The effects of witness mental illness and use of special measures in court on individual mock juror decision-making

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It is unclear whether witness mental illness and special measures used with witnesses in court impacts juror decision-making. Participants (*N*=204) from the general public and student population completed a measure assessing attitudes towards mental illness before reading a mock trial vignette where witness mental illness (depression, schizophrenia, no mental illness) and the special measure used in court (screen, intermediary, no special measure) were manipulated. Participants were then instructed to formulate judgements about the witness testimony provided (reliability, competency, credibility) and their likelihood of finding the defendant guilty. The findings showed that witnesses with depression were perceived as significantly more competent than witnesses with schizophrenia, or with no mental illness. Witnesses with depression were also perceived as significantly more competent than witnesses with schizophrenia when a screen was used in court. There was however no difference in competency ratings for witnesses with depression versus those with schizophrenia when no special measure was used, or when an intermediary was used, although witnesses with depression were still viewed more favourably overall. These findings suggest that some awareness of these biases is needed in court. Improving clarity about why special measures are used in court might also go some way towards addressing this issue.

Keywords: witness mental illness; special measures; intermediary; screen; jury decision-making

Introduction

Stigma towards individuals suffering from mental illness is common in society (Oexle & Corrigan, 2018; Rüsch et al., 2005), with research showing it to be both a cross-diagnostic (Mannarini & Boffo, 2015) and cross-cultural phenomenon (Abdullah & Brown, 2011; Mannarini et al 2017, 2018). In relation to mental health, stigma can be defined as beliefs and

attitudes associated with the perception of mental illness as an undesirable characteristic that discredits a person and may result in social distancing behaviours and discrimination (Jones et al., 1984; Link & Phelan, 2001). As one of the public's primary sources of information about mental health (Mossiere & Maeder, 2015), the overwhelmingly negative depiction of mental illness in the media is thought to be a significant contributor to the stigmatisation of individuals with mental illnesses (Ben-Zeev et al., 2010; Hyler et al., 1991; Philo et al., 1994; Signorielli, 1989). Of concern, however, research suggests that stigma and discrimination towards individuals with a mental illness can have worse consequences than the conditions themselves (Thornicroft et al., 2016). Although initiatives exist around the world that are designed to reduce stigmatisation towards mental illness, research suggests that they tend to produce only short- to medium-term knowledge about mental illness and, less often, attitudinal improvements (Clement et al., 2013; Higgins et al., 2011). It is clear, therefore, that much more must still be done to address, and reduce, the stigma associated with mental illness in society.

The criminal justice system is one important area within which to understand the impact of stigmatisation on individuals with mental illnesses. To date, much of the research within the criminal justice domain has focused on rehabilitation initiatives in prisons for people with a mental illness upon release into the community (e.g., Brandt, 2012; Farnworth & Munoz, 2009; Forrester et al., 2018). However, less research has explored the impact of mental illness related stigma during courtroom trial proceedings. Of the work that does exist, research has tended to focus on defendant mental illness and the impact that this can have on juror decision-making (e.g., Barnett & Appelbaum, 2010; Berryessa et al., 2015; Sandys et al., 2013; Termeer & Szeto, 2021; Wolbransky, 2011). To our knowledge, there is currently no direct evidence that exists concerning the decision-making of jury members when witnesses with a mental illness give evidence in court. Furthermore, it is currently unknown

as to whether the use of special measures for witnesses with a mental illness impacts juror decision-making. The Youth Justice and Criminal Justice Evidence Act (YJCEA, 1999) in England and Wales, the Criminal Evidence (Northern Ireland) Order (1999) in Northern Ireland, and the Criminal Procedure (Scotland) Act (1995) in Scotland, grants vulnerable and intimidated witnesses, including those diagnosed with a mental illness, the use of alternative trial arrangements in situations when the courts are satisfied that this will maximise the quality of a witness's testimony (Ellison & Munro, 2014). The aim of the current study was to therefore explore the issue of juror stigma towards witnesses with a mental illness and to determine whether the use of special measures influences the decision-making process.

Beliefs About Mental Illness

The stigmatisation of individuals is thought to develop from labelling differences between one person and others (Link & Phelan, 2001). With regard to mental illness, evidence suggests that when individuals are given a label, such as "depressed" or "schizophrenic", this separates *us* from *them*, providing justification for excluding, or devaluing, them as people (Link & Phelan, 2001). Although the knowledge of mental illness is thought to have somewhat improved (Kendler & Prescott, 2006; Schnyder et al., 2018), research shows that people still perceive individuals with a mental illness as dangerous, unpredictable in their behaviour, and more likely to lose control (Angermeyer & Matschinger, 2005; Walker & Read, 2002), which in turn, can lead to social distancing behaviours and a fear of people with mental health conditions (e.g., Appelbaum & Scurich, 2014; Pescosolido et al., 1999). This perception is thought to persist despite research showing that the relationship between many mental illnesses and violent behaviour does not exist (McGinty et al., 2018; Walker & Read, 2002) and only a minority of people with mental illnesses are in fact violent (e.g., Link et al., 1999).

There are, however, often notable differences in people's perceptions of individuals labelled with different mental illnesses, with research suggesting that certain types of mental illness are perceived more negatively than others. For example, in a British survey where respondents were asked questions about specific mental illnesses, the most negative views were expressed about those individuals with schizophrenia, alcoholism, and drug dependence (Crips et al., 2000). These preconceptions mirror those demonstrates in other countries (e.g., the USA - Pescosolido et al., 1999). Additionally, people have been found to maintain greater social distance from individuals labelled with "schizophrenia" than with "depression" (e.g., Angermeyer & Matschinger, 2003; Angermeyer et al., 2004; Crisp et al., 2000; Griffiths et al., 2006; Lauber et al., 2004; Marie & Miles, 2008), which is likely the result of people labelled with "schizophrenia" being perceived as more untrustworthy, unpredictable, irrational, and violent compared to individuals labelled with "depression" (e.g., Angermeyer et al., 2004; Angermeyer & Dietrich, 2006; Berryessa et al., 2015; Corrigan et al., 2000; Meltzer & Rowlands, 2000; Schomerus et al., 2010). Research also suggests that individuals with depression are perceived as having a better prognosis overall compared to those with schizophrenia (Goerg et al., 2004; Hugo et al., 2003; Schomerus et al., 2006). This is thought to arise from people assuming that depression has less of a biological basis than schizophrenia (Angermeyer & Matschinger, 2003; Schomerus et al., 2006). The belief that people with depression have more personal responsibility for the onset of their illness compared to schizophrenia (Jorm et al., 1997) might also contribute to this perception.

Stigmatisation and the Criminal Justice System

In common law countries, criminal trial courts operate an adversarial justice system whereby two advocates represent their parties' case before an impartial group of people, known as a jury, attempt to determine the truth and pass judgement on the guilt of the defendant. In the United Kingdom, serious criminal cases are typically observed in Crown

Courts whereby 12 individuals randomly selected from the population to be members of the jury are asked to consider evidence and settle on a verdict. Jurors therefore have a pivotal role in the deliberation of defendant guilt (Bornstein & Greene, 2011) and are asked to decide the outcome of a case based solely on the evidence given at trial, the instructions given by the trial judge, and to make their decision without sympathy, prejudice, or fear (Mossiere & Maeder, 2015; Thomas, 2010).

Although jurors are meant to remain impartial, individual members are likely to bring with them their previous life experiences, knowledge, and biases, all of which can impact upon the decision-making process (Colwell, 2005; Louden & Skeem, 2007; Nikonova & Ogloff, 2005). Indeed, research has shown jurors to be influenced by the sex (e.g., Maeder & Dempsey, 2013; Thomas, 2010), race (e.g., Kemmelmeier, 2005; Mitchel et al., 2005), age (e.g., Pozzulo & Dempsey, 2009; Pozzulo et al., 2010), and attractiveness of the defendant (e.g., Kutys, 2012; Maeder et al., 2015; Pozzulo & Dempsey, 2009). Pre-trial publicity (e.g., Kramer et al.,1990; Ruva et al., 2006; Taylor & Tarrant, 2019), the comprehension of legal terminology and complex material (e.g, Gilovich et al., 2001; Trimboli, 2008), and the use of expert witnesses in court (e.g., Crowley et al., 1994; Geiselman et al., 2002; Klettke et al., 2010; McKimmie et al., 2004; Schuller & Cripps, 1998) have also been found to impact on decision-making. Such biases may be explicit, or conscious, meaning that individuals are aware that they are making decisions based on biases such as those outlined above. However, many of these biases are implicit, or unconscious, meaning that an individual is not aware that their decision-making is affected by these biases (Rachlinski et al., 2008). In a recent meta-analysis, only a weak association was found between implicit biases and racial and ethnic discrimination when measuring biases using the Implicit Association Test (IAT) (Carlsson & Agerstrom, 2016; Oswald et al., 2013). This might therefore suggest that implicit biases are not problematic to the trial process and procedural fairness in the courtroom.

However, these studies were specifically assessing whether the IAT, as an implicit measure, can meaningfully predict discrimination. Of particular concern for the purposes of the present research are the findings that implicit biases are known to be pervasive and can affect crucial juror functions including the evaluation of evidence, recall of facts, and judgement of guilt (Roberts, 2012).

Mental Illness and Decision-Making in Court

In terms of mental illness, research has tended to focus on the mental health of the defendant and the impact that this can have on juror decision-making. The evidence suggests that particularly strong and negative attitudes are often attached to individuals who are labelled with both a mental illness and as an offender, which in some cases can result in the wrongful conviction of an innocent person (Lamb & Weinberger, 1998). In a review of archival data from court cases, Wolbransky (2011) found that jurors were more likely to assign harsher verdicts and recommend the death penalty to individuals who were described as mentally, or emotionally, "disturbed". Thus, when deliberating guilt, the defendant's diagnosis could be viewed as an aggravating factor, which increases culpability for the crime committed (Berryessa et al., 2015; Sandys et al., 2018).

Alternatively, some studies suggest that mental illness might be viewed more sympathetically and serve as a protective factor against severe punishment by providing a reason for an individual's anti-social behaviour (Barnett & Appelbaum, 2010; Barnett et al., 2004). Indeed, Garvey (1998) found that mock jurors were less likely to vote for the death penalty if the defendant is reported to have a mental disorder, and Sabbagh (2011) found that that defendants with a mental illness were given more lenient sentences than those without a mental illness diagnosis. Additionally, certain mental illnesses were viewed more favourably than others in the courtroom, whereby defendants with schizophrenia were given more "not

guilty" verdicts (Termeer & Szeto, 2021), more lenient sentences (Murdoch, 2018), and attributed less blame (Fenwick, 2011) than defendants with depression or with no mental illness. These findings are consistent with the patronisation effect (Gibbons et al., 1979) which suggests that people are more likely to attribute the behaviour of vulnerable individuals to external, rather than internal factors. As a result, people believe vulnerable individuals to be less responsible for their actions and driven by the inaccurate preconception that they are incompetent and do not lack control over their own lives (Najdowski et al., 2009). Others, however, have found no impact of mental illness type (including schizophrenia, depression, substance abuse, and obsessive-compulsive disorder) on the decision-making of jurors (e.g., Mossiere & Maeder, 2015).

To our knowledge, there is no direct evidence concerning the decision-making of jury members when *witnesses* with a mental illness give evidence in court. However, this is an important area of investigation as it has long been thought that both the competency of the witness to testify and the credibility assigned to that testimony, are determinative of the outcome in court (Ermert, 1989). If this is the case, it is important to understand what impact witness mental might have on decisions made by the jury. Although jury members are unlikely to be directly informed about the witness's mental health, the opposing party may choose to question the witness about their condition and any associated symptoms present during their observation of the crime. The opposing party may also choose to call an expert witness to the stand with the purpose of explaining to the jury about the impact that a particular mental illness can have on a person's ability as a witness. In such circumstances, members of the jury will become aware of the witness's mental illness when testifying in court. However, if certain biases around mental illness exist, jurors might run the risk of evaluating these individuals based on stereotypes rather than taking the whole picture of how they presented themselves at the stand (Su, 2020). Consequently, if a jury member dismisses

a witness because of some bias that they might, or might not, be aware that they are employing, then the trial process becomes less fair (Su, 2020).

Of further concern, are the challenges in acquiring the testimony of someone with a mental illness in court. Indeed, many of the common features of the court environment and criminal justice process can be triggers for mental distress and may exacerbate symptoms (Mind, 2010). Therefore, there may be no question as to the ability of a witness with a mental illness to testify - the witness is still able to recount events, they know the difference between the truth and a lie, and they understand that false statements are punishable as crimes (Mueller & Kirkpatrick, 2000). Nevertheless, the pressure of testifying in a court environment combined with the witness's mental illness may prevent them from reaching their full capacity on the stand (Barnett & Appelbaum, 2010). Lastly, it should be acknowledged that there is an increasing likelihood with which people who have a mental illness might be asked to testify as a witness in court. At present, there are no official, published statistics on the number of witnesses giving evidence who are classed as vulnerable or intimidated in some way (Fairclough, 2020). However, it is thought that at least 1 in 4 people suffer from some form of mental illness in the UK (Mind, 2010), and, along with the rest of the population, these individuals can also be witnesses to a crime. Furthermore, as some researchers have previously noted, the growing prevalence of community-based treatment, and thus an individual's presence in the community, could make them more likely to be the observers of criminal events (Barnett & Appelbaum, 2010).

Research with other vulnerable witnesses giving evidence in court is also limited. However, the findings of these studies may provide some indication as to how witnesses with a mental illness might be perceived. For instance, Stobbs and Kebbell (2003), found that while mock jurors perceived witnesses with learning disabilities to be fundamentally honest, they are reluctant to rely on the evidence provided by these witnesses when making decisions

in court. Witnesses with mental illnesses are also likely to face additional challenges in court. For example, mental illness, along with the pressure of providing accurate evidence, could lead to an individual feeling fearful of, or intimidated by, the court process and believing they will be judged as an unreliable witness that is not taken seriously (Barnett & Appelbaum, 2010). In some circumstances, the perceived stigma could worsen symptoms further, or lead to that person becoming unresponsive, meaning the individual is unable to provide reliable evidence in court (Barnett & Appelbaum, 2010; Kobau et al., 2010). This might lead to a risk of psychological harm to them, and for the party for whom they are testifying (Barnett & Appelbaum, 2010). The present study will address this gap by determining whether jury decision-making is affected by witness mental illness. Specifically, the study will explore any differences in decision-making when a witness has schizophrenia, a mental illness known as having a higher degree of stigmatisation, compared to when a witness has depression, a mental illness that has received less stigmatisation in society.

The Use of Special Measures in Court

In accordance with the adversarial principle of orality, witnesses in criminal proceedings are typically required to give evidence live in an open court (Ellison & Munro, 2014). However, it is becoming increasingly accepted that this process places heavy demands on witnesses and is likely to be a source of considerable stress for many going to court (Home Office, 1998), which is likely to impact on the ability of the witness to give their best evidence (Ellison, 2001; Spencer & Flinn, 1993). Special measures provide adaptations to the traditional way in which evidence is collected and received in criminal trials, with the central aim of improving the quality of evidence given (Fairclough, 2020). In England and Wales, special measures were introduced under the YJCEA (1999) in an effort to address some of the challenges associated with giving oral evidence in court without compromising the fairness of the trial for the accused. For Northern Ireland the statutory provision for special measures falls under the

Criminal Evidence (Northern Ireland) Order (1999). The relevant legislative provision for Scotland is the Criminal Procedure (Scotland). Special measures grant vulnerable and intimidated witnesses the use of alternative trial arrangements in situations where the courts are satisfied that this will maximise the quality of a witness's testimony (Ellison & Munro, 2014). In England Wales and Northern Ireland, a witness is considered vulnerable if they are under the age of 18 years and/or have a mental illness or impairment of intelligence, social functioning, or physical disability. In Scotland, vulnerable witnesses also include those whose evidence may be diminished due to fear or distress in connection with testifying in proceedings, are the complainant of offences including sexual offences, trafficking offences, domestic abuse or stalking, and who are considered at a significant risk of harm by reason of the fact that they are giving evidence in the proceedings (Criminal Procedure (Scotland) Act, 1995). Types of special measures available to a witness who satisfies these conditions are broadly similar across all jurisdictions, although there are some differences. All jurisdictions include the use of pre-recorded evidence-in-chief, giving testimony via a live link, and the removal of wigs and gowns. The use of pre-recorded cross-examination is available in England, Wales and Scotland, but is not yet implemented in Northern Ireland. In England, Wales and Northern Ireland, screens are also used to shield the witness from the defendant, although in Scotland, the accused can still see the witness behind a screen via a video link. The use of an intermediary (a trained professional who sits next to the witness and facilitates communication between the courts and vulnerable witnesses/victims) is available in England, Wales and Northern Ireland, although for now, there is still no provision for intermediaries in Scotland.

Several studies have examined the impact that the introduction of special measures has had for witnesses and victims giving evidence in court, with research indicating a high level of appreciation of protection provided by these. For example, witnesses have reported special measures as being helpful and allowing them to give evidence that they would not otherwise

have been willing, or able, to give (Burton et al., 2007; Hamlyn et al., 2004). Children have also reported feeling more capable of providing their evidence (e.g., Goodman et al., 1998; Landstrom & Granhag, 2010; Plotnikoff & Woolfson, 2009; Wilson & Davies, 1999), less nervous, and making fewer errors when responding to misleading questions whilst communicating via a live video link compared to being in the courtroom (Doherty-Sneddon & McAuley, 2000; Goodman et al., 1998). The use of intermediaries has also been found to be beneficial in addressing mental health needs and helping facilitate communication with vulnerable people (Cooper & Mattison, 2017).

However, significant concerns have also been raised regarding the negative influence that special measures might have on the fact-finding process and trial fairness. For instance, research suggests that the use of special measures by adult sexual offence complainants may unfairly prejudice the defence by providing an undeserved level of credibility to the victim's testimony (Burton et al., 2006; Payne, 2009). Others have noted that the absence of the witness or victim in court, through the use of a live-link, can create a physical distance between them and the jury, which might lead to their account being believed, or sympathised with, to a lesser extent (Hamlyn et al., 2004; Payne, 2009).

Jurors' Perceptions of Vulnerable Witnesses

Research has also considered the influence of special measures on juror-decision making, although the overwhelming focus so far has been with child witnesses and the use of the live link. Despite some research showing that children's testimony given via a live-link leads to more accurate responses (Goodman et al., 1998), others have found jurors to perceive children as less credible, accurate, detailed and believable when observed giving testimony via a live link compared to giving evidence in person (Eaton et al., 2001; Goodman et al., 1998; Landstrom et al., 2007; Landstrom & Granhag, 2010; McAuliff & Kovera, 2012; McAuliff et

al., 2015). In contrast, others have reported no differences in the perception of child witnesses when giving evidence via a live link compared to open court testimony (Davies, 1999; Orcutt et al., 2001; Ross et al., 1994; Taylor & Joudo, 2005). In terms of perceptions of the defendant, research has shown that jurors are less likely to convict the defendant when children provide testimony via a live link than in person (Eaton et al., 2001; Goodman et al., 1998).

Considerably less research has explored the use of other types of special measures in court and the impact these might have on juror decision-making, although some do exist. Research concerning the use of an intermediary supporting a child witness found jurors rated their behaviour and the quality of the cross-examination more highly when an intermediary was involved during the process (Collins et al., 2017). In terms of a screen used to shield the victim from the defendant's view, mock jurors have been found to perceive a sexual assault victim more positively when this is used in court (Sheahan et al., 2021). The same researchers also found that jurors were more likely to assign higher defendant guilt ratings when a screen was used (Sheahan et al., 2021). As such, the use of special measures with victims and with child witnesses might be viewed more favourably by jurors, although they could impact more negatively on defendants when used with victims in the courtroom. What is not yet clear is how the use of special measures with *adult witnesses* are perceived by jurors and how this might impact on decisions made about the witness and the defendant in court.

This avenue of research is also important in determining whether special measures are having their intended purpose when used in the courtroom. Although the central aim of all special measures is to improve the quality of evidence given, it is possible that their use could be viewed differently with witnesses. Indeed, it might be that the use of such measures exacerbates any stigmatised beliefs that a jury member might have about mental illness. This could be especially problematic for those special measures that appear more invasive to members of the jury, such as an intermediary or a screen. In England and Wales, intermediaries

are sat, or stood, next to the witness whilst giving evidence in court. At the discretion of the judge, they are also permitted to intervene during questioning if their communication recommendations for the vulnerable witness are not adhered to (Crown Prosecution Service, 2021). Screens might appear invasive by being placed around the witness box, preventing the witness from being seen by the defendant. Expectancy Violation Theory (EVT; Burgoon & Hale, 1988) proposes that, when approaching social interactions, individuals expect others to engage in certain behaviours that are feasible for a particular setting, purpose, and set of individuals, based on previous experiences and social norms (Burgoon & Hubbard, 2005; McAuliff & Kovera, 2012). When these expectations are violated, an evaluative process is engaged in whereby the meaning of the violation is perceived as either positive or negative (Smethurst & Collins, 2019). McAuliff and Kovera (2012) proposed two explanations for how this might impact on the juror decision-making process in legal settings. First, jurors may perceive the vulnerable witnesses' testimonies as exceeding their expectations. For example, jurors might expect the witness to be lacking the competency to testify because of their mental illness, yet, if the ability to give evidence effectively improves with the use of special measures, then the juror may become doubtful of the overall accuracy of the testimony provided. Even though this outcome is desirable from the courtroom's standpoint (i.e., the witness has testified well), it could still lead to more negative outcomes for the witness as jurors' expectancies have been violated. In such circumstances, the juror might then mistakenly attribute the witnesses' more composed demeanour to other sources, such as coaching of the witness (McAuliff & Kovera, 2012).

Alternatively, jurors' expectations might not be met, and so are violated but in the opposite direction. In this instance, the ability of the witness may be overestimated based on the knowledge that the witness is accommodated in some way whilst giving evidence in court, so is therefore more capable of testifying well. However, as already noted, although special

measures have been found to somewhat reduce the stress of testifying (e.g., Burton et al., 2007; Goodman et al., 1998; Hamlyn et al., 2004), this pressure is still likely to exist and prevent them from reaching their full capacity on the stand (Barnett & Appelbaum, 2010). Thus, jurors' expectations are again violated, resulting in the witness being perceived more negatively. This effect could be more evident when an intermediary is used as their purpose is to facilitate communication, which without its use, could otherwise potentially impact on the quality and coherence of the testimony (Smethurst & Collins, 2019). In contrast, whilst the use of other special measures, like the screen, is also intended to improve communication, it might be more likely that this is viewed by jurors as a protective measure concealing them from the view of the defendant. Consequently then, witnesses with mental illnesses might be placed at a greater disadvantage during the courtroom process than other witnesses. Considering such procedural innovations have been designed to enhance the quality of testimony provided by vulnerable witnesses, the testimony provided may be of limited value if it is not perceived by jurors as credible (Cashmore & Bussey, 1996).

Conversely, jurors might view the witness with a mental illness more positively when special measures are used, as has typically been found so far with child witnesses and victims of sexual assault (e.g., Collins et al., 2017; Sheahan et al., 2021). Such findings might then align more with the assumptions of the patronisation effect discussed above (Gibbons et al., 1979). Therefore, although the main purpose of special measures is not to reduce witness bias, this might be an unintended, but positive, by-product of their use. The present study will address this gap in the literature by determining whether the use of an intermediary or a screen impacts juror decision-making.

The Present Study: Rationale and Hypotheses

To our knowledge, there is no study to date concerning the decision-making of jury members when witnesses with a mental illness give evidence in court. What is also unclear at present is whether the use of certain types of special measures, particularly an intermediary or a screen, impacts on the fairness of criminal proceedings for cases involving vulnerable individuals. The present study, therefore, explored the issue of stigma typically assigned to different mental illnesses and investigated whether such perceptions impact juror decision-making. Specifically, the study incorporated a witness with schizophrenia (representing a higher degree of stigmatisation in society), a witness with depression (representing a more common mental illness category), and a witness with no mental illness as a control condition. We also explored whether the use of an intermediary, or a screen to shield the witness from the defendant, impacts on juror decision-making when the witness has a mental illness. In terms of decision-making, we sought to identify the impact of witness mental illness and the use of special measures on ratings of witness competency, credibility, and reliability. Furthermore, to determine whether witness mental illness and the use of special measures impacts on the outcome of the trial, defendant guilt ratings were obtained.

The present study proposed the following hypotheses to address the impact of witness mental illness on jury decision-making;

H1: In line with previous literature, we predicted that participants would rate witnesses with no mental illness as being significantly more competent, credible, and reliable than witnesses with schizophrenia or depression. Participants would also rate witnesses with depression as being significantly more competent, credible, and reliable than witnesses with schizophrenia.

H2: There is currently no research investigating the effect of witness mental illness on ratings of defendant guilt. However, in line with much of the previous

literature on defendant mental illness, it was hypothesised that participants would be significantly more likely to find the defendant guilty when a witness has schizophrenia or depression compared to when a witness has no mental illness.

We were more tentative in our predictions regarding witness mental illness and the use of special measures in court. However, in line with the reviewed literature the following hypotheses were formed;

H3: Participants would rate witnesses with depression and schizophrenia as significantly less competent, credible, and reliable when no special measure is used in court compared to when an intermediary or a screen is used in court. Furthermore, participants would rate witnesses with schizophrenia as significantly less competent, credible and reliable than witnesses with depression when an intermediary, a screen, or no special measure is used in court.

H4: Participants would be significantly more likely to find the defendant guilty when a witness with a mental illness testifies using either an intermediary or a screen in court, compared to witnesses with a mental illness who testify with no special measure in court.

Method

Participants

Two hundred and four participants were recruited from both the general public and the student population (135 females, 69 males; age M = 23.71 years, SD = 8.53) using volunteer and opportunity sampling. The data from two additional participants were excluded from the final analysis due to providing incomplete responses. The inclusion criteria for this study required all individuals to be aged 18 years or above. All participants provided informed

consent to take part and were made aware of their right to withdraw and the confidentiality and anonymity of the data obtained. The study was approved by local university ethics committee procedures.

Materials

Demographic Information

Participants were asked to provide their age and gender using open-ended responses and were also given the option 'prefer not to answer'.

Case Trial Vignette

All participants received the same two-page mock trial vignette describing a child abuse case that we developed for use in this study. However, for each case trial vignette, witness mental illness (depression, schizophrenia, no mental illness), the corresponding symptoms, and the type of special measure used in court (screen, intermediary, no special measure) was manipulated. The explanation and symptoms used for each mental illness were obtained from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; 2013) to ensure that an objective explanation was provided to participants. For the content of the vignettes to be comparable with a real-world courtroom situation, only one version of the vignette was used as part of the 'no mental illness' condition whereby no special measure was included. This is because current UK legislation (YJCEA, 1999) only permits vulnerable and intimidated witnesses, including those with a mental illness, the use of alternative trial arrangements in court. Thus, in total, there were seven different mock trial vignettes (depression plus the use of screen/intermediary/no special measure; schizophrenia plus use of screen/intermediary no special measure; no mental illness plus no special measure).

Each case trial vignette included a summary of the court trial which set the scene of the criminal case and explained the charges against the defendant. A description of both the

witness and defendant testimonies were provided, with the defendant's case stressing denial of all charges and claiming the accusations to be false. The defendant was charged with child abuse, criminal threats, and aggravated physical assault towards his 4-year-old son. The wife of the defendant was the only bystander witness to the alleged offences. Instructions for the participant were also provided, which included describing their role as a member of the jury, what they would be asked to do, and the decisions they would be asked to make. A short definition and description of the special measure used in the case trial vignette was also provided to ensure participants understood the relevance of its use in the case trial.

Case Trial Vignette Questions

After reading the vignette, all participants were asked ten multiple-choice questions to ensure they had read, fully attended to, and understood the case material presented to them. Examples of the questions asked included *"Did the perpetrator have a mental illness?" (yes/no), "How many witnesses were there to the alleged incident?" (one/two/three/four), "What happened to the victim?" (allegedly in a car accident/allegedly physically assaulted/allegedly fell down the stairs), and "How many jury members were in the trial case?" (8/7/12/11).* To determine how many participants had attended to the case trial vignette, an overall percentage score was calculated for each participant by identifying how many questions of the ten questions were answered correctly before being converted to a percentage. All participants answered questions with an accuracy of 70% or more, which was deemed an appropriate level of accuracy for inclusion in the study.

Post-Trial Questions

To measure participants perceptions of the witness testimony presented in the trial case, three question items were included after reading the court trial transcript which asked participants to rate how competent, credible and reliable they believed the witness to be

(ranging from "1 = not at all" to "10 = very much so"). One further question item was also included which asked participants to rate how likely they would be to find the defendant guilty (ranging from "1 = not at all guilty" to "10 = certainly guilty").

Participants were provided with a definition of each variable (Oxford University Press, 2021) they were asked to rate. For witness competency, *"Competency can be defined as the ability of a person to act effectively or do something well*". For witness reliability, participants were informed that *"Reliability can be defined as whether the testimony can be trusted"*. For witness credibility, participants were informed that *"Credibility can be defined as whether the testimony was believable"*. For defendant guilt, participants were informed that *"Guilt can be defined as how responsible the defendant is for the crime committed"*.

Attitudes Towards Persons with Mental Illness Scale

The Attitudes Towards Persons with Mental Illness (APWMI) scale (Kobau et al., 201) was used to measure participants attitudes towards mental illness. We included this measure to control for any pre-existing biases that might already exist around mental illnesses, and therefore to ensure that any significant findings resulting from the main study variables were due to experimental manipulation that were part of the current study. This scale has previously been used in other studies of a similar nature (e.g., Moissiere & Maeder, 2015), and is based on the British Omnibus National Survey (Crisp et al., 2000) which was designed to assess familiarity of people with mental illnesses. The scale was created with no postulation made about the type of mental illness, with the expectation that participants self-define the construct. The APWMI scale comprises 11 items, each rated using a 5-point Likert scale (ranging from "strongly disagree" to "strongly agree"). Examples of the question items in the scale include statements such as *"I believe a person with mental illness is a danger to others"* and *"I believe a person with mental illness is unpredictable"*, with participants asked

to rate how much they agree, or disagree, with the statements. Total scores are calculated across the 11-items, with five items being reverse scored for analyses. Higher overall scores indicate more positive attitudes towards mental health conditions, with the full range of possible scores being 1-55.

The APWMI scale has been demonstrated to be a valid measurement of overall attitudes and perceptions towards mental illnesses, showing rigorous convergent validity with other similar measures (Kobau et al., 2010). Previous studies have also reported acceptable internal consistency (α = .67; Mossiere & Maeder, 2015). In this study, Cronbach's alpha for the 11 items was found to be moderately acceptable (α = .57). Further observation of the items revealed that the removal of one question (Q11) would have somewhat improved internal consistency (α = .63). However, this was not deemed to be a sufficient enough increase for removal of this item before final data analysis.

Procedure

The experiment was carried out online using Qualtrics software. Participants were randomly assigned to one of seven experimental conditions whereby the mental illness of the witness and the special measure used in court were manipulated. Participants therefore took part in one of the following conditions: (1) witness with no mental illness and no special measure used (n = 30); (2) witness with depression and no special measure used (n = 27); (3) witness with depression and a protective screen used (n = 30); (4) witness with depression alongside an intermediary (n = 30); (5) witness with schizophrenia and no special measure used (n = 31); (6) witness with schizophrenia and a protective screen used (n = 27); (7) witness with schizophrenia alongside an intermediary (n = 29).

In all conditions, participants first read an information sheet, provided online informed consent, and completed demographic questions. Next, participants completed the

APWMI scale. We acknowledge that presenting participants with the scale prior to reading the vignette may have provided some suggestion as to the focus of the research. However, in line with other research in this area (e.g., Mossiere & Maeder, 2015), the APWMI scale was intentionally presented to participants before exposure to the case trial vignette to ensure a true measure of attitudes towards mental illness was obtained without the influence of other information (specifically, the vignette) presented in the study. The participants were then instructed to carefully read the court trial vignette describing a physical assault charge and imagine themselves as a juror in the courtroom as the trial took place. After reading the vignette, participants were asked several multiple-choice questions to ensure they had all read and understood the case material presented to them. Following this, participants were instructed to assess the witness evidence and case information before completing the post-trial questions where they were asked to formulate their judgements about the witness testimony provided (reliability, competency and credibility) and their likelihood of finding the defendant guilty. Lastly, participants were provided with an onscreen debrief.

Research Design and Analytical Plan

To account for the use of only seven vignettes in the study as a result of the 'no mental illness' condition never being assigned any special measures, the data were analysed in two parts using analysis of covariance (ANCOVA). First, we aimed to establish whether the witness having a mental illness impacted juror decisions of the witness and defendant. Thus, a one-way between-subjects ANCOVA was employed. The between-subjects factor was witness mental illness (depression, schizophrenia, no mental illness)[1]. The covariate included was attitudes towards mental illness (measured using the APWMI scale). The dependant

[1] To calculate mean scores for the schizophrenia and depression conditions, data was collapsed across all three special measure conditions (screen, intermediary, no special measure).

variables were witness competency, witness credibility, witness reliability, and likelihood of finding the defendant guilty.

Second, we investigated whether special measures used to protect witnesses with mental illnesses in court impacted juror decision-making. As such, the 'no mental illness' condition was excluded from this part of the analysis. Thus, a 2 x 3 between-subjects ANCOVA was employed. The between-subjects factors were witness mental illness (depression, schizophrenia) and special measure used in court (intermediary, screen, no special measure). The covariate, once again, was attitudes towards mental illness (measured using the APWMI scale). The dependant variables were witness competency, witness credibility, witness reliability, and likelihood of finding the defendant guilty.

A post hoc sensitivity power analysis was conducted using the software package GPower (Erdfedler et al., 1996). The sample size of 204 was used along with an alpha level of .05 and power ($1 - \beta$) set to 80%. The recommended effect size cut-offs used for this assessment were as follows; small ($\eta_p^2 = .01$), moderate ($\eta_p^2 = .06$), and large ($\eta_p^2 = .14$). The post hoc analyses revealed that the minimum effect size that could be reliably detected was $\eta_p^2 = .07$. This was deemed as more than adequate for a study of this nature at the moderate to large effect size level.

Results

Attitudes Towards Persons with Mental Illness

Overall, attitudes towards persons with mental illness scores ranged from 29.00 to 53.00 (M = 41.97; SD = 4.45). This sample did not display very negative attitudes towards mental illness, as demonstrated by the mean score falling on the higher end of the rating scale. These findings are comparable to others who have also used the APWMI scale in research studies of a similar nature (e.g., Mossiere & Maeder, 2015).

Witness Mental Illness and Juror Decision-Making

Table 1 provides descriptive statistics for each study condition for witness competency, credibility, reliability, and likelihood of finding the defendant guilty.

[TABLE 1 HERE]

Witness Competency

There was a significant main effect of mental illness on witness competency ratings whilst adjusting for attitudes towards mental illness, $F(2, 200) = 9.56$, $p = .001$, $\eta_p^2 = .09$. Post hoc pairwise comparisons showed that witness competency ratings were significantly lower when the witness was reported as having schizophrenia compared to when the witness was reported as having depression ($p = .001$). Witness competency ratings were also significantly lower when the witness was not reported as having a mental illness compared to when the witness was reported as having depression ($p = .014$). In contrast, there was no significant difference in witness competency ratings when the witness was not reported as having a mental illness compared to when the witness was reported as having schizophrenia ($p = 1.00$).

The covariate attitudes towards mental illness was significantly related to witness competency ratings. Specifically, more positive attitudes towards mental illness resulted in higher witness competency ratings, $\beta = .06$, $t(203) = 2.57$, $p = .011$, $\eta_p^2 = .03$.

Witness Reliability

There was a significant main effect of witness mental illness on witness reliability ratings whilst adjusting for attitudes towards mental illness, $F(2, 200) = 5.19$, $p = .006$, $\eta_p^2 = .05$. Post hoc pairwise comparisons showed that witness reliability ratings were significantly

lower when the witness was reported as having no mental illness compared to when the witness was reported as having depression (p = .008). In contrast, there was no significant difference in witness reliability ratings when the witness was reported as having schizophrenia compared to when the witness was reported as having no mental illness (p = .347), nor when the witness was reported as having schizophrenia compared to when the witness was reported as having depression (p = 125).

The covariate attitudes towards mental illness was also significantly related to witness reliability ratings. Specifically, more positive attitudes towards mental illness resulted in higher witness reliability ratings, β = .05, $t(203) = 1.99$, p = .048, η_p^2 = .02.

Witness Credibility

There was no significant main effect of witness mental illness on witness credibility ratings whilst adjusting for attitudes towards mental illness, $F(2, 199) = 2.70$, p = . 070, η_p^2 = .03. However, the covariate attitudes towards mental illness was significantly related to witness credibility ratings. Specifically, more positive attitudes towards mental illness resulted in higher witness credibility ratings, β = .07, $t(202) = 2.80$, p = .006, η_p^2 = .04.

Defendant Guilt

There was no significant main effect of witness mental illness on ratings of defendant guilt whilst adjusting for attitudes towards mental illness, $F(2, 200) = .02$, p = .983, η_p^2 = .001. The covariate attitudes towards mental illness was not significantly related to the likelihood of finding the defendant guilty, β = .02, $t(203) = .79$, p = .430, η_p^2 = .003.

Witness Mental Illness and The Use of Special Measures on Juror Decision-Making

Table 2 provides descriptive statistics for each study condition for witness competency, credibility, reliability and likelihood of finding the defendant guilty.

[TABLE 2 HERE]

Witness Competency

There was a significant main effect of witness mental illness on witness competency ratings whilst adjusting for attitudes towards mental illness, $F(1, 167) = 17.52$, $p = .001$, $\eta_p^2 = .10$. There was also significant main effect of special measure on witness competency ratings whilst adjusting for attitudes towards mental illness, $F(2, 167) = 4.42$, $p = .013$, $\eta_p^2 = .05$.

However, these main effects were qualified by a significant interaction effect between witness mental illness and special measure on witness competency ratings whilst adjusting for attitudes towards mental illness, $F(2, 167) = 3.68$, $p = .027$, $\eta_p^2 = .04$. Simple main effects analyses showed that, when no special measure was used in court, there was no significant difference in witness competency ratings when witnesses were reported as having schizophrenia ($M = 6.67$, $SD = 1.63$) compared to when witnesses were reported as having depression ($M = 6.96$, $SD = 2.10$), $t(56) = -.63$, $p = .532$, $d = 0.16$. In contrast, when a screen was used in court, witness competency ratings were significantly lower when witnesses were reported as having schizophrenia ($M = 6.31$, $SD = 1.46$) compared to when witnesses were reported as having depression ($M = 8.35$, $SD = 2.06$), $t(55) = -4.13$, $p = .001$, $d = 1.10$. Furthermore, for when an intermediary was used in court, witness competency ratings were significantly lower when witnesses were reported as having schizophrenia ($M = 5.85$, $SD = 1.77$) compared to when witnesses were reported as having depression ($M = 6.84$, $SD = 1.65$), $t(59) = -2.87$, $p = .006$, $d = 0.74$. These findings are depicted in Figure 1.

[FIGURE 1 HERE]

When the witness was reported as having depression, witness competency ratings were significantly lower when an intermediary was used in court (M = 6.84, SD = 1.65) compared to when a screen was used in court (M = 8.35, SD = 2.06), $t(58) = 2.35$, $p = .022$, $d = 0.61$. Witness competency ratings were also significantly lower when no special measure was used in court (M = 6.96, SD = 2.10) compared to when a screen was used in court (M = 8.35, SD = 2.06), $t(55) = -2.44$, $p = .018$, $d = 0.64$. In contrast, there was no significant difference in witness competency ratings when no special measure was used in court (M = 6.96, SD = 2.10) compared to when an intermediary was used in court (M = 6.84, SD = 1.65), $t(55) = -.42$, $p = .673$, $d = 0.11$.

When the witness was reported as having schizophrenia, there was no significant difference in witness competency ratings when an intermediary was used in court (M = 5.85, SD = 1.77) compared to when a screen was used in court (M = 6.31, SD = 1.46), $t(56) = .98$, $p = .332$, $d = 0.26$. There was also no significant difference in witness competency ratings when no special measure was used in court (M = 6.67, SD = 1.63) compared to when a screen was used in court (M = 6.31, SD = 1.46), $t(56) = -.79$, $p = .435$, $d = 0.21$. Finally, there was no significant difference in witness competency ratings when an intermediary was used in court (M = 5.85, SD = 1.77) compared to when no special measure was used in court (M = 6.67, SD = 1.63), $t(60) = 1.72$, $p = .091$, $d = 0.43$. These findings are depicted in Figure 2.

[FIGURE 2 HERE]

The covariate attitudes towards mental illness was also significantly related to witness competency ratings. Specifically, more positive attitudes towards mental illness resulted in higher witness competency ratings, $\beta = .11$, $t(173) = 3.50$, $p = .001$, $\eta_p^2 = .07$.

Witness Reliability

There was a significant main effect of witness mental illness on witness reliability ratings whilst adjusting for attitudes towards mental illness, $F(1, 167) = 3.93$, $p = .049$, $\eta_p^2 = .02$. Post hoc pairwise comparisons showed that witness reliability ratings were significantly lower when the witness was reported as having schizophrenia compared to when the witness was reported as having depression ($p = .049$).

There was no significant main effect of special measure on witness reliability ratings, $F(2, 167) = .97$, $p = .380$, $\eta_p^2 = .01$, nor was there a significant interaction between witness mental illness and special measure, $F(2, 167) = 1.01$, $p = .365$, $\eta_p^2 = .01$. However, the covariate attitudes towards mental illness was significantly related to witness reliability ratings. Specifically, more positive attitudes towards mental illness resulted in higher witness reliability ratings, $\beta = .11$, $t(173) = 3.23$, $p = .002$, $\eta_p^2 = .06$.

Witness Credibility

There was no significant main effect of witness mental illness, $F(1, 167) = 2.64$, $p = .1.06$, $\eta_p^2 = .02$, or special measure, $F(2, 167) = .17$, $p = .842$, $\eta_p^2 = .01$, on witness credibility ratings whilst adjusting for attitudes towards mental illness. There was also no significant interaction between witness mental illness and special measure, $F(2, 167) = .091$, $p = .913$, $\eta_p^2 = .001$. However, the covariate attitudes towards mental illness was significantly related to witness credibility ratings. Specifically, more positive attitudes towards mental illness resulted in higher witness credibility ratings, $\beta = .11$, $t(173) = 3.23$, $p = .002$, $\eta_p^2 = .06$.

Defendant Guilt

There was no significant main effect of witness mental illness, $F(1, 167) = .01$, $p = .921$, $\eta_p^2 = .01$, or special measure, $F(2, 167) = .1.21$, $p = .302$, $\eta_p^2 = .01$ on witness credibility ratings whilst adjusting for attitudes towards mental illness. There was also no significant interaction between witness mental illness and special measure, $F(2, 167) = .12$, $p = .890$, η_p^2

= .001. Finally, the covariate attitudes towards mental illness was not significantly related to the likelihood of finding the defendant guilty, $\beta = .07$, $t(173) = 1.80$, $p = .074$, $\eta_p^2 = .02$.[2]

Discussion

The present study sought to determine the extent to which witness mental illness and the use of special measures in court impact the decision-making of individual mock jurors. Specifically, the research looked to identify how jurors rated witnesses with a mental illness known to have a higher degree of stigmatisation in society (schizophrenia), witnesses with a more common mental illness category (depression), and witnesses with no mental illness. We also explored that impact of special measures on juror decision-making, and specifically, those procedural aids that might appear more invasive in the courtroom (an intermediary and a screen).

Witness Mental Illness and Jury Decision-Making

Witness Competency, Reliability and Credibility Ratings

Our findings partially supported H1 whereby witness mental illness was found to significantly impact ratings of competency. Specifically, participants rated witnesses with schizophrenia as significantly less competent than witnesses with depression when giving evidence in court. This finding returned a moderate effect size ($\eta_p^2 = .10$) indicating real-world practical significance. More generally, this finding suggests that stigma towards individuals with mental illnesses still exists and can impact on decisions that people make about individuals. This is in line with previous research that has shown how merely labelling someone as having a mental illness can negatively impact perceptions of these individuals (e.g., Appelbaum & Scurich, 2014; Pescosolido et al., 1999; Sandys et al., 2018).

[2] The authors also ran the full analyses without the inclusion of the 'attitudes towards mental illness' covariate. All findings returned from this analysis were identical to those outlined here where the covariate was included in the analyses.

Additionally, the finding supports the view that increased stigmatisation is typically associated more with schizophrenia than for depression (e.g., Angermeyer & Matschinger, 2003; Angermeyer et al., 2004; Crisp et al., 2000; Griffiths et al., 2006; Lauber et al., 2004; Marie & Miles, 2008), suggesting that those mental illnesses attributed with more negative beliefs surrounding them are likely to be more damaging to the decision-making process. In the context of the present study, this finding supports the view that jury members do make decisions based on stigmatisation and negative misconceptions about mental illness (Crocker et al., 2013; Montgomery et al., 2005). This outcome is particularly problematic given that jurors are asked to decide the outcome of a case solely on the evidence given at trial, the instructions given by the trial judge, and to make their decision without sympathy, prejudice, or fear (Mossiere & Maeder, 2015; Thomas, 2010). However, the present findings suggest that jurors are unlikely to remain impartial if the mental health of the witness is brought into question in court and, instead, are likely to make decisions based on their own beliefs. In a real-world courtroom context, this could be damaging to the trial process and may impact on the reliance of witness testimony provided as part of the case.

However, contrary to H1, this finding was not identified for ratings of witness reliability or credibility. One reason for this might be a result of the definition connected to competency. Competency can be defined as the ability of a person to act effectively or do something well (Oxford University Press, 2021). In a courtroom context, competency refers to whether a witness can understand questions and be understood by members of the court (YJCEA, 1999). In other words, competency is a skill of ability, and defines how *able* a person is to do something. It is possible, therefore, that in the context of the present study, ratings of competency were made given based on a person's belief about how *cognitively able* they thought the witness was in providing testimony in court. This interpretation seems somewhat plausible given that cognitive impairment is often assumed to be greater in

individuals with schizophrenia than with depression (Neu et al., 2019). However, whilst cognitive dysfunctions have been well documented and denote a trait marker for schizophrenia (Rund & Borg, 1999), research provides strong evidence that cognitive impairment is a primary aspect of both schizophrenia and depression (Hugdahl & Calhoun, 2010). Therefore, it is unlikely that the negative beliefs, which appear to be stronger for individuals with schizophrenia than they are for depression, is justified, further adding to the concern that stigmatisation about individuals with certain mental illnesses can impact on juror decision-making in court.

In addition, in terms of help-seeking beliefs, findings from public perception surveys indicate that the general practitioner is most frequently recommended as a helping source for individuals with depression (Angermeyer et al., 1999; Benkert et al., 1997; Goldney et al., 2001; Hillert et al., 1999; Jorm et al., 1999; Kohn et al., 2000; Lauber et al., 2001; Ylla & Hidalgo, 1999). However, in the case of schizophrenia, medication is frequently favoured as the most appropriate treatment (Gaebel et al., 2002; Stuart & Arboleda-Florez, 2001), suggesting that the public may view people with schizophrenia as needing greater assistance to relieve their condition. Anti-psychotic medication has been found to negatively impact on memory in people who take this to treat their mental illness (Moritz et al., 2004). Knowing this information could affect perceptions about the individual's ability to function effectively and, in the context of this study, the ability to provide appropriate testimony in court. Nevertheless, individuals with depression are also known to take medication for their condition (Prado et al., 2018) which has been shown to impact on functioning capacity (Amado-Boccara et al., 1995; Brooks & Hoblyn, 2007), particularly when used persistently (McClintock et al., 2010). This suggests that a greater awareness is needed regarding the sources of treatment people might seek for relief of their mental illness symptoms, and how

these can sometimes be similar across a range of mental health conditions – something that people may not currently be aware of.

In comparison, reliability and credibility can be defined as the quality of being able to be trusted or believed (Mind, 2010; Oxford University Press, 2021). It might then be the case that whilst participants believed witnesses with schizophrenia to be less able to provide competent testimony compared to witnesses with depression, they did not view the same witness as untrustworthy when giving evidence in court. This is consistent with the viewpoint that there is a difference between the ability to recall details and the underlying reliability or credibility of an account, and as such, neither credibility nor reliability should have any automatic bearing on the believability of the testimony provided (Mind, 2010). The finding is also somewhat in line with research which found that, whilst mock jurors perceived witnesses with learning disabilities to be fundamentally honest, they are reluctant to rely on the evidence presented when making decisions in court (Stobbs & Kebbell, 2003). The present findings therefore suggest that the decisions made about witnesses with mental illnesses are likely to be similar to those that are made about witnesses with learning disabilities.

A somewhat unexpected finding was that there was no difference in competency, reliability, or credibility ratings for those witnesses with schizophrenia and those witnesses with no mental illness. Additionally, participants rated witnesses with depression as significantly *more* competent and reliable compared to witnesses with no mental illness. This finding returned a small-to-moderate effect size ($\eta_p^2 = .05$), indicating some real-world practical significance. This is encouraging as it seems to suggest that stigmatisation and negative perceptions of some mental illnesses are improving, and is particularly apparent for those individuals with depression. This finding appears to hold true for situations where decisions can have far reaching consequences and impact significantly on people's lives. It would therefore appear that initiatives and interventions designed to improve knowledge and

overcome issues of stigmatisation may be working to some extent, and thus lending further support to the view that increasing familiarity can reduce stigmatisation and negative attitudes towards people with mental illnesses (Angermeyer et al., 2004). An increase in acceptance towards people with depression found in this study may not be that surprising given the particular focus on reducing stigma towards this mental illness in society (Christensen et al., 2004; Griffiths et al., 2004; Hegerl et al., 2003; Jorm et al., 2003; Paykel et al., 1998). In comparison, initiatives directed solely towards reducing stigma around schizophrenia tend to be less prevalent. Furthermore, when initiatives do incorporate schizophrenia as part of their awareness campaign, attitudes towards people with schizophrenia have been found to remain virtually unchanged (Akroyd & Wyllie, 2002; Wolf et al., 1996, 1999). The findings from the present study therefore suggest that whilst interventions and initiatives are moving in the right direction, there is still much more that could be done to overcome the stigmatisation that continues to exist for certain types of mental illnesses in society.

Defendant Guilt Ratings

Contrary to H2, there was no difference in ratings of defendant guilt when comparing witnesses who had depression, schizophrenia, or no mental illness. Given the limited research in this area so far, it was unknown as to whether witness mental illness would directly impact on decisions about the guilt of the defendant. However, although somewhat mixed, previous research has tended to suggest that when deciding upon guilt, defendant mental illness could be seen as an aggravating factor which increases culpability of a crime (e.g., Berryessa et al., 2015; Sandys et al., 2018; Wolbransky, 2011) and in some cases can result in the wrongful conviction of an innocent person (Lamb & Weinberger, 1998). Despite the witness in the current study being assigned a mental illness rather than the defendant, the mere presence of mental illness as a factor in the courtroom could have impacted on decisions made. This,

nevertheless, was not the case. Rather, it appears that decisions about defendant guilt were unaffected by witness mental illness. Participants appeared able to separate characteristics of the witness from those of the defendant, and from the case presented at trial. This is a promising finding as it suggests that whilst biases around witness mental illness do exist and can impact on decisions made about the witness, this factor alone is unlikely to impact on decisions made about the guilt of the defendant at trial.

Attitudes Towards Persons with Mental Illness

The present study controlled for attitudes towards mental illness which enabled the researchers to be more confident in their assertions about the experimental manipulations made for witness mental illness. The findings showed that more positive attitudes towards mental illness resulted in significantly higher witness competency, reliability, and credibility ratings. This finding may seem somewhat unsurprising given that more negative attitudes towards defendants with a mental illness often lead to more negative perceptions towards these individuals (e.g., Lamb & Weinberger, 1998; Sandy et al., 2018; Wolbransky, 2011). However, it was unclear as to whether this finding would also be evident for witnesses with a mental illness. The present finding is one that is ultimately of some concern, particularly in a courtroom setting, as it suggests that a jury member who holds particularly negative attitudes towards individuals with a mental illness will likely perceive them as less competent, reliable, and credible than a jury member who holds more positive attitudes.

Some researchers have emphasised that attitudes towards mental illness might impact on decision-making because of an issue inherent in the sample population used. For example, research suggests that courses in psychology can result in more favourable attitudes towards mental illness (e.g., Dixon, 1967; Kendra et al., 2012; Mossiere & Maeder 2015) because these students are more educated about mental illness and, therefore, less biased compared to

the general public (Reiko, 2008). The present study did recruit participants from the student population, many of whom were psychology students. However, many individuals were also recruited from the general population, making this sample more generalisable and representative of a typical population. What is of particular concern here is the finding that negative attitudes towards witnesses with mental illness existed despite some of the participants involved presumably having a greater awareness, knowledge, and understanding of different mental health conditions. Future research may therefore choose to directly compare different sample populations to determine the extent to which negative attitudes towards mental illness amongst these individuals prevail.

Further, it is worth highlighting the moderately acceptable outcome of the reliability analysis ($\alpha = .57$) for the APWMI scale used in the current study. Although this indicates some level of reliability in the measure used, caution should be placed on the interpretation of these findings when taking this into account. Additionally, the findings returned small effect sizes for each of the main outcome variables ($\eta_p^2 = .02$ to $.04$), indicating limited practical significance. Therefore, future research should look to identify other measures for determining attitudes towards witnesses with mental illnesses in their work.

Witness Mental Illness and The Use of Special Measures on Juror Decision-Making

Witness Competency, Reliability and Credibility Ratings

Contrary to H3, when considering the type of special measure employed, participants rated witnesses with depression as significantly less competent when no special measure was used compared to when a screen was used in court. This finding returned a moderate effect size ($d = 0.64$) indicating some real-world practical significance. These findings suggest that, at least for witnesses with depression, the use of a screen to shield the witness from the defendant can improve perceptions of witness competency and may be viewed favourably by individual jury

members in the courtroom. Such findings are in line with previous research that has also found victims (Sheahan et al., 2021) and child witnesses (Collin et al., 2017) to be viewed more positively when a screen is used in court. One reason for this might be that participants in the study viewed this type of special measure as a means of protection from the defendant rather than as a limitation in their competency. This interpretation seems plausible given that screens are put in place to protect the witness, or victim, from being in view of the defendant in court. The fact that this finding was identified for witnesses with depression may also not be surprising given that participants in this study rated witnesses with depression as more competent than witnesses with schizophrenia – a finding that was attributed to a more noteworthy reduction in stigmatisation for those with depression compared to schizophrenia. Thus, it can be concluded that for witnesses with depression, the use of a screen does not appear to be detrimental to the perception of witness competency by individual jury members when used in court.

However, contrary to H3, there was no difference in competency ratings for witnesses with schizophrenia when no special measure was used compared to when a screen was used in court. Thus, these findings suggest that although a screen might be viewed favourably for witnesses with depression, the same does not hold true for witnesses with schizophrenia. This finding lends further support to the suggestion that a greater awareness of the stigmatisation that exists for individuals with mental illnesses is warranted. An increase in understanding as to why special measures are used in court is also likely to be beneficial in an attempt to better educate jury members about their purpose in the courtroom. Additionally, it might be that jurors' expectations are violated in some way when witnesses with schizophrenia, as opposed to depression, make use of a screen as a procedural aid and as such, might lend some support to EVT (Burgoon & Hale, 1988). Although it might be expected that competency ratings would reduce if expectations were violated, the fact that competency ratings did not improve

when a screen was used with witnesses with schizophrenia, as was the case with depression, might suggest the findings align somewhat with this theory. However, it should be noted that this study did not specifically test this theory, nor did it intend to do so. Nevertheless, given this outcome, future work could look to identify whether jurors make decisions due to a violation in their expectations.

In contrast to H3, there was no difference in competency ratings for witnesses with schizophrenia and depression when no special measure was used and when an intermediary was used in court. This suggests that regardless of mental illness type, the use of an intermediary does not appear to be viewed more favourably by jurors compared to when no special measure is used in court. Such findings are different to that of previous research which has found the use of an intermediary to be beneficial to juror decision-making with child witnesses (Collins et al., 2017). The differences in these findings could be attributable to the age of the witnesses, rather than it being an effect of witness mental illness. Indeed, some studies have found that child witnesses are viewed as more credible than adult witnesses when witness age was varied (8, 21, or 74 years) (Ross et al., 1990). Therefore, it might be the case that previous research has found a positive influence of the use of an intermediary because it was used with children. Nevertheless, research exploring witness age is still considerably mixed, with findings also showing that child witnesses were viewed as less competent and credible than adult witnesses too (e.g., Goodman et al., 1987; Leippe et al., 1993; Newcombe & Bransgrove, 2007; Pozzulo & Dempsey, 2009). As such, it is unlikely that this explanation alone is sufficient in explaining the present findings with the use of an intermediary in court.

Nevertheless, there does appear to be some leniency for witnesses with depression compared to witnesses with schizophrenia when an intermediary is used in court. Indeed, witnesses with schizophrenia were rated as significantly less competent than those witnesses

with depression when an intermediary was used. This finding returned a moderate-to-large effect size (d = 0.74), indicating real-world practical significance. As such, it appears that this procedural aid was still viewed more favourably for witnesses with depression than for witnesses with schizophrenia. This could be due to the role of an intermediary in court. Specifically, the presence of another individual alongside the witness could have led participants to believe that some form of assistance was required, and that this assistance was due to a limitation in ability, rather than to facilitate communication between the court and the witness if necessary. The fact that this finding was most apparent for witnesses with schizophrenia further highlights the concern that more negative views are held towards schizophrenia and can negatively impact on decision-making in the courtroom.

One additional finding to note was that participants rated witnesses with depression as significantly less competent when an intermediary was used compared to when a screen was used in court. This finding returned a moderate effect size (d = 0.61), indicating real-world practical significance. However, there was no difference in competency ratings when a screen was used and when an intermediary was used in court for witnesses with schizophrenia. This suggests that whilst the use of an intermediary is viewed more favourably for witnesses with depression than for witnesses with schizophrenia, it is still a measure that is viewed more negatively than others when employed in the courtroom. As such, it appears that the use of an intermediary might appear more invasive by jurors when used in the courtroom compared to a screen. Participants in the present study were provided with an explanation as to why certain special measures are utilised in court. This, however, does not appear to have been sufficient to make clear the true purpose of special measures, and to eliminate any negative views held towards these - and particularly for those witnesses with mental illnesses that are viewed more negatively in society. Alternatively, the explanation provided may have sufficiently described the true aims of special measures in court but, despite this, participants

still held these stigmatised views. Future research should, therefore, aim to determine whether education and awareness around the use of special measures is effective for jury members, and if so, what type of education may be most suited for use in the courtroom.

Defendant Guilt Ratings

Contrary to H4, there was no difference in ratings of defendant guilt when a screen or an intermediary was used compared to when no special measure was used in court. This was a somewhat unexpected finding, particularly for the use of a screen, given that previous research has shown mock jurors to be more likely to render a guilty verdict and assign higher guilt ratings to a defendant when this testimonial aid was used by victims in court (e.g., Sheahan et al., 2021). The difference in findings, however, might be explained by the fact that the present study used a witness as the person who testified in court instead of a victim. Furthermore, the victim used in previous work was a child (either 6 or 15 years of age) (Sheahan et al., 2021), whereas the present research used an adult witness. As previously noted, child witnesses and victims are sometimes viewed more favourably by jury members in the courtroom (e.g., Ross et al., 1990). Shehan et al. (2021) also manipulated the familiarity of the victim with the defendant (either a stepfather or an unfamiliar handyman). As such, the findings might have been attributable to the inclusion of this variable in their study. Nevertheless, what is particularly promising about these findings is that it suggests that if the prosecution party were to call an adult witness with either schizophrenia or depression, and a screen or an intermediary was used when giving evidence in court, these factors alone are unlikely to be sufficient to directly impact on ratings of defendant guilt.

Limitations and Future Directions

In addition to the future suggestions already outlined, there are several other areas that the researchers believe are warranted for further investigation. First, although a proportion of

our participants were males (34%), the majority were females. Previous research has shown that juror gender is related to attitudes around mental health, with males often holding more negative attitudes towards mental illness than females (Mossiere & Maeder, 2015). Therefore, future research should explore whether gender biases exist and how they might impact on the findings by using more gender-balanced samples. Previous research has also shown that younger participants are likely to assign harsher verdicts compared to older adults (Mossiere & Dalby, 2008; Mossiere & Maeder, 2015). Participants in the present study had a mean age of 24 years and were therefore considered to be young adults. The fact that there was no significant effect of witness mental illness or the use of special measures on defendant guilt ratings in the present study is somewhat promising as it suggests that these young adults were not more likely to assign harsher verdicts. However, future research should look to compare the decisions of younger and older adults to determine whether any differences may exist.

The present study used the APWMI scale to measure participants attitudes towards mental illness. This scale is designed to assess the familiarity of people with some of the most common mental illnesses. However, for reasons of generalisability, the scale does not ask about specific mental illnesses and therefore requires participants to self-define the construct of mental illness. The APWMI scale was chosen to be most appropriate for the present study as it has been used in similar previous work (e.g., Mossiere & Maeder, 2015). Additionally, asking participants to self-define the construct of mental illness allowed them to generate their own ideas without directing them in any way. However, this meant that we were unable to determine which mental illness, or illnesses, were being considered when completing the scale. This would have enabled us to establish whether attitudes towards mental illnesses specific to the current work impacted on the findings. Future research should therefore seek

to use a scale with mental illnesses specific to those being investigated to determine whether there are any differences in findings.

Finally, the present study asked participants to make decisions about defendant guilt without any deliberation with others. Of course, in a real-world courtroom, deliberation over the final verdict would be fundamental to the court process. Furthermore, it is likely that jury members would discuss any witness testimony provided at trial and consider their ability to testify. Jury deliberation is a significant part of the process, with research suggesting that around 22% of jurors changed their mind from their initial view after deliberation had taken place (Tinsley, 2001). Research has also shown that deliberation can strengthen biases known to impact on the decisions that people make (Kramer et al., 1990). As such, future work should look to incorporate jury deliberation into their design to determine whether this can influence on the findings identified.

Conclusions

The present study was designed to extend the limited literature examining the use of special measures in a courtroom and, to our knowledge, is the only study to date to investigate the impact of their use alongside adult witnesses with mental illnesses who testify in court. Our findings showed that stigmatisation towards mental illness still exists and is particularly prevalent with those conditions that are viewed more negatively in society. Nevertheless, the findings also suggest that depression, a mental illness that has received greater awareness in recent years are perceived less negatively, is in some instances, viewed more positively when compared to individuals with no mental illness. In terms of the types of special measures employed in court for adult witnesses with a mental illness, the use of a screen is viewed more favourably than the use of an intermediary. However, this only appears to be the case for witnesses with depression. The findings therefore give us reason to identify

whether increasing awareness for all mental illnesses, with a particular attention for those perceived most negatively, would be beneficial. The findings also suggest that some awareness of these biases is needed in a courtroom environment. Future research might look to explore whether the use of educational materials about biases surrounding mental illness and how these impact on the decision-making of jurors. Additionally, it should be made clear to jury members as to why certain special measures are used in court, emphasising their role in aiding the court's process, rather than hindering it. Future research should continue to explore this area further and address the limitations outlined, to fully understand the impact of witness mental illness and special measures and the implications of these for a real-world courtroom setting.

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Table 1.

Means (M), standard deviations (SD), adjusted means (Madj), standard error (SE) and total number of participants (N) in the mental health conditions for witness competency, credibility, reliability, and likelihood of finding the defendant guilty.

Table 2.

Means (M), standard deviations (SD), adjusted means (Madj), standard error (SE) and total number of participants (N) in the mental health and special measure conditions for witness competency, credibility, reliability, and likelihood of finding the defendant guilty.

Figure 1. Mean witness competency ratings for the special measure conditions, depicted separately for depression and schizophrenia. 95% confidence intervals are also shown.

Figure 2. Mean competency rating for the mental health conditions, depicted separately for no special measure, screen and intermediary. 95% confidence intervals are also shown.

[Tables and Figures have been uploaded as separate documents].

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