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Parole, where psychiatry meets public protection

ARTICLE

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SUMMARY

This article aims to provide psychiatrists with an overview of early release of serving prisoners and parole, using the example of the Parole Board for England and Wales. The centrality of risk assessment and management and its clinical implications for release are reviewed. Offenders who come before a parole board and require a psychiatrist to be a member of the panel and who need evidence from psychiatrists on their disorder are often characterised by the complexity of their mental disorder. Offenders with complex mental disorder have difficulty assessing effective treatment and aftercare pathways, which can result in not being released. Offenders remitted back to prison following hospital transfer for treatment experience particular problems in being released. Three roles for psychiatrists in parole hearings are identified and guidance for effective participation in hearings is discussed. Commissioning implications of the difficulty assessing the need for community aftercare are noted.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand how early release forms part of sentencing, the role of parole in implementing early release and current concerns about its place in criminal justice
- recognise the effect that mental disorder in prisoners has on their review by a parole board, the effect of complexity of an offender's mental disorder on release decisions and the crucial role played by mental health community aftercare of released prisoners
- understand the difference between the responsibilities of the psychiatrist as a parole board member and as a professional or expert witness to parole hearings.

KEY WORDS

Forensic mental health services; psychiatry and law; risk assessment; prison mental health; parole board.

Contact with a parole board, whether as a clinician or as an expert witness, is for most psychiatrists an occasional clinical duty; the need for and purpose of that clinical input may not be immediately apparent. We argue that psychiatric involvement in the parole process is essential for clinically informed decisions on release. The article aims to equip psychiatrists with sufficient background knowledge of parole and parole boards to provide effective input and to understand their role in that process.

Early release of prisoners and parole systems can only be understood in the context of a particular country's social, political and judicial history and its contemporary concerns regarding offenders and risk. We have accordingly chosen to anchor our review of the interface between psychiatry and parole on one jurisdiction, that of the parole system in England and Wales; the issues identified will be relevant to other jurisdictions (Supplementary Table 1).

Early release, risk and community management

Early release

Guiney (2018) has observed that in contemporary Western societies most prisoners will achieve early release before the end of their sentence. The parole process, involving discretionary release, community supervision and threat of recall, has become an established part of the sentencing framework for England and Wales. Tracing its history, Guiney (2018) describes several phases in its development, shaped by changing societal and political beliefs and attitudes to crime and punishment, ranging from optimism concerning rehabilitation of offenders (in the 1960s) to contemporary emphasis on punishment and containment of 'dangerous' offenders.

Despite its benefits and widespread use (Box 1), parole is subject to critical review (Guiney 2018; Padfield 2020). Advocates of 'truth in sentencing' argue that the sentence should mean that the stipulated term be served: life should mean life and a determinate sentence should be served in full rather than employing early release (although recent reforms mean that judges in England and Wales now explain the minimum custodial term and the licence period when passing sentence). If an individual is recalled following early release, delays in the system, lengthy periods for professional

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BOX 1 Early release and parole

Definition

Early release is the legal and administrative mechanism by which the custodial element of a sentence is reduced, with the remainder of the sentence served in the community under licence; thus, it divides a sentence into a portion served in prison and a portion served in the community.

Parole, administered through a board, is the mechanism by which the decision is made to release a prisoner subject to licence conditions and subject to recall if licence conditions are breached.

Types of early release (England and Wales)

Depending on the type of sentence imposed by a court, early release can be:

- Automatic: Mainly at the halfway point of sentence (with some particular sentence types released automatically at the three-quarters stage). Automatic release does not involve the parole system. Release is governed by licence conditions, which if breached can lead to recall.
- Conditional: Release with licence conditions, where the Parole Board decides it is no longer necessary to keep the offender in prison for the protection of the public.
- Re-release: The Parole Board also considers re-release of prisoners who are recalled for breach of their licence conditions. Re-release is conditional, with licence conditions for release.

In addition, certain offenders who might otherwise be subject to parole decision on release can, in restricted circumstances, be released through executive decision not involving the Parole Board.

Potential benefits of early release through parole (Guiney 2018)

- It allows identification of offenders who have made sufficient progress in their sentence to reduce risk and who have a risk management plan in place to effectively manage them in the community. If they meet the test for release, they must then be released by the parole board.
- It allows identification of offenders who have not made sufficient progress to move on to community supervision; by this means 'dangerous' offenders are not released.
- It enhances commitment of offenders to rehabilitation, allowing them to demonstrate sufficient progress to be released.
- It promotes individualised release plans targeted at successful reintegration into society through licence conditions and supervision.

Other types of early release (not discussed further here) provide governments administrating penal systems with a much needed safety valve of last resort to manage and reduce prison numbers. (Guiney 2018; Parole Board 2019)

judgement on risk to be made and limited availability of rehabilitation combine to lead to a long period in custody – in essence a prolongation of confinement in custody, (re)sentencing by the back door. Guiney (2018) cites the principle that 'the greater the authority concentrated in the prison release decision, the greater the need for procedural regularity', leading to arguments for parole to be a fully fledged judicial process (Padfield 2020).

Parole decisions and risk

Parole decisions are about risk. In England and Wales, the test for release is that the Parole Board must not give a direction for release unless it is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined in prison (Legal Aid, Sentencing and Punishment of Offenders Act 2012: section 125). The test is contested on the grounds of concerns regarding the accuracy of clinical, actuarial or structured professional judgement (SPJ), leading to concern that the offender is at the mercy of individual variation in professional judgements of risk.

The use of SPJ risk assessment tools such as the Historical Clinical Risk Management-20 scale (HCR-20) and Violence Risk Appraisal Guide (VRAG) within the Parole Board process requires some reflection. These SPJ assessments are clinical tools whose original purpose is completely different from how they are being used to determine levels of risk to inform a decision on release from prison. The limitations of the HCR-20 used in this context have been recognised (Vojt 2013; Singh 2020). Singh et al (2020) found that among those identified as high risk by SPJ tools including the HCR-20, subsequent rates of violence were more dependent on local factors and SPJ could not be relied on to predict future violence. Vojt and colleagues (Vojt 2013) found that the HCR-20 could not predict violence either in hospital or the community in a population of male patients in a high secure hospital. Singh et al concluded that SPJs did not 'assign reliably a predetermined numerical probability to the potential for an individual to act violently'. Yet this is exactly how they are used for Parole Board hearings. Instead, risk assessment should inform risk management, with the HCR-20 used to generate scenarios to be used for risk management planning and not to generate a risk probability score.

Mental disorder as a risk factor for reoffending/community failure following release by a parole board

In their 2016 worldwide review of the mental health of prisoners, Fazel and colleagues stated that 'Research has consistently shown that prisoners have high rates of psychiatric disorders, and in some countries more people with severe mental illness are in prisons than in psychiatric hospitals' (Fazel 2016). The last major study in England and Wales (Singleton 1998) found levels of mental disorder in prisoners similar to those found in other countries' prisons and significantly higher than in the wider community: there is no reason to

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suppose levels have diminished in the 25 years since this work was undertaken. Nevertheless, the House of Commons Justice Committee report on mental health in prisons concluded 'there is no clear picture of the extent or nature of mental ill health in prisons' (House of Commons Justice Committee 2021: para. 6).

An important study carried out in 2007–2009 (Jakobowitz 2017) assessed the treatment needs of a sample of prisoners in both a male and a female prison in London. They found that most of the prisoners had a mental disorder that affected their behaviour and functioning, which should be treated. They concluded:

> 'disorders in prison are more severe, and for many in our study the consequences of unmet need appeared serious. Prison mental health services remain under-resourced, prison regimes do not conduce to effective treatment delivery, and incarceration disrupts treatment planning'.

What are the implications of high levels of mental illness in prisoners? Until recently, it was not known whether this increased their risk when released. Chang and colleagues investigated the association between psychiatric disorders, including substance use disorder, and violent reoffending in over 47 000 prisoners released in Sweden (Chang 2015). They found that all psychiatric disorders were associated with increased risk of violence, with greatest risk in the case of alcohol and drug misuse.

The findings of Chang et al (2015) led Appleby and colleagues to explore the role of psychiatric disorders in the high reoffending rates of released prisoners. They concluded that 'treatment of psychiatric disorders in prisons and on release is crucial but will not be enough to bring about a major reduction in violent crime' (Appleby 2015). They recommended that treatment, including aftercare, should include social support to address the complexity of these offenders' problems, with a coordinated risk management plan involving multiple agencies.

Bebbington et al (2021), reviewing the mental health of ex-prisoners, stated that 'recidivism seems likely to be linked to the mental health and social situations characteristic of released prisoners'. A meta-analysis of risk factors for recidivism in offenders sentenced to community sentences (Yukhnenko 2020) found that mental health needs and substance misuse, among other things, were dynamic risk factors for reoffending. They concluded that both factors are 'modifiable' and therefore intervention could reduce that risk. But, of course, this relies on being able to ensure good mental health support in the community.

We were unable to identify high-quality systematic research into the needs of offenders with mental health problems subject to long sentences and whose release is determined by parole board decisions on risk. A natural experiment, the introduction of a new indeterminate sentence in English law called imprisonment for public protection (IPP) has allowed some examination of the needs of long-term indeterminate prisoners. Our purpose was not to critique the sentence itself but instead to use the population of IPP prisoners remaining in custody to explore the needs of long-sentence prisoners (for a critique of the IPP sentence, along with a summary of its history and consequences, see House of Commons Justice Committee, 2022). The IPP sentence, which came into force in April 2005, introduced a novel type of sentence which was based not on 'just deserts' but on future dangerousness. By 2010 the government acknowledged that the treatment of IPP prisoners was not defensible, and this led to the abolition of IPP for new convictions in December 2012. In practice it left in prison a substantial number of IPP prisoners (1492 by September 2022) who had never been released, remaining in prison well beyond the tariff set for their sentence, with now almost the same number (1434) who had been released and subsequently recalled while under supervision in the community (House of Commons Justice Committee 2022: p. 3) (for review of recalled prisoners see Edgar et al, 2020).

IPP prisoners remaining in custody remain subject to the Parole Board test for release. Parole Board members have noted the high prevalence of mental disorder in this group. This has been confirmed by several reviews (Sainsbury Centre for Mental Health 2008; HM Inspectorate of Prisons 2016). All found an increased proportion of IPP prisoners with mental disorder compared with the general prison population.

In respect of recalled IPP prisoners HM Inspectorate of Prisons (2016) found 'anecdotal evidence that gaps in the provision of some key community services, for example mental health services, can lead to a breakdown of the release plan', i.e. recall to prison was because of unmet mental health needs. Their report makes recommendations that we endorse and that apply equally to other long-sentence prisoners with complex needs who are 'stuck' in the system. The report recommended that probation risk management plans for release should take account of mental healthcare needs. It identified a need for specific commissioning of community aftercare services tailored to the needs of released offenders. For 'stuck' IPP prisoners, the report recommended that hospital rehabilitation should be provided in selected cases to prepare the offender for community release and aftercare. Current mental health legislation on transfer to

hospital of serving prisoners does not allow parole panels to direct or recommend such transfers, although panels can direct reports to assess need for treatment.

Although new IPP sentences are no longer passed, similar problems are seen in prisoners with complex mental disorders who are now sentenced to extended determinate sentences (which have replaced IPP sentences). They will often have been released, recalled to prison and have a Parole Board review as a result.

The experience of Parole Board psychiatrists is that too often it appears that prisoners with complex mental disorder who have active symptoms of mental illness are unable to meet the test for release because they are assessed as not needing transfer to hospital for treatment and rehabilitation and/or they do not have an aftercare plan for their management in the community. Community mental health team policies routinely preclude acceptance of a referral for a prisoner until the individual is in the community and registered with a general practitioner. Contractual arrangements for the commissioning of community forensic service often limit their provision to those who have progressed through forensic secure hospital services, ignoring the more complex and higher-risk prison releases, whose only support may be less well-resourced and less risk aware community mental health teams (CMHTs), with protocols leading to early discharge from case-loads of those who fail to keep appointments.

Complexity of mental disorder

Tyrer & Mulder (2022: pp. 57–68), examining comorbidity between personality disorder and other conditions, conclude that there is considerable overlap between personality disorder and psychiatric disorder (including substance use disorders) and identify a model, a 'spectrum or co-aggregation', to describe this complexity. This model implies that personality disorder and psychiatric disorder overlap phenomenologically and 'are simultaneously expressed in the same person'. IPP prisoners remaining in custody exemplify this with patterns of behaviour and mental state abnormalities arising from pre-existing conditions augmented by the traumatic effects of the indeterminacy of the sentence, loss of hope and resentment at the unfairness of being held in prison long after their tariff has expired. Their behaviour, which can include significant self-harm and high levels of anxiety, is associated with disruptive behaviour and difficulty engaging with the prison regime and prison-based treatment programmes. Although many exhibit marked mental state changes, they are usually held not to reach the threshold for transfer to hospital for treatment. Duggan & Tyrer (2022) conclude that mental health services provide treatment services for specific disorders, usually requiring commitment to treatment, but do not have management systems to engage and manage those with complex needs. The result is that such prisoners become 'stuck', unable to demonstrate that they have made sufficient progress and/or have a community management plan in place to manage their complexity.

Hospital transfers

One group of prisoners who present challenges at Parole Board hearings are those who have been transferred to hospital for treatment under mental health legislation and are subsequently remitted back to prison. The scale of this has increased over the past two decades. In 2003, 96 patients were remitted back to prison; by 2019, this number had tripled to 295 (Ministry of Justice 2020a). Over the same period the number of transfers to hospital of sentenced prisoners doubled from 489 in 2003 to 1039 in 2019. The reason for the disproportionate increase in remitted prisoners is not understood, but the potential impact on Parole Board hearings can be inferred from some recent work by the Offender Research Network. Leonard and colleagues prospectively studied a cohort of patients who were remitted to prison from NHS medium secure units in England (Leonard 2020). They summarised previous work as follows:

> 'Persons who are remitted to prison are a vulnerable group of psychiatric patients, two-thirds of whom have a primary diagnosis of severe mental illness (SMI). In comparison to patients discharged via a community care pathway, those remitted to prison experience significantly more psychotic symptoms at time of discharge and are assessed both to be at a significantly higher risk of future violence and to have a lower prevalence of protective factors that mitigate subsequent risks of offending and relapse' (Leonard 2020).

Leonard et al (2020) found that 28% of remitted patients were sent back to prison because they were assessed as 'not engaging with treatment' or because they were too high risk to remain in a medium secure unit. But a subsequent study confirmed that they had not been referred to high secure services (Leonard 2021). They also found that remittal to prison resulted in a loss of access to aftercare, for example several of their cohort were remitted close to their earliest release date or parole eligibility date, and they questioned why these patients did not remain in the medium secure unit to be released from there, which may well have ensured a more successful discharge to the community. It is unclear whether services

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subsequently met their obligations under section 117 of the Mental Health Act 1983, which entitles individuals detained under the Act to continued aftercare services on discharge. Section 117 aftercare applies both to those discharged from hospital to the community and to those remitted back to prison. The remitting team's responsibility for review and aftercare under section 117 is rarely acknowledged in post-remission care planning: 'out of sight, out of mind'.

This resonates with our experience of prisoners who were remitted to prison and were told at their subsequent Parole Board hearing that they were not eligible to be supported by the local forensic outreach and liaison service team because that was available only for patients discharged directly from the medium secure unit, even though their needs were identical to those patients.

Community aftercare of offenders released on parole

A recent study which analysed a sample from the 2014 English National Survey of Psychiatric Morbidity (Bebbington 2021) examined the mental health of ex-prisoners and found that they had 'extremely high rates' of mental disorder, including psychosis. The authors concluded that:

> 'If the complex social and psychiatric problems faced by ex-prisoners are to be managed effectively, good liaison is necessary, both within and between agencies. This is best served when prison management, probation services, and the psychiatric teams in the prison and the community work together, in tandem with primary medical care, and local authority social and housing services, as required. Done effectively, this will mitigate both mental health difficulties and the risk of recidivism' (Bebbington 2021).

They acknowledged that this level of liaison has not happened, and to facilitate it they recommended that the prison mental health team should have a lead role in managing release. This can only work if the prison team has sufficient power to direct aftercare; otherwise they are helpless in the face of protocols that allow engagement only when the individual is established in the community. A joint thematic inspection of the criminal justice 'journey' for individuals with mental health needs and disorders (HM Inspectorate of Probation 2021) highlighted a number of deficiencies, including that the continuity of mental healthcare from custody into the community is generally poor and that the waiting lists for community mental healthcare are very long: in one example it took 24 months to be seen. The authors concluded that prisons are served by a poorly performing and disjointed system. They suggested that because of the length of these waiting lists, mentally ill people released on licence would often be recalled to prison because their mental health deteriorated before they could be assessed by the community team, supporting the previous conclusion of Edgar et al (2020).

An example of good liaison and joint working between mental health services and the National Probation Service (NPS) is described by Bourn et al (2015). Although much of this work was focused on community sentenced offenders, it also included an innovative 'approved premises' managed by the NPS but set up in partnership with the local forensic secure service, specifically for mentally disordered offenders released from prison.

Psychiatrists' roles in parole hearings

The Parole Board for England and Wales is a court-like body with powers falling short of those familiar to psychiatrists reporting to criminal courts or mental health review tribunals (Box 2). The Parole Board differs in three important ways:

- the inquisitorial nature of the hearing
- the test employed for release
- the inherent expertise of parole panels with a psychiatric member.

Criminal courts in England and Wales operate an adversarial process. The Parole Board, however, in common with mental health review tribunals, adopts an inquisitorial approach, reviewing an extensive dossier of evidence, interrogating that 'evidence' and directing further reports if needed, and directly questioning witnesses; thus, it both generates and appraises the evidence used in decision-making.

It is not always appreciated by psychiatric witnesses in parole hearings that the test being applied by the Parole Board is solely concerned with risk and does not directly concern the welfare of the offender. The onus is on the offender to show that their risk has reduced sufficiently to be released. This contrasts with mental health legislation, where the detaining authority must make the case for continued detention; if it fails to do so, release is mandatory. This is the opposite of the test for parole. Padfield (2020) argues that a judicial body should have the freedom to look at all aspects of a prisoner's case when making decisions on release, as availability of treatment and rehabilitation affects sentence length. This can present ethical challenges to both the psychiatrist member of the parole panel and psychiatric witnesses to the hearing.

Appraising the reliability of scientific evidence is a challenge for courts. Parole panels have a distinct

BOX 2 The Parole Board for England and Wales

The Parole Board for England and Wales is an independent public body responsible for the parole system. It conducts risk assessments on prisoners to determine whether they can be safely released to the community. It was established in 1968 under the Criminal Justice Act 1967 and became an independent executive non-departmental public body on 1 July 1996 under the Criminal Justice and Public Order Act 1994. The Parole Board is governed by the Parole Board Rules, secondary legislation that sets out the procedures that must be followed when determining parole cases.

The Parole Board deals with four main groups of prisoners:

- Extended determinate sentences: these are prisoners with a fixed number of years for their sentence and an extended licence period fixed by law. At the discretion of the Board, they have the potential for early release, serving the remainder of their sentence in the community under licence but subject to recall if they breach licence conditions.
- Indeterminate sentences: These are prisoners with life sentences and those with indeterminate sentences of imprisonment for public protection (IPP). IPP prisoners must spend a minimum amount of time in prison before they are considered for release by the Parole Board, but there is no set date as to when they must be released.
- Sentences for offenders of particular concern, including terrorists and serious child sex offenders.
- Recalled prisoners: The Parole Board reviews all IPP recall cases and any determinate recall cases referred by the Secretary of State for Justice.

The Parole Board fulfils three main functions:

- it decides whether to release all indeterminate (life and IPP sentences) and some extended determinate sentence prisoners, approving licence conditions when it does so
- it reviews the circumstances in which all indeterminate and some determinate sentence prisoners who have been recalled to prison for alleged or actual reoffending, or breach of licence during the probation supervision period, and decides whether to re-release these prisoners
- it makes recommendations (therefore non-binding) to the Secretary of State for Justice for the transfer of indeterminate sentence prisoners from a closed (high- or medium-security) prison to an open (low-security) prison.

Membership

Parole decisions are made by an independent panel of members. Members come from a variety of professional backgrounds. Members include independent members drawn from a wide spectrum of society and members appointed as specialists, being either judges, psychiatrists or psychologists (some with additional terrorist risk expertise). All are part-time appointments.

For the year 2021–2022, there were 346 Parole Board members (all part time), comprising:

- 190 independent members
- 55 judicial members
- 64 psychology members
- 37 psychiatry members.

The current membership list is available to the public through the annual report of the Parole Board (Parole Board 2022).

The psychiatrist member must hold registration in a recognised psychiatric specialty and have at least 5 years' experience in a senior position but does not need to hold a licence to practise.

Key statistics for 2021–2022

The cases of 22 530 individuals were considered by the Parole Board through a sifting system called Member Case Assessment (MCA). The majority had their cases decided through a hearing based on papers only. The remaining 8835 (39%) were referred to an oral hearing; the decisions for 6344 of those referred were as follows:

- 2354 (37% of completed hearings) remained in custody
- 556 (9% of completed hearings) had a recommendation made to the Secretary of State for transfer to open conditions
- 3434 (54% of completed hearings) were released.

(Parole Board 2019, 2022; Beard 2023)

advantage over other courts, as when psychiatric evidence is presented, the panel has the advantage of the psychiatrist member, who can scrutinise evidence for its scientific value and the weight to be attributed to it; thus, parole panels directly appraise the reliability and admissibility of psychiatric evidence (Box 3).

Three roles can be identified for psychiatrists within parole hearings.

Psychiatrist as Parole Board member

The psychiatrist member when sitting on parole hearings is discharging a judicial role. They are expected to use their psychiatric knowledge and experience to help the panel understand professional and expert psychiatric evidence, advise on its reliability and lead questioning of clinical witnesses (both psychiatrists and psychologists) and usually also of the prisoner if the individual has a history of mental disorder. They do not conduct a psychiatric assessment of the offender, confining their role to their judicial function. The psychiatrist member will contribute in other ways, such as appraising the capacity of offenders to participate effectively in proceedings, advising on modifications to the hearing process to take account of vulnerabilities and applying their knowledge to better direct the content of professional and expert witness reports. Where expert or professional psychiatric and psychology opinions are not in agreement, the psychiatrist panel member will play a pivotal role in judging which opinion the panel relies on when reaching their decision.

Although their role as a panel member is a judicial role, the psychiatrist member retains their registration; they are still inescapably a doctor. However, the psychiatrist member does not carry out a clinical examination of the prisoner. There may be tension between their judicial and clinical roles. Parole panels have neither powers nor obligations to take steps to address deficiencies in treatment provided or availability of treatment and aftercare. However, the psychiatrist member of the Parole

BOX 3 Professional witnesses to the Parole Board for England and Wales

The Generic Parole Process Framework (Ministry of Justice 2020b) gives guidance for in-reach teams providing professional reports to Parole Board panels which in our view should equally apply to clinicians acting as gatekeepers to services.

We reproduce sections 5.6.18 and 5.6.19 of the framework here:

'5.6.18 Prison healthcare staff will be asked to provide evidence to the Parole Board on a professional basis, not an expert basis. This means that they are required to provide factual evidence about the prisoner's health, such as the diagnosis, including any autism diagnosis, their physical capacity, the treatment being provided, and, where appropriate, their prognosis. They are not required to provide an opinion on the prisoner's risk of harm and should not offer one. The task of assessing risk is the responsibility of the POM [Prison Offender Manager], COM[Community Offender Manager]/Probation Practitioner and in some cases, a psychologist or other expert.'

'5.6.19 NHS England and NHS Wales have confirmed that requests by the Parole Board for professional evidence, including oral evidence, are covered by existing healthcare contracts, and therefore should be completed as "business as usual" tasks […].'

Board will nevertheless as a doctor have a duty to try to ensure that prisoners receive proper assessment or treatment and aftercare for their mental disorder. Dual responsibility is an inescapable ethical dilemma for Parole Board psychiatrists (Box 3). The psychiatrist member generates evidence through professionally informed interviewing and then uses that evidence to decide on release, thus further blurring their judicial and professional duties.

Psychiatrist as professional witness

Most psychiatric reports that parole panels require, from either in-reach prison teams or catchment area services, address one of two areas: either the prisoner's current psychiatric treatment needs and how these can be met in prison or through hospital transfer, or advice on continuing treatment needs and availability in the community, if release can be directed (see the section above on Community aftercare). Community teams assert that they do not have a duty, or have the capacity, to provide reports to parole panels on aftercare while the prisoner remains detained. In-reach teams are obliged, for patients under their care, to provide advice on need for continuing aftercare but do not have powers to direct that care in the community, limiting the usefulness of such reports for parole purposes. For prisoners who may be treatment avoidant and not in contact with in-reach, obtaining a clinical review for parole hearings can be exceedingly difficult. These significant gaps in what should constitute routine clinical care result in delays in panels receiving full information before making decisions, thus in practice resulting in prisoners remaining in custody while the panel endeavours to resolve the issue.

Community general and forensic psychiatrists providing evidence as professional witnesses on treatment availability and community aftercare often do so with multiple and conflicting roles and responsibilities. In the public health system, the psychiatrist has obligations to the state to fairly distribute health resources and thereby acts as a gatekeeper to psychiatric healthcare. They will have duties to their team to ensure that their service does not accept responsibility for patients they feel they cannot manage. The psychiatrist may have had previous contact with the prisoner, for example providing reports at time of sentence or may have had previous clinical responsibility. This makes providing professional evidence to parole hearings a complex clinical activity (Box 3). There is a temptation for gatekeepers to services to concentrate on one facet of a complex presentation to deem the offender as unsuitable for their service, resulting in no offer of treatment or continuing community care (Duggan 2022).

Guidance for in-reach teams (which in our opinion applies to all professional witnesses) on providing an opinion on risk is available (Box 3); that advice is that they should not express an opinion on risk for release (Ministry of Justice 2020b: section 5.6.18). However, risk assessment is a routine part of clinical practice, for example to decide whether a team can safely manage a patient, and must therefore form part of the professional witness's evidence. We interpret this to mean that the report writer is not expected to and should not express an opinion on suitability for release but can and should disclose any risk evaluation conducted as part of their clinical review, thus contributing to the parole panel's assessment of whether the offender meets the test for release.

Psychiatrist as expert witness

There are no specific procedural rules governing expert witnesses in Parole Board hearings in England and Wales as there are for criminal courts. Rix et al (2020) provide detailed guidance for witnesses to criminal courts, including procedural rules that govern admissibility of evidence and

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duties of an expert witness. We consider that the standards and rules governing expert evidence to criminal courts (Rix 2020) apply equally to evidence to parole hearings, although they are not laid down in statutory instruments.

Although expert witnesses should provide opinion only within their area of expertise, for parole board hearings, because of the complexity of many offenders, area of expertise needs to be generously interpreted. Experts to the Parole Board will need to encompass all aspects of a complex presentation. Reports need to be focused on the specific issues that lie outside the 'knowledge and experience' of Parole Board panels, taking account of the inherent expertise available through having a psychiatrist member. The panel will have considerable knowledge of the impact of personality disorder and substance misuse on the risk of long-term offending. What is needed is preparedness to engage with complexity and with treatment-avoidant offenders, and at times to advise of differences in view between, for example, mental health in-reach teams and catchment area services.

Conclusions

We have made the case that psychiatry has an essential function in the parole system for public protection. This is because, first, parole is integral to sentencing in the criminal justice system; second, risk is the sole test for release on parole; and third, mental disorder is a significant driver of risk in a substantial number of prisoners. It therefore follows that effective treatment during a sentence and effective management of mental disorder in the community are essential to the risk management plan for this group and will contribute to public safety, reducing recalls to prison and lessening the burden of mental ill health both in prison and in the community. This role begins with effective diversion from custody, both before sentencing and during a sentence. It is dependent on high-quality prison mental health services working in partnership with mental health services outside the prison and multi-agency working. It will then have a direct impact on the length of the sentence effectively served. We have identified three roles for psychiatrists encountering parole systems and reviewed the practice implications, standards applicable to these roles and how psychiatrists can most effectively fulfil them. We consider that the provision to the parole board of good-quality psychiatric evidence regarding the complexity of presentation and pathway to release of offenders with mental disorder is of such importance that exposure to the parole process should form part of the training of psychiatrists, particularly that of forensic psychiatrists.

Effective treatment as described depends on the commissioning of appropriate psychiatric services both in prisons and in the community. The recent change in the commissioning of specialist mental health services, including forensic services, with NHS-led 'provider collaboratives' provides an opportunity for the often proposed transition between services to be seamless, especially between prison mental health services and both in-patient forensic and community mental health services. This was a core part of guidance for commissioners of forensic mental health services published in 2013 (Joint Commissioning Panel for Mental Health 2013) but it has yet to be achieved. One way to progress this would be if forensic mental health services had care management responsibility for treatment and aftercare for offender patients in their catchment area, including those in prison. This would then include the planning of their release back into the community to ensure that services are provided to fully meet their mental health needs.

Supplementary material

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Author contributions

All three authors wrote sections of the article and together edited the whole article.

Declaration of interest

None.

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MCQs

Select the single best option for each question stem

1 Early release:
- a is always decided through a parole board decision
- b requires the prisoner to abide by licence conditions for release
- c applies only to prisoners on indeterminate sentences
- d results in the ending of the sentence
- e is a system that operates only in England and Wales.

2 An acknowledged view about a parole-based release system is:
- a it is preferable to release by a judicial body
- b it can result in a determinate sentence prisoner spending longer in prison than the sentence they received in court
- c it is based on highly accurate risk assessment tools
- d in England and Wales, the decision to release includes consideration of the welfare of the prisoner
- e for prisoners serving indeterminate sentences (life) a decision not to release results in remaining in prison beyond the tariff period set for punishment.

3 The Parole Board for England and Wales has powers to:
- a direct release and direct prisoners to open prison conditions
- b direct release and recommend transfer of prisoners to open conditions
- c direct transfer of prisoners to hospital for treatment of mental disorder
- d make recommendations only, for release and open conditions
- e direct treatment of prisoners in prison.

4 As regards mental disorder in prisoners in England and Wales:
- a it is known that the level of mental disorder is increasing year by year
- b there is no evidence that it can cause prisoners to be violent following release
- c substance misuse does not have any effect on a released prisoner's risk of violence
- d social support following release from prison is as important as treatment of their mental illness in preventing recall to prison
- e continuity of treatment of mental disorder between prison and the community is known to be particularly good.

5 The psychiatrist member of the Parole Board for England and Wales:
- a sits as a generic Parole Board member
- b sits as a full judicial member of the Parole Board
- c conducts a full clinical examination of the prisoner as part of the parole process
- d is not required to hold medical registration
- e relinquishes all medical responsibilities when sitting as a Parole Board member.