emotions can become so impaired that the person becomes psychotic (i.e. loses contact with reality). This involves inaccurate sensory input resulting in loss of contact with reality, leading to unusual and deviant behavioural and emotional responses, in turn leading to severe personal, social and occupational dysfunction.

What are common symptoms of Schizophrenia?

Positive Symptons	Negative Symptoms
Delusions that their thoughts and behaviours are controlled by outside forces, they are God or a famous person, all things that are happening revolve around them or that they are being persecuted by others	Slower to think, talk and move including lack of meaningful speech, toneless voice, flat emotions, and being vague and repetitive
Hallucinations in the form of hearing voices or seeing / smelling / feeling / tasting things which are not there. These voices can be perceived as someone else speaking their thoughts or someone else speaking. While voices can be supportive, most people with schizophrenia experience these as very negative and hostile.	Disorganised thinking and speech including shifting from one topic to the next without a clear connection and repeating words and statements over and over again
Indifferent to social contacts and a breakdown of social skills	Changed sleeping patterns and a lack of energy
Inappropriate behaviour	Long periods of motionlessness and silence

BI-POLAR DISORDER

What is Bi-polar Disorder?

Bi-polar Disorder is a severe mental health condition characterised by significant mood swings including manic highs and depressive lows. People with Bi-polar Disorder can be said to miss the brakes that other people have on their emotions. That means that even minor positive or negative events, like having an uplifting conversation with friends or someone being rude to them, can result in them becoming extremely elated or depressed. After this their mood can then swing to the opposite side again (i.e. from depressed to elated and vice versa) and this can continue for a considerable time.

Significant mood swings can take place over a period of months or within as short a period as half an hour which is referred to as Rapid Cycling. It is important for people with Bi-polar Disorder to avoid triggers for mood swings, as well as stress, as much as possible to avoid their condition deteriorating. People with Bi-polar Disorder have an increased risk of committing suicide when they are experiencing a low mood.

What forms of Bi-polar Disorder are there?

Currently Bi-polar Disorder is defined as Bi-polar Disorder I and Bi-polar Disorder II. People with Bi-polar Disorder II do not tend to experience psychosis as part of their condition, although they can display unrealistic levels of optimism. Bi-polar Disorder II also is more likely to involve Rapid Cycling and more periods of depression rather than high moods.

What are common symptoms of Bi-polar Disorder?

"Mania" (Bi-polar I) or "Hypomania" (Bi-polar II)	"Low Mood"
Feeling euphoric and experiencing everything as brighter and more beautiful	Extreme tearfulness at all times
Having positive delusions and hallucinations (Bi-polar I only)	Feeling sad, hopeless and guilty
Feeling inappropriately optimistic about own abilities, importance and attractiveness	Lacking energy and motivation
Feeling full of energy and great new ideas and having racing thoughts	Having obsessive negative or pessimistic thoughts which are often illogical
Starting many new plans and projects which are often unrealistic	Feeling extremely anxious

Engaging in risk-taking behaviour like spending large amounts of money, having unsafe sex or not taking care of their personal safety or wellbeing	Having difficulty concentrating
Behaving inappropriately including laughing inappropriately, invading personal space or being overly familiar	Lacking motivation even in relation to serious issues that might affect them
Speaking much faster	Withdrawal from social situations
Getting easily irritated with people who cannot keep up with their ideas	Not taking care of personal hygiene
Not feeling like sleeping and staying awake for long periods of time	Wanting to sleep all the time
Unusual sensitivity to light, sound and touch	Suicidal ideation

"Mixed State"	
Where a person experiences symptoms of Mania or Hypomania at the same time as a low Mood which carries a higher risk of suicide	For example, combines feeling extremely anxious with psychosis or feelings of hopelessness with being unable to sleep

CLINICAL DEPRESSION

What is Clinical Depression?

Clinical depression is a mental health condition in which the person feels persistently sad for weeks, months or even years. The term clinical depression is often used when there is no obvious reason for someone to be depressed, like experiencing a bereavement or long-term unemployment. It is thought that this type of depression is the result of a naturally occurring chemical imbalance in the brain. This type of depression can often be difficult to treat as it does not respond well to therapy or medication.

What are common symptoms of Clinical Depression?

Psychological Symptons	
Feeling hopelessness	Feeling tearful
Having no motivation or interest	Getting no enjoyment out of life
Feeling worried and anxious	Feeling irritable of others
Having no motivation or interest in things	Finding that thoughts have slowed
Having low self-esteem	Engaging in self-harming
Finding it difficult to make decisions	Having suicidal ideation
Physical Symptons	
Speaking or moving more slowly than usual	Unexplained aches and pains
Lack of energy	Waking up very early in the morning
Change in appetite or weight	Loss of libido
Not taking care of personal hygiene	Constipation
Social Symptons	
Avoiding friends and social activities	Low mood affecting relationships

OBSESSIVE COMPULSIVE DISORDER

What is Obsessive Compulsive Disorder?

Obsessive Compulsive Disorder (OCD) is a mental health condition which involves obsessive thoughts which make the person feels anxious, disgusted or unsafe (either in relation to self or others). Compulsive behaviours or mental acts are used in a repetitive manner to ease these thoughts and thereby temporarily relieve these thoughts.
What are common symptoms of Obsessive Compulsive Disorder?

What are common symptoms of Obsessive Compulsive Disorder?

People with OCD will follow this cycle:	
1. Obsessive thoughts	› Fear of deliberately or accidentally harming themselves or others › Fear of disease or contamination › Need for symmetry or orderliness
2. Anxiety or distress	
3. Compulsive behaviours (Not all these behaviours are obvious when you first meet the person or just for a short time. Many people with OCD will also try to mask their symptoms as they are aware these are irrational.)	Including obsessively and repeatedly: › Checking that doors are locked, gas is turned off etc. › Cleaning and hand washing › Touching things a set number of times › Hoarding › Trying to think 'neutralising thoughts' › Ordering and arranging › Counting › Repeating words silently
4. Temporary relief	Then back to the start of the cycle with obsessive thoughts

People with OCD will appear distracted as they are over-thinking or engaged in mental acts like thinking 'neutralising' thoughts, repeating words or counting in their heads	It might be useful to let the person complete any rituals or thoughts so that they can concentrate on what you want to talk to them about directly after that
People with OCD might ask for constant reassurance about seemingly minor or illogical issues	When working with people with OCD in a clinical setting, it is good practice to not provide reassurance when asked for it. However, as a short term measure it might be useful to do this to (temporarily) reduce anxiety

MENTAL HEALTH ISSUES

GENERALISED ANXIETY DISORDER

What is Generalised Anxiety Disorder?

Generalised Anxiety Disorder is an anxiety disorder which causes people to feel anxious most days about a wide range of situations and issues. Research has suggested that Generalised Anxiety Disorder might have a number of causes including an imbalance of certain brain chemicals resulting in over-activity in the brain involved in emotions and behaviours. This is often combined with previous experience of trauma, abuse or bereavement and, drug of alcohol abuse. Recent research has shown that experiencing anxiety poses a greater suicide risk than having depression.

What are the common symptoms of Generalised Anxiety Disorder?

Psychological Symptons	Irritability
Restlessness	A constant sense of dread
A constant feeling of being on edge	Difficulty concentrating
Physical Symptons	
Dizziness	Difficulty swallowing
Trembling or shaking	Tiredness
Shortness of breath	Stomach ache
Dry mouth	Excessive sweating
Muscle aches and tensions	Palpitations

POST TRAUMATIC STRESS DISORDER

What is Post Traumatic Stress Disorder?

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder caused by experiencing stressful, frightening or distressing events including natural disasters, serious accidents, prolonged abuse or violence, serious assaults, experiencing combat or becoming a victim of a terrorist attack. PTSD mostly develops within a month of experiencing such an event but can appear months or even years later.

What are the symptoms of Post Traumatic Stress Disorder?

Re-experiencing	Avoidance
Vivid and involuntary flashbacks, nightmares and sensations like smells and sounds	Avoiding certain people or place that might remind them of the event.
Physical symptoms like pain, sweating and trembling	Avoiding talking about their experience
Intrusive negative thoughts about why this happened to them or how they could have stopped it from happening; feelings of shame and guilt	

Emotional Numbing	Hyperarousal
Trying not to feel anything at all	'Feeling on edge' all the time and constantly being aware of real or perceived threats
Becoming isolated and withdrawn	Irritability, angry outbursts, insomnia and difficulty concentrating

STRESS AND ANXIETY

What are stress and anxiety?

People have different life experiences and also have different levels of resilience when it comes to dealing with the issues they face. These are the reasons why some people might experience stress and anxiety while others do not. Stress and anxiety are the feelings of being under too much mental or emotional pressure worrying constantly. It is a sign that a person is not coping well with issues that they are facing in their everyday life, including their contact with the CJS.

What are the symptoms of stress and anxiety?

Head aches	Muscle tension
Dizziness	Sleeping problems
Tiredness	Constant worrying
(Also see Generalised Anxiety Disorder – Symptoms)	

DEPRESSION

What is Depression?

Depression is a low mood because of something that has happened or is happening to you or people you care about. Depression is different from feeling a bit low as it does not go away within a couple of weeks.

What are the symptoms of Low Moods and Depression?

For more than a couple of weeks experiencing feelings of:	
Sadness	Worry
Tiredness	Anger and frustration
Anxiety	Low self-esteem
Tearfulness	Suicidal or self-harming ideations
(Also see Clinical Depression – Symptoms)	

OTHER INDICATORS OF MENTAL DISTRESS

PANIC ATTACKS

What are Panic Attacks?

Panic attacks are a rush of intensive feelings and physical symptoms due to an overwhelming sense of fear lasting between five and twenty minutes.

What are the symptoms of a Panic Attack?

An overwhelming sense of fear	Palpitations
Shortness of breath	Sweating
Trembling	A choking sensation
Chest pain	Feeling sick

SELF-HARMING

What is self-harming?

Self-harming is intentionally injuring the body as a way of coping with or expressing mental distress or punishing themselves. Young people, those experiencing psychotic episodes and those with a Personality Disorder are particularly at risk of self-harm. With the agreement of their Psychiatrist, some people you come across might engage in self-harming in a controlled environment using for example sterile scalpels.

What types of self-harming are there?

- Cutting, pinching or burning their skin
- Taking overdoses or poisoning themselves
- Misusing alcohol and drugs
- Punching themselves or banging their head off walls
- Deliberately starving themselves or binge eating
- Engaging in unsafe sex or putting their personal safety at risk in other ways

PSYCHOSIS

What is Psychosis?

Psychosis is a mental health problem that causes people to perceive and interpret things differently from those around them severely disrupting thinking emotions and behaviours. The two forms of psychosis are hallucinations and delusions. Hallucinations involve mostly hearing voices, but also seeing, smelling or tasting, things that are not there. Delusions involve a person believing things that are obviously untrue. Most experiences of hallucinations and delusions are negative and hostile but some people might experience these as positive and comforting.

Some people who might experience psychoses on a regular basis might be able to mask them for a short or even longer period. Others can be so acutely unwell and in distress that they are easily identifiable. Psychosis is not a permanent state of being but rather an episode that might never reoccur or reoccur only occasionally.

What causes psychosis?

- Mental health conditions like schizophrenia, Bi-polar Disorder I, and severe Clinical Depression can cause psychoses, especially were medication has not been taken
- Severe stress and anxiety over a long time
- Alcohol and drug misuse (especially cannabis)
- Long-term lack of sleep often associated with a chaotic lifestyle
- A range of general medical conditions
- No clear reason that can be established during or after the episode

SUICIDAL IDEATION

What is Suicidal Ideation?

Suicidal Ideation is the desire to intentionally end your life as a result of feeling overwhelmed by negative feelings.

What makes someone vulnerable to experiencing suicidal ideation?

- Having a mental health condition like Schizophrenia, Bipolar Disorder or Depression or a Borderline Personality Disorder
- Experiencing a psychosis for reasons other than a mental health condition especially if it is the first time
- Experiencing extreme stress and anxiety due to stressful events
- Misusing alcohol and drugs
- Experiencing social and economic deprivation
- Having experienced bereavement, trauma or abuse
- Being isolated from family and friends, disengaged from mental health services and institutions that might monitor their mental wellbeing like school, work & youth club

What are the warning signs of suicidal ideation?

- **Actually threatening to hurt or kill themselves**
- **Talking or writing about death or suicide**
- **Actively looking for ways to kill themselves like stockpiling tablets or making nooses**
- Becoming increasingly withdrawn from family, friends as well as health and support services
- Saying things like: *"What is the point of things anyway", "I know things are never going to get better"* or *"I feel trapped and do not see a way out."*
- Acting recklessly and engaging in dangerous activities without a concern for the consequences should things go wrong
- Having episodes of sudden anger and rage
- Seemingly putting their affairs in order before such as sorting out possession and making a will
- A sudden lift in mood which could indicate that they have made a decision to attempt suicide

PERSONALITY DISORDERS

What is a Personality Disorder?

A Personality Disorder develops where a person is unable to adapt their behaviour to cope with the more challenging aspects of life. Their personality types are the result of learned past behaviour and inappropriate coping strategies. People with a Personality Disorder tend to hold strong beliefs about the world around them and the motivations of other people. They tend to react to each and every situation they come across in the same manner and do not learn from what happens to them or change their behaviour as result.

A diagnosis of Personality Disorder can only be made if a person's personality and behaviours are problematic to themselves or others are persistent from adolescence into adulthood and affect a number of different areas in the person's life. Personality Disorders can be difficult to diagnose and can result in difficulty in engaging effectively with health services or CJS interventions. Between 12 and 15 different Personality Disorders have currently been classified. In this guide only the Personality Disorders which can result in people coming in regular contact with the CJS system will be discussed.

Information on Care Pathways

Health & Social Care Board, Regional Care Pathway for Personality Disorders, HSCB (October 2014)

BORDERLINE PERSONALITY DISORDER

Borderline Personality Disorder is the most common personality disorder for women. It is also known as an "emotionally unstable personality disorder". The term "Borderline" does not mean that the person does not have a full personality disorder. Borderline Personality Disorder and Bi-polar Disorder II can have very similar symptoms.

However, people in the last group do tend to learn from their experiences and change their behaviour accordingly. People with a Borderline Personality Disorder diagnoses often have previous experience of trauma and abuse, and often become serial victims due to domestic abuse. People with this type of personality disorder are also often seen in A&E or in prison serving short-term sentences.

Signs that someone might have a Borderline Personality Disorder are:

- Difficulty forming healthy relationships and instead engaging in unstable and emotionally intensive relationships
- Fearing rejection or abandonment by partners or individual health professionals they have developed a relationship with
- Strongly seeing themselves as part of couple or having a strong relationship with an individual health / CJS professional whom they can idealise
- Difficulty managing emotions and experiencing severe mood swings
- Being impulsive and engaging in dangerous activities putting their personal safety and health at risk
- Having an eating disorder
- Having previous experience of serious self-harming and suicide attempts

ANTI-SOCIAL PERSONALITY DISORDER

Anti-social Personality Disorder is the most common personality disorder among men who offend.

Signs that someone might have an Anti-social Personality Disorder are:

- Previous experience of coming into contact with the CJS or being involved in offending
- Being impulsive without considering the consequences or impact on others
- Lacking empathy and sounding 'scripted' when discussing emotions
- Being physically violent and getting into a lot of fights
- Having difficulty holding down a job or staying in education or training
- Lying frequently and without difficulty
- Enjoying doing risky things
- Dependency on alcohol and drugs

NARCISSISTIC PERSONALITY DISORDER

Narcissistic Personality Disorder is less common that Anti-social Personality Disorder but it is more common among people in contact with the CJS.

Signs that someone might have a Narcissistic Personality Disorder are:

Often manipulating and taking advantage of other people.

- Delusions of grandeur in both fantasy and behaviour believing themselves special
- Feeling undervalued or unrecognised for their achievements
- Believing that other people are jealous of them
- Needing attention and admiration
- Lacking empathy

PARANOID PERSONALITY DISORDER

A person with Paranoid Personality Disorder is more likely to come into contact with the CJS due to them making threats, taking revenge, carrying out what they would consider pre-emptive strikes or being involved in domestic abuse and control.

Signs that someone might have a Paranoid Personality Disorder are:

- Seeing other people as hostile, exploitative and persecuting them
- Responding quickly with anger or counter attacks to perceived threats
- Searching for hidden meanings to confirm suspicions of disloyalty, untrustworthiness and cheating
- Reluctant to confide in others and rejecting help when offered
- Bearing grudges and long-standing disproportionate resentments
- Making repeated threats or instigating grievances on a regular basis especially against a particular person.

Personal Experience

J. is a 26 year old woman who was convicted of a serious assault on a man, resulting in her being subject to a three year Probation Order. She has a diagnosis of Borderline Personality Disorder (also known as Emotionally Unstable Personality Disorder).

As a child, J. was known to Social Services and spent periods in foster care and residential children's homes. From adolescence she led a transient life, including periods of homelessness, moving across Trust areas and with no contact with her family and minimal social support. J. has been the victim of domestic abuse within intimate relationships. Many of her previous housing placements have broken down due to her substance abuse, unstructured and chaotic lifestyle.

J was referred to the PBNI Psychology Department at the case management stage for assessment. The referring probation officer suspected that she may have intellectual deficits and was also concerned about her perceived vulnerability in the community. It was suspected that she was being exploited by others and she was not linked with any community mental health or addiction services.

Once J. had engaged with a preliminary psychological assessment, it was identified that referrals were warranted for further interventions from the community learning disability service as well as to the community mental health team (in order that she might access addiction and personality disorder services, as appropriate). This case is currently being managed on a multi-agency basis with the involvement of the community forensic mental health team and PBNI.

APPENDIX A: MEDICATIONS FOR MENTAL HEALTH CONDITIONS AND ISSUES

Medications to treat mental health issues or reduce symptoms can be divided in four categories:

Type of Medication	For Treatment Of
Anti-depressants	› Depression › Low moods in Bipolar Disorder › Some forms of anxiety › OCD › Eating disorders
Anti-psychotics	› Psychosis › Schizophrenia › Mania or hypomania associated with Bipolar Disorder I and II › Rapid cycling associated with Bipolar Disorder II › Severe anxiety › Sometimes for a Personality Disorder
Mood stabilisers	› Bipolar Disorder › Recurrent severe depression › Aggression › Reducing the risk of fits associated with certain anti-psychotics › Sometimes for a Personality Disorder
Sleeping pills and tranquillisers	› Severe anxiety › Severe insomnia

People with mental health conditions might be taking more than one type of medication at the same time. For example, someone with Bipolar Disorder could develop frequent manias or hypo-manias when taking certain types of anti-depressants. However, if this medication is taken together with an anti-psychotic, this often will address the many low moods a person might be experiencing.

In addition, you might come across people who have been prescribed medication to address their substance abuse issues in relation to alcohol, opiates or heroine. Others

might have been prescribed medication to dampen their urges to reoffend and this usually comes in the form of an injection.

Most medications are taken in tablet form, but some also come in liquid form or are administered via an injection. Some medications for Schizophrenia, including Clozapine which is also known as Azaleptin, Clopine, Clozaril, Denzapine, Fazaclo and Froidir, need to be taken at exactly the same time each day. Even a slight delay can result in the person having to start building up their drug-taking regime again.

Just because medication has been prescribed, do not assume that the person is actually taking it or taking it as often as they should. Some symptoms of mental health distress can be a very positive experience which the person does not want to address. At the same time many medications for mental health conditions can have severe and unpleasant side effects. Remembering to take medication can also be difficult when someone is unwell, is arrested or becomes a victim. It also can take a considerable time for the right balance of medications to be established, and sometimes medication is not effective at all for unclear reasons.

This website lets you enter brand or generic names of medications and then provides you with information about it: www.choiceandmedication.org/hscni

APPENDIX B: ACCESSING SUPPORT WHEN A PERSON IS AT RISK OF SEVERE AND IMMEDIATE HARM

Please note that this guidance does not replace local protocols your organisation might have in place.

Severe and immediate harm includes recent severe self-harming or immediate plans to engage in this. This includes having access to tools to carry this out or, access to tablets or poisons. Disclosure of having taken an overdose or ingesting a poisonous substance should always be considered a severe and immediate risk until, if or when, this has been assessed by a medical professional.

In relation to suicidal ideation, severe and immediate harm relates to any immediate plans a person might have to commit suicide now, as soon as they have left you or in the next couple of days. Having immediate plans means that they have thought about how they are going to commit suicide and, what to get or where to go to carry this out. This does not include mentioning that they feel suicidal in general as this might be instead an attempt to reach out to you and therefore it is important not to panic and close down any conversation. For some people experiencing mental health distress, talking about suicide might be a coping strategy to let off steam as knowing that this option is available to them.

At all times trust your own instinct. It is better to have taken action when it was not really needed after all, than take a serious risk.

If	Then
The person has done serious harm to themselves or has immediate plans to self-harm severely or commit suicide and has immediate access to means to do so	› Take them to A&E or phone an ambulance › If the person does not want to go to hospital, phone the police on 999
If the person discloses that they feel suicidal and/or have plans to severely harm themselves in the immediate future	› Check with the person if they have their own Care Plan or a WRAP Plan as this will provide emergency contact details for this person › Where this is no Care Plan or WRAP Plan in place, make an emergency appointment with the person's GP or GP out-of hours service (See Appendix A) The emergency contact in the person's Plan or the GP can then make a referral to the local Trust's Mental Health Team If this person does not want you to contact anyone, try and agree a safeguarding plan as taught in suicide prevention training you might have attended previously; This would include details of the 24-hour Lifeline Service (Appendix A)
If the person discloses that they feel suicidal and/or feel they might harm themselves in future	› Advise them to contact their GP for further support and any referrals › Provide details of Lifeline

APPENDIX C – USEFUL CONTACTS

OUT-OF-HOURS GP SERVICES	
North & West Belfast	› 028 9074 4447
South & East Belfast	› 028 9079 6220
Southern Trust Area	› 028 3839 9201
North Down & Ards,	› 028 9182 2344
Lisburn & Downpatrick	› 028 9260 2204
Northern Trust Area	› 028 2566 3500
Western Trust Area	› 028 7186 5195

HELP LINES	
LifeLine Life Line text phone	› 0808 808 8000 (free of charge) › 18001808 8000 (free of charge)
If you, or someone you know, is in distress or despair, call Lifeline. Lines are open 24 hours a day, seven days a week.	Calls to Lifeline are answered by trained counsellors who can provide help and support.
Samaritans	› 08457 90 90 90 › jo@samaritans.org
Child Line	› 0800 1111

OTHER SUPPORT SERVICES
A full list of support services in your area can be found in your local area at: www.publichealth.hscni.net/publications/directory-serviceshelp-improve-mental-health-and-emotional-wellbeing
'Minding Your Head' website for a list of local services: www.mindingyourhead.info

MINORITY IDENTITY GROUPS	
Minority Sexual Orientation	› The Rainbow Project 028 90319030
Trans-gendered	› Cara-Friend 028 90278636
All Disabilities	› Disability Action 028 90297880 or text phone 028 90297882
Learning Disabilities	› Mencap 0808 808 1111
Autism Spectrum Disorder	› Autism NI 028 90401729
Minority Ethnic Background	
NI Council for Ethnic Minorities	› 028 90238645
Chinese Welfare Association	› 028 90288277
An Munia Tober	› 028 90438265

VULNERABLE VICTIMS AND WITNESSES	
Registered Intermediaries Scheme	› 028 9052 0554 › intermediaries@dojni.x.gsi.gov.uk
Victims and Witnesses Care Unit	
Belfast Office	› 028 90544797 › vwcubelfast@ppsni.gsi.gov.uk
Foyle Office	› 028 71340632 › vwcufoyle@ppsni.gsi.gov.uk
Special Measures	The Public Prosecution Service, the NSPCC and Victim Support can advise on this.
NSPCC Young Witness Service	
Antrim	› 028 94487533
Belfast	› 028 20441650
L'Derry	› 028 71279555
Newry	› 028 30834849
Portadown	› 028 38349381
Victim Support NI	› 028 90243133

APPENDIX D - FURTHER READING

Centre for Mental Health, Personality Disorder – A Briefing for People Working in the Criminal Justice System, Centre for Mental Health (January 2009)

Centre for Mental Health, Briefing 39 – Mental Health Care and the Criminal Justice System, Centre for Mental Health (2011)

Centre for Mental Health, Briefing 45: Probation Services and Mental Health, Centre for Mental Health (December 2012)

Centre for Mental Health, Childhood Behavioural Problems: A Briefing for Prison Officers, Centre for Mental Health (January 2014)

Department of Health, Working with Personality Disordered Offenders – A Practitioners Guide, DoH (January 2011)

Department of Justice, Achieving Best Evidence in Criminal Proceedings – Guidance on Interviewing, Victims and Witnesses, the Use of Special Measures, and the Provision of Pre-trial Therapy, Department of Justice (January 2012)

Department of Justice, Achieving Best Evidence in Criminal Proceedings – Guidance on Interviewing, Victims and Witnesses, the Use of Special Measures, and the Provision of Pre-trial Therapy, Department of Justice (January 2012)

Durcan, G., Keys to Diversion – Best Practice for Offenders With Multiple Needs, Centre for Mental Health (April 2014)

McConnell, P. and Talbot J., Mental Health and Learning Disabilities in the Criminal Courts – Information for Magistrates, District Judges and Court Staff, Prison Reform Trust and Rethink Mental Health (2013)

Mind For Better Mental Health – Achieving Justice for Victims and Witnesses with Mental Distress – A Mental Health Toolkit for Prosecutors and Advocates, Mind (2010)

Northern Ireland Commissioner for Children and Young People, She's a Legend – The Role of Significant Adults in the Lives of Children and Young in Contact with the Criminal Justice System, NICCY (December 2012)

Public Health Agency, Improving the Lives of People Who Self-harm, PHA (February '15)

Talbot, J, Seen and Heard – Supporting Vulnerable Children in the Youth Justice System, Prison Reform Trust (2010)

Wright, S. Dr. And Liddle M., Young Offenders and Trauma: Experience and Impact A Practitioner's Guide, Beyond Youth Custody (2014)

Youth Justice Board for England and Wales, Screening for Mental Disorders in the Youth Justice System – Youth Justice Board for England & Wales (Not dated)

Department of
Justice
www.dojni.gov.uk

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Accessing Fair Justice and Improving Mental Health Outcomes