the Parole Board

working with others to protect the public

Specialist Reports Guidance

December 2023 (V1.1)

Document History

Document version	Date of Issue	Revision description
Version 1.0	15.11.2017	This guidance was created as part of the Parole Board's project to launch fully revised and updated member guidance.
Version 1.1	20.12.2023	Revised title and updated to improve advice on: • Commissioning reports • Deciding if a specialist member is needed on an oral hearing panel • Application of the *Rice* recommendation • Issues of prisoner consent

Contents

1 Introduction

1.1 This guidance has been prepared to support Parole Board ("Board") panels in identifying when a specialist report may be required and in making directions for specialist reports. Specialist reports can include psychological and psychiatric reports, prison healthcare reports and reports from other specialist professionals.

1.2 The guidance is relevant to panels considering cases at the Member Case Assessment (MCA) stage, at the oral hearing stage, or when acting as a Duty Member. All are referred to as "the panel". It sets out guidance on:

- Mental Health difficulties and the prison population;
- Personality disorder;
- The link between mental health difficulties and risk;
- Psychologists and psychiatrists;
- Specialist psychological and psychiatric reports on risk;
- Prison healthcare reports relating to mental healthcare;
- Professionals involved in preparing specialist reports;
- Guidance in directing psychological and psychiatric reports;
- Consent and engagement;
- Specialist members.

1.3 For the purpose of this guidance, the term 'mental health difficulty' is used; however, if a prisoner has a diagnosis under the Mental Health Act 1983, the term used is 'mental health disorder'[1].

2 Mental Health Difficulties and the Prison Population

2.1 A systematic review[2] of 62 surveys of the prison population from 12 Western countries showed that, among men:

- 3.7% experienced psychosis to a degree that would merit treatment;
- 10% experienced major depression (that is, not transient mood changes or low mood);
- 65% had a personality disorder, including 47% with antisocial personality disorder.

2.2 These figures are in line with the most comprehensive study of psychiatric disorders in the UK prison population[3]. Whilst now dated, these do reflect the high level of mental health problems across the prison population.

---

[1] As defined by the Mental Health Act as "any disorder or disability of the mind".

[2] Fazel S, Danesh J: Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys. Lancet 359:545–50, 2002. Anasseril E. Daniel, MD. (2007). Care of the Mentally Ill in Prisons: Challenges and Solutions. The Journal of the American Academy of Psychiatry and the Law. 35, 406-410.

[3] Singleton, Nicola & Meltzer, Howard & Gatward, Rebecca & Coid, Jeremy & Deasy, Derek. (1998). Psychiatric Morbidity Among Prisoners: Summary Report.

2.3 Female prisoners similarly showed the same over-representation of mental health difficulties in studies. With the prevalence of mental health difficulties greater among women in prison than in the male estate[4]:

- 4% experienced psychosis;
- 12% experienced major depression;
- 42% presented with a personality disorder.

2.4 In 2020, HM Inspectorate of Prisons conducted a thematic review[5] interviewing over 70 men, women, and children across six prisons. This review found that 52% of those interviewed had mental health difficulties and only 22% found it easy to see a mental health worker. It evidenced the current and continuing issues of over representation of mental health difficulties within the prison population.

2.5 Mental health difficulties can encompass a range of experiences, and may attract diagnoses including the following: anxiety, depression, eating disorders, post-traumatic stress disorder (PTSD), anxiety disorders, psychosis, organic disorders, short-term and long-term issues arising from traumatic brain injury, suicidal behaviour, distress associated with all forms of abuse, attention deficit hyperactivity disorder (ADHD), and other neurodevelopmental disorders, including learning disability and autistic spectrum disorders (ASD). It should be noted that some health providers adopt a more stringent approach on what constitutes mental health and so panels may need advice on who should be responsible for complying with a relevant direction. All forms of mental health difficulty are over-represented in the prison population compared to the general population[6].

2.6 Most prisoners with significant mental health difficulties have features of more than one mental health problem, with a large percentage also having significant substance misuse problems.

2.7 Compared to the general population, prisoners are more likely to be economically disadvantaged, have low literacy and numeracy levels, have often been excluded from school, lack vocational and employment skills, and have borderline or mild learning disability. Many will have experienced Adverse Childhood Experiences such as abuse or being in care and can have long lasting effects. Black, Asian, and minority ethnic groups are also over-represented in prison, many of whom have experienced intergenerational racial trauma. These social characteristics in turn increase the likelihood of mental health difficulties[7].

2.8 Prisoners with unmet mental health needs are at higher risk of suicide attempts, mortality, and recidivism after release[8].

---

[4] *Prison health - Health and Social Care Committee - House of Commons (parliament.uk)*
[5] *HM Inspectorate of Prisons. (2021). HM Chief Inspector of Prisons for England and Wales: Annual Report 2020–21. London: HM Inspectorate of Prisons.*
[6] *Prison health - Health and Social Care Committee - House of Commons (parliament.uk)*
[7] *The Bromley Briefings produced by the Prison Reform Trust*
[8] *Baranyi G, Scholl, C, Fazel S, Patel V, Priebe S & Mundt A. Severe mental illness and substance use in prisoners in low-income and middle-income countries; a systematic review and meta-analysis of prevalence studies. Lancet Global Health, 7, e461-71, 2019.*

2.9 Given this, and the prevalence of mental health difficulties amongst prisoners, understanding the link, if any, between mental health difficulties and the risk the prisoner poses is central to panel's decision making.

3 Personality Disorders

3.1 Personality disorders are a set of patterns of thinking, emotions and behaviour that often develop as a result of coping with and surviving Adverse Childhood Experiences. These patterns of beliefs may have been adaptive for the person during their childhood, but often go on to cause problems for them and for others in adulthood. As an adult, the person may have developed unhelpful and powerful beliefs and assumptions about themselves, other people, and the world around them.

3.2 Personality disorders fall into a range of diagnostic categories; however, in reality, there is a lot of overlap between different personality disorders and a lot of variation between individuals within each diagnostic category. For a personality disorder to be present, the characteristics need to be outside the norm of the society in which the individual lives (problematic), chronic throughout an individual's life, constant (persistent) and result in distress in a number of personal and social contexts (pervasive).

3.3 It is important to understand that personality characteristics are on a continuum - from normal variation through personality disorder difficulties to a personality disorder with the difference between normal variation, difficulty, and disorder. These can be differences of degree rather than differences of kind. For example, being cautious is a normal personality characteristic; being suspicious may be a personality disorder difficulty and being paranoid may be a recognisable personality disorder. However, they all range in differences in degree of a common personality characteristic.

3.4 The dysfunctional patterns of thinking and behaviour that underlie personality disorders are developed over a long time, starting in childhood. Adult personality difficulties arise from a complex interplay between temperament/genetic endowment, developmental problems and adverse experiences, brain development, and adverse social problems such as poverty or discrimination. For example, a child brought up in an environment where violence is frequently used to settle arguments, where alcohol and drugs are used to self-medicate anger and sorrow, and where it is advantageous to lie to avoid punishment, may adopt these behaviours which will endure into their adult life.

3.5 Personality disorders typically require long-term interventions, although some can and do improve in the right environment. The types of regimes that could address personality disorders include those that focus on creating the right 'relational environments'. These are likely to be psychologically informed and will focus on providing a regime that uses the established evidence around Rehabilitative Culture, Procedural Justice, and improving the quality of the relationships between staff and prisoners.

3.6 Holistic, therapeutic environments such as these include Therapeutic Communities (TCs) and Psychologically Informed Planned Environments (PIPEs). Even without treatment, personality disorders/traits can improve given a positive environment, maturation, good interpersonal interactions, the development of trusting relationships and pro-social modelling. There are no medications specifically approved for personality disorder, however medication can be prescribed to treat problems associated with it. For example, depression, anxiety, persistent hyper-arousal and irritability, or psychotic symptoms.

3.7 It is difficult to draw conclusions about personality under the age of 25. Whilst there might be indications of personality disorder for a young person, sometimes termed "emerging personality disorder", professionals *must not* provide a formal diagnosis for a young person due to their age. This does not mean that personality disorder traits are not relevant to risk, but that drawing any final conclusion on emerging personality disorder during the intense developmental changes occurring in late adolescence is hazardous.

3.8 There is considerable overlap between the different personality disorders and with other forms of disorder, for example Autistic Spectrum Disorder and learning disability, which can complicate assessment. Personality disorder has been a diagnosis of exclusion from treatment in the past[9], but there is now a comprehensive personality disorder pathway for prisoners which seeks to apply best practice to management of personality disorder.

3.9 The Offender Personality Disorder Pathway (OPDP) is jointly commissioned by HMPPS and NHS England. It aims to provide psychologically informed services to prisoners and support to staff members working with this group. It targets people who are deemed to be high risk of serious harm or a high risk of reoffending in a harmful way, and who are likely to meet the diagnostic criteria for personality disorder. There is a different inclusion criterion for men and women to acknowledge the impact of gender on how people's difficulties present. Those on the pathway may be the least likely to be willing or able to access other types of services, or to do so without additional support. For more details on this pathway, please refer to the Parole Board Guidance on Interventions[10] and also to the HMPPS practitioner's guide: "Working with people in the Criminal Justice System showing personality difficulties: A Practitioner's Guide".

3.10 The OPDP requires Probation Service staff to use an evidence-based screening tool on the Probation caseload to determine their suitability for the Pathway (see below); however, this is not evidence of a diagnosis.

3.11 An assessment of personality disorder can sometimes help to understand someone's risk, but personality disorder, or traits of personality disorder, are not always relevant to risk. Even if personality disorder is not relevant to risk, it may be relevant to a person's treatability, their response to or ability to engage in programmes, or their manageability under supervision

[9] *NHS NIMHE Personality Disorder: no longer a diagnosis of exclusion*
[10] *At the time of writing, Parole Board guidance on interventions is in development.*

in the community. An understanding of personality traits could help parole panels to understand why someone has not benefited from a programme or intervention. It could also inform useful strategies to help prison or probation staff to engage positively with the prisoner, and a formal diagnosis may not be needed.

3.12 There are controversies surrounding personality disorder. Diagnosis is often less reliable than for mental illnesses, with differing diagnoses arising from various professionals and assessments. In addition, there is a view amongst many that the diagnosis is blaming and unhelpful. It can be seen to locate all the problems within the person rather than understanding that the person's difficulties are often a result of attempting to cope with and adapt to adverse conditions, such as abuse.

3.13 Panels may wish to consider that there is an emerging trend away from diagnosing personality disorder, and it can often now be talked about in terms of previous trauma and symptomology of that trauma i.e. 'personality traits'. Reports will often identify what problems the person has in terms of how they engage with other people, and themselves, why the psychologist/psychiatrist thinks they function in the way that they do e.g., the historical context of the current presenting problems (or formulation), and how best to help this person as they go forwards. Sometimes a diagnosis can pave the way to services and treatment pathways, but other times it may be seen as stigmatising. A formal personality disorder diagnosis is not needed to access the PD pathway. Therefore, rather than focusing on the diagnosis, it can be more helpful to focus on the traits displayed.

3.14 Professionals giving evidence to a parole panel should be able to explain to what extent personality disorder or traits are relevant to risk. A diagnosis (or otherwise) of personality disorder may not be necessary or, indeed, helpful, but professionals giving evidence should be able to explain the role of personality traits in the formulation of the prisoner's behaviour.

3.15 Seeking further specialist guidance, either in the shape of a report, via consultation with a specialist member or by a specialist member sitting on the panel may be required if:

- the risk assessment is uncertain;
- the offending is odd or unusual;
- the prisoner's presentation is bizarre or unusual;
- the prisoner is highly distressed or emotionally volatile;
- the prisoner has had a great deal of input from mental health or psychological services in the past;
- the prisoner has a history of disengagement and difficult relationships with support services;
- there is much disagreement from professionals as to diagnosis and on what intervention is required; and
- the prisoner has failed to make significant improvement from previous treatment, or it is unclear what treatment pathway is appropriate for them.

3.16 For more information on consultations with a specialist member and when a specialist member may be needed on the panel, please see section 15 of this guidance.

4 The Link Between Mental Health Difficulties and Risk

Where there is a direct link between mental health difficulties and risk

4.1 Violent or sexual offences may arise directly from specific features of mental health difficulties. Examples include:

- Individual who attacks their father with a knife believing him to be Satan;
- Individual with no previous convictions who at the age of 66 seriously assaults their neighbour. It emerged later that the prisoner was suffering from dementia;
- Individual who kills their children when suffering from post-natal depression; and
- Individual who acts on command hallucinations (voices commanding them to do something).

Where Mental Health Difficulties are a Contextual Factor

4.2 Mental health difficulties (including personality disorders) may set the scene within which violent and sexual offending occurs. Examples include:

- Individuals who have been sexually abused in childhood who go on in adult life to experience significant psychological problems and commit sexual offences themselves;
- Personality disorders which involve antisocial attitudes, emotional dysregulation and distorted thinking can form the background to offending; and
- Paranoid traits, paranoid symptoms, and the experience of abnormal mental phenomena such as hallucinations, which lead the prisoner to have a distorted view of the world. This can then lead them to commit offences, sometimes from a distorted sense of self defence.

Where there is an Indirect Link between Mental Health Difficulties and Risk

4.3 This is perhaps the most common way in which mental health difficulties impact upon risk. Examples include:

- An individual who is paranoid and experiencing psychosis but that was not a major factor at the time of the index offence;
- Mental health difficulties affect the ability of the individual to participate in interventions to address other risk factors;
- Mental health difficulties affect the ability of the individual to co-operate well with supervision;
- Mental health difficulties are associated with significant substance misuse and marked problems in social integration; and

- On release, un-treated mental health difficulties can lead to a downward spiral of substance misuse, social isolation and disengagement from statutory supervision and reoffending.

5 Professionals Involved in Preparing Reports

5.1 Psychology is the scientific study of people, the mind and behaviour. **Psychologists** attempt to understand the role of mental functions in individual and social behaviour. **Forensic psychology** is the application of psychological knowledge within the context of the Criminal Justice System, in this case to prisoners and offending behaviour, and their risk to the public.

5.2 Forensic psychologists use their knowledge to make evidence-based assessments about when reoffending may occur. They are skilled in the use of risk assessment tools and other assessment techniques (please see guidance on Risk Assessment for more information). Many forensic psychologists are directly employed by HMPPS.

5.3 Registration with the Health and Care Professions Council (HCPC) is a professional requirement for psychologists. Only Registered Psychologists are allowed to use the protected title "Forensic Psychologist"[11].

5.4 Non-registered psychologists may call themselves consultants or refer to a related but un-protected title e.g., "criminal psychologist". Chartership is a qualification granted by the British Psychological Society (BPS). Chartered Psychologists are not necessarily Registered Psychologists although they usually are.

5.5 Several of the forensic psychologists who produce reports on behalf of HMPPS for the Parole Board are "trainees" in terms of their Registered Psychologist status with the HCPC and therefore would not use the title 'Registered' or 'Forensic' without also denoting they are a trainee. Trainee Psychologists will have their reports produced under supervision from a Registered Psychologist. If called upon to give evidence, trainee psychologists may, on occasion, request their supervisor to be present at the oral hearing. The route to Registered status can be lengthy, and many trainee psychologists are experienced and competent in their field. They may also be fully qualified to perform a particular role, for example as a programme lead, even if they have not yet achieved Registered status[12].

5.6 It is important to be aware of the registration and experience of the psychologist providing evidence to a panel. Psychologists providing assessment reports for parole reviews should be Registered and able to use a relevant protected title, or be under the supervision of a Registered Psychologist, to ensure professional standards are maintained.

---

[11] Other protected titles include practitioner psychologist, registered psychologist, clinical psychologist, counselling psychologist, health psychologist, educational psychologist, occupational psychologist and sport and exercise psychologist.

[12] NB Since 2009 psychologists are required to obtain registration with the Health Care Professions Council (HCPC) to practice independently. Prior to 2009, psychologists became chartered with the British Psychological Society (BPS).

5.7 The HCPC maintains a list of Registered Psychologists which can be checked if information is needed on the modality in which the psychologist is registered: HCPC Website.

5.8 For prisoner commissioned reports, panels will need to consider the qualifications of the practitioner within their risk assessments and ensure they are suitably trained. Some psychologists may be registered with a different protected title (e.g., Educational/Clinical). The panel should assure itself that they are qualified to report on the matters required. If panels have concerns about the qualifications of the practitioner, they may wish to issue a direction to obtain clarification on qualifications. If there remain concerns about whether they are suitably trained, the panel will need to determine what weight to give to their evidence.

5.9 In practice, the pool of Registered practitioners is quite small, and a number will produce reports for both HMPPS and those commissioned by the prisoner.

5.10 Occasionally, it may be considered that the nature of the problem is such that another type of psychological assessment is required, for example a neuropsychological assessment or clinical psychological assessment. These psychologists are rarely employed by HMPPS, and such assessments would need to be commissioned through the prison Healthcare Unit if the report is regarding sentence planning, or the Offender Management Unit in the prison if the report is a risk-based report[13]. It may be useful for panels to consult with a specialist member where they are considering directing such a report (please see section 15 on consulting with a specialist member).

5.11 **Psychiatrists** are medically qualified doctors who, following their general medical training, specialise in psychiatry. **Forensic psychiatry** is that branch of psychiatry that deals with individuals with mental health disorders involved in the criminal justice system, including individuals in prison and individuals transferred to hospital under s47/49 or 45A of the Mental Health Act. Reports for the Board may be produced by psychiatrists working in prison within Mental Health In-Reach teams (MHIRT)[14] whilst others may be employed in NHS forensic units or units in the independent sector providing treatment to prisoners, or by specialists working solely in report writing practice.

5.12 It is important to note that the funding and commissioning arrangements for specialist risk reports are not part of the NHS service specification and therefore are funded by the prison (but are an unfunded cost that they have to find). At times, such reports can be difficult to source and therefore careful consideration of the need and utility of these is required. See section 11 on practical arrangements for more information.

[13] HMPPS has produced guidance for prison staff.
[14] Such reports will be reports based upon mental health diagnoses, compliance and general stability. These are not risk based mental health reports.

5.13 Psychologists and psychiatrists overlap to some extent in the populations they serve, clinical skills, assessment methods, and expertise in risk assessment. Thus, both professions can have expertise in the assessment of people with personality disorder, neurodevelopmental disorders such as ADHD, learning disability, or acquired brain injury. Forensic psychiatrists may take primary responsibility for people with mental illnesses such as schizophrenia, whilst forensic psychologists may have greater expertise in the application of psychological methods to offender treatment programmes and structured risk assessment.

5.14 Psychiatrists will take a clinical judgement approach, addressing individual characteristics and taking particular account of functional impairment, sometimes, but not always, employing structured assessment tools. Forensic psychologists generally favour structured assessments when assessing for responsivity factors, such as personality disorder or psychopathy. These may include the International Personality Disorder Examination (IPDE) or the Hare Psychopathy Checklist (PCL-R). They will also tend to employ structured professional judgement tools to assess for risk, such as the Historical Clinical Risk Management–20 (HCR-20) or the Sexual Violence Risk–20 (SVR-20). Most will produce an individual formulation explaining the function of the offending behaviour and the associated risk factors. Judgement must be exercised in deciding who to direct a report from (see sections 6, 7 and 8 below).

5.15 Please refer to the Parole Board Guidance on Risk Assessment for further information on structured professional judgement tools.

6 Types of Reports

6.1 The Board recognises two broad categories of evidence from professional witnesses including psychiatrists and psychologists: professional evidence and expert evidence.

Professional evidence

6.2 When a prisoner is under the care of a medical practitioner, the panel can direct a written report on the factual evidence concerning their treatment. This factual evidence may include the diagnosis reached by the practitioner, what treatment has been provided, previous compliance with treatment, likely effects of treatment, and any need for follow-up treatment. Panels can then consider what weight to place on the treatment (either in hospital or in prison) and determine if any further may be interventions required.

6.3 Panels may receive reports from psychiatrists or psychologists on a prisoner's clinical condition or a summary of the treatment received and response to that treatment either in prison or in hospital. Such reports are professional evidence forming part of the factual evidence of the case.

6.4 Healthcare reports are a form of professional evidence. The HMPPS Generic Parole Process (GPP) Policy Framework provides advice on healthcare reports for the parole process. It provides the following guidance:

"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 a diagnosis, including any autism diagnosis, their physical capacity, the treatment provided, and, where appropriate, the prognosis. They are not required to provide an opinion on the prisoner's risk of harm and should not offer one."

6.5 Where a prisoner is being assessed or is receiving treatment for a mental health difficulty from a prison based MHIRT, a healthcare report may be requested. HMPPS consulted with NHS England and NHS Wales on the guidance to healthcare staff contained in the GPP Policy Framework. Both organisations have agreed that requests by the panel for professional evidence (not risk reports), including oral evidence, are covered by existing healthcare contracts and therefore should be completed as "business as usual" tasks[15].

6.6 Healthcare reports must be completed on an *SPR F Health Care Report* template. Healthcare reports may be completed by any qualified healthcare staff. In cases where the panel requires a report on a particular issue from a particular practitioner, this should be stated clearly in the directions.

6.7 For example, where treatment is being carried out by the community psychiatric nurse, the report may be directed to that practitioner, or where the panel requires particular information about medication and its effects, the report might be directed to a consultant psychiatrist.

6.8 In particularly complex cases, the panel may direct that the report should be prepared by the Consultant Psychiatrist in the relevant team to assist in issues of diagnosis and necessary treatment. Indications for such a direction may include:

- a period of treatment in hospital under the Mental Health Act during the current sentence;
- a prior period of detention for treatment under the Mental Health Act (sections 3, 37, 47 or 48) which qualifies the prisoner for mandatory S117 aftercare[16];
- referrals for such in-patient treatment which have not resulted in transfer but have led to assessments by secure hospital services and advice on continuing treatment;
- emphasis on the value of psychiatric reports in the sentencing remarks, with the judge directing that the reports be retained on file to assist future clinicians in assessing and treating the defendant; and
- any comments on the complexity of cases in previous Parole Board decisions.

[15] As noted in 5.6.267 HMPPS Generic Parole Process (GPP) Policy Framework
[16] the relevant catchment area service may be asked to hold a Care Programme Approach meeting involving relevant agencies and provide treatment plans for the prisoner as part of the Risk Management Plan, if release is directed

6.9 This list is not exhaustive: if in doubt, it may be helpful to consult with a specialist member for advice. Please see section 13 for more information.

6.10 Similarly, psychologists may produce reports on treatment or specific assessments they have undertaken with prisoners (for example assessment of intellectual functioning). These reports should be completed on an *SPR E Psychology Risk Assessment Report* template.

Expert evidence

6.11 Expert evidence differs from professional evidence in that it contains opinions in addition to factual information.

6.12 A panel may require an opinion from the medical practitioner concerning a prisoner's mental health. Evidence on the link between mental health difficulties and risk constitutes opinion rather than fact. This will go beyond the factual matters referred to above and will include the expert's opinion on how the mental health difficulty may affect risk.

6.13 Reports by psychiatrists or psychologists on risk or other matters constitute expert evidence. In most cases, this will require the report writer to carry out a specific assessment (often utilising structured assessments or psychometric tools) to inform an opinion on the relevant area of concern. Please refer to the Guidance on Risk Assessment for information on assessment tools.

6.14 Expert reports are the responsibility of HMPPS (or prisoner if prisoner commissioned) to provide and as stated above, their value in the proceedings needs to be clearly articulated before asking for them to be commissioned.

Principles following the Rice review recommendation

6.15 In order to maintain objectivity and avoid therapeutic bias, panels should ensure that any Psychological Risk Assessments (PRA) undertaken in prison in the dossiers, either from HMPPS or prisoner-commissioned psychologists, are completed by professionals who have not previously been involved in treatment or therapy with the prisoner being assessed.

6.16 This has been best practice following the HM Inspectorate of Probation independent review of the case of Anthony Rice in 2006[17]. The recommendation from that review was:

> *"At the key decision-making points in a prisoner's sentence there should be a separate assessment of the prisoner that is independent of the treatment and which takes into account all available evidence."*

[17] *HMIP An Independent Review of a Serious Further Review Case: Anthony Rice 2006*

6.17 Although a good prior knowledge of a prisoner can be an advantage when assessing risk, extensive involvement in treatment may at times hamper objectivity in risk assessment. Similarly, involvement in repeated risk assessments over a period of time may impair objective assessment and the panel will need to consider what weight to put on their assessments.

6.18 For this reason, the Board's position aligns with the recommendation from the *Rice* review and is that such risk assessments for prisoners should be undertaken independently.

6.19 Panels will need to be alive to the possibility of a professional in a prison or hospital setting who has prior knowledge or engagement with the prisoner in terms of treatment, producing a report that may not have been subject to critical challenge or scrutiny from colleagues. In all situations, the panel will need to explore this carefully with the clinician to ensure that there has been sufficient multi-disciplinary scrutiny to guard against therapeutic bias.

6.20 However, there are some considerations and exceptions to this. Prisoners who are transferred to hospital will often have a PRA undertaken by the psychologists on the multi-disciplinary team. This is an exception to the above and is accepted practice in a clinical setting and may add weight to their assessment. In these settings, tools such as the HCR-20 are usually discussed and agreed by the whole team involving those who have worked with the prisoner, which may act as a safeguard against any treating clinician's bias. Consequently, risk assessments completed and signed off by the clinical team for prisoners in a hospital setting may be accepted without the requirement for another view independent of the treating team.

6.21 Caution should be taken in cases where prisoners are transferred to small pre-release rehabilitation units with more limited clinical resources, as is seen from time to time. If the panel undertaking the review is unfamiliar with the unit where the transferred prisoner is detained, and unsure whether it is supported by comprehensive multidisciplinary teams, then it may be helpful to consult with a specialist member for advice prior to determining whether an independent risk assessment is required and/or seek clarification from the clinician concerning the context and oversight of their assessment.

6.22 Whilst the above principles are to be followed, panels should note that the *Rice* case was an extreme, with limited time between the intervention treatment and the risk assessment. In some instances, the period of time that has elapsed since engagement in treatment delivery may provide the distance for a practitioner to undertake a risk assessment that is sufficiently separate.

6.23 Panels may wish to check the type of report provided in cases where it has been written by a professional who has provided or overseen treatment of the prisoner. The report may not be provided as a full risk assessment report but may have been produced for a different purpose, for example as a summary of progress and formulation, or perhaps as an exit report following a period of time in a Personality Disorder treatment Unit.

Mental Capacity Assessment

6.24 Where there are concerns about whether a prisoner has the mental capacity to make decisions about their parole review or to effectively participate in it, a mental capacity assessment may be required. Issues of mental capacity are specific to the person and must relate to the matter in which they must make a decision, and their decision making at a specific point in time. In these cases, the relevant area of decision-making is the mental capacity of the prisoner to understand and make decisions in the parole process, in effect "*to conduct the parole proceedings*". As such, evidence that the prisoner lacks mental capacity to manage their finances or understand their care needs may not suffice if the aspect of parole is not covered.

6.25 The Mental Capacity Act 2005 states a person is assumed to have capacity unless proved otherwise. Furthermore, an unwise decision (i.e., not wanting to be legally represented in a parole review) does not automatically mean the person lacks capacity in that regard.

6.26 There are four elements to consider:

1. the prisoner's ability to understand the relevant information;
2. their ability to retain that information in mind;
3. their ability to use that information as the basis for their choices or decisions in respect of their parole process; and
4. their ability to communicate their decision.

6.27 All four elements must be present to have capacity in such matters. Conditions which may interfere with capacity include dementia, where information may not be retained; learning difficulties where information may not be understood; and paranoid illnesses where information may not be believed and so may not be used as the basis for decision making. Mental capacity can fluctuate and so this needs to be kept under review and in response to any change in circumstances. When a parole review takes longer than usual, the prisoner may regain capacity at some point or indeed it may deteriorate.

6.28 In theory, anyone can assess the probable mental capacity of another person. For everyday decisions, a relative or carer is the person most suitable to assess whether a person is able to make a particular decision. However, professionals will need to formally assess mental capacity when decisions are more complex, for example when liberty is at stake, as in the case of parole.

6.29 Panels will need to be able to identify cases where capacity is in doubt and take appropriate steps to ensure that this is explored. It may be that by making some adjustments the prisoner can be supported to make decisions without the need for a mental capacity assessment. This could be, for example, by using more appropriate language and repetition to convey complex concepts (please see Oral Hearing Guidance section on prisoners with vulnerabilities for more information). Another example might be where a report highlights an untreated paranoid illness leading to treatment being given which supports the prisoner to be able to make decisions.

6.30 Where a prisoner is found to lack mental capacity, the Parole Board, working with the Public Protection Casework Section (PPCS), has a process in place whereby a litigation friend can be appointed to make decisions and enable effective participation, either directly or by instructing a legal representative. This is supported by the Parole Board Rules 2019 (as amended). Please refer to the guidance on Mental Capacity and Litigation Friend for more detailed information.

7 Psychological or Psychiatric Risk Report?

7.1 When considering if a specialist report providing expert evidence is needed, panels should apply the following considerations:

- whether the additional information provided in the report is necessary to make a balanced risk assessment and/or provide a fair hearing;
- whether the information is available through other means; and
- the timescale within which the report can be produced.

7.2 It is important to focus on what is needed in a particular case, rather than taking a formulaic approach, every case referred to the Board will be different and should be treated as such. See section 12 on Responsibilities and Expectations.

7.3 Specialist reports are directed to provide a panel with an expert assessment of risk employing psychological methodologies and/or to provide an understanding of the link between psychological and/or mental health difficulties and risk. Not all cases require specialist assessments. In the majority of cases where a specialist report is required, a report from a forensic psychologist will be the appropriate direction. Psychiatric reports are reserved for particular cases where the expertise of a psychiatrist is necessary to assess risk in a prisoner with a mental health difficulty.

7.4 A specialist **psychology report** can be sought to provide:

- An assessment of the link between personality and risk;
- An assessment of personality, including diagnosis of personality disorder (but note that understanding the particular pattern of traits and beliefs, and their relationship to risk, is often more helpful than determining whether a diagnosis of a specific personality disorder applies);
- An assessment of intelligence and cognitive impairment where this may affect how best to address risk and ability to engage in standard programmes;[18]
- A report to address risk associated with specific psychological difficulties, such as psychopathy, learning disability, Autistic Spectrum Disorder or acquired brain injury;[19]
- An assessment of risk following a significant event, for example offence paralleling behaviour/adjudication in prison or recall;

[18] It is important to note that these are not always reports that are provided by forensic psychologists and it may be that it is necessary for another practitioner to undertake the report.
[19] It is important to note that these are not always reports that are provided by forensic psychologists and it may be that it is necessary for another practitioner to undertake the report.

- A re-assessment of risk following completion of an intervention, either in prison or in hospital (note that a PRA may be directed, if required, following completion of sexual offender treatment, if such an assessment has not been provided);
- An assessment of whether there are potential outstanding areas requiring risk reduction; and
- A formulation of risk in prisoners with particularly complex mental health/psychological difficulties.

7.5 A specialist **psychiatric report** can be sought to provide:

- An assessment of risk where mental illness, including comorbid personality disorder (but less usually when the problem is personality disorder alone) is a significant risk factor (for example, where the prisoner committed the offence while experiencing psychosis);
- An assessment of risk where the prisoner's mental health has been a concern during the course of their sentence, particularly when transfer to hospital for treatment has occurred;
- An assessment where mental illness is a significant ongoing concern and may affect the prisoner's ability to engage with programmes, regimes or supervision; and
- When a panel is concerned about a prisoner's mental health in relation to risk and they are not engaged with the MHIRT, or refuses to be assessed by them, or has been screened by them but they are not involved in treatment provision.

7.6 **Factors in the dossier** that *may* alert a panel to consider directing a specialist report include:

- A history of engagement with psychiatric and mental health services referenced in the pre-sentence report or from psychiatric or psychological reports prepared for sentencing;
- Community or prison contact with mental health services especially in-patient treatment during the current sentence;
- Previous disposals following conviction which include detention for treatment under the Mental Health Act 1983 (hospital orders);
- Previous detention under civil sections of the Mental Health Act 1983 (i.e., section 2, 3 and Community Treatment Orders);
- Vulnerability issues, i.e., young age at conviction, history of self-harm, alcohol or drug misuse history, all of which are common problems in the prison population but nonetheless should trigger careful assessment of need;
- Where mental-health instability has been identified as a core risk factor but there is a lack of clarity about whether this has been addressed or managed;
- Where a prisoner has undertaken unconventional treatment (non-accredited programmes) and is unsuitable for standard offender behaviour programmes such that it is difficult to draw conclusions regarding risk reduction;
- Where there is evidence that completion of treatment has not reduced risk (often an indicator of personality problems/personality disorder or Autistic Spectrum Disorder may be present);

- Where offences may raise specific issues of concern: sadistic offences, arson, child cruelty, fixated prisoners (stalking, repeated stereotyped offending);
- An unusual offending pattern:

  - committing a single catastrophic violent or sexual offence; or
  - a cluster of offences distinct from but not predictable from a previous offending pattern; or
  - offending starting when significantly older than usual, with good prior social adjustment, particularly the onset of sexually disinhibited offending in an older man, perhaps suggesting dementia.

- Concerns by the community offender manager (COM) or prison offender manager (POM) that mental health issues are interfering with engagement or cooperation with supervision;
- Where there are questions about whether neuropsychological/ neurodevelopmental issues (for example head injury, ASD, learning disability) impact upon ability to participate in offender treatment programmes or ability to make effective use of supervision/management in the community;
- Where there are conflicting specialist reports reaching different conclusions regarding risk management;
- Observation by prison staff of unusual concerning behaviours out of keeping with the prisoner's usual presentation;
- Assessing risk in prisoners who deny responsibility for their offences; and
- Where the prisoner has made very limited progress throughout custody or demonstrated difficulty applying learning from OBPs (offending behaviour programmes).

8 Directions for Reports

8.1 It is imperative to make clear any specific directions for reports to ensure that the right report is produced by the right professional for the right reasons. This will avoid adjournments/deferrals if the report, however comprehensive it may be, does not address the specific questions the panel has identified as needing to be addressed.

8.2 HMPPS is currently piloting a model for the provision of HMPPS PRA reports at the MCA stage within the Generic Parole Process (GPP). The GPP Psychology pilot aims to ensure the early identification and provision of such reports, where assessed as appropriate.

8.3 The pilot commenced in February 2020 and is continuing while evaluation is underway. It is not yet confirmed whether this will be taken into business as usual.

8.4 The GPP Psychology Pilot was set up as a process to enable an early review of cases to be undertaken by an HMPPS psychologist in readiness for forthcoming parole reviews. A psychologist reviews the available file information relating to the prisoner's case, including, where possible, having a discussion with the relevant COM and/or POM. They then provide

a view, within a Psychology Case Advice Note (PCA-N), about whether a PRA report would be beneficial to the assessment of the prisoner's risk by the Board. The PCA-N is included in the dossier that is disclosed to the prisoner when the case is formally referred to the Board. To avoid any confusion between pilot and non-pilot cases, a 'Note to the Board' is included in the dossier of all pilot cases advising the panel that the case falls within the pilot process.

8.5 The PCA-N will provide a clear recommendation on whether a PRA report is considered to be beneficial to the review of the case. Where a PRA report has been recommended but is not ready at the MCA stage, the panel can direct the PRA report if they assess it to be necessary.

8.6 If the PCA-N does not recommend that a PRA would add value, panels can still direct a report if they are not wholly persuaded and are of the view that it is necessary. The direction should clearly state the issues they would like the report to address.

8.7 The PCA-N is **not** a risk assessment or a full file review and is solely aimed at providing a view on whether a PRA would add value given what is already known about the case.

Writing directions for specialist reports

8.8 The following steps may facilitate writing clear specific directions for specialist reports.

Step one: Identify what is needed

8.9 Identify precisely what information is needed to inform the panel's assessment of risk. Time spent getting this right will assist report writers to provide reports with the correct focus. Before directing a report, check that it is necessary for the core purpose of the panel's risk assessment and management of the case (as noted in paragraph 7.1 above).

Step two: Decide which type of report

8.10 Decide which type of report is required, drawing from a limited menu. The following terms should be employed:

- Psychological Risk Assessment
- Forensic Psychiatry Risk Assessment
- Specialist Psychological/Psychiatric report to provide an expert opinion on X
- Healthcare report in accordance with the HMPPS GPP Policy Framework.

8.11 When directing the report, avoid specifying a particular assessment tool or methodology, as this is not within the Board's remit. The appropriate tool to use will depend on the specific characteristics of the prisoner and is a matter for the expertise of the psychologist or psychiatrist. Instead, the direction should specify in lay terms what it is that the panel wants to understand and leave it to the specialist to employ the appropriate tools.

8.12 However, it may be useful to specify *"a structured risk assessment"* leaving it to the professional to employ the appropriate structured risk assessment tool. It is much more helpful to request an assessment of the presence of personality disturbance, disorder, or traits and the relationship between any evident traits, risk of further serious sex/violent offending and implications for treatment/risk management rather than specifying a particular specialised assessment tool.

8.13 A good psychological assessment, if directed to assess whether there is evidence of personality disorder/traits and how this affects risk, will determine on the basis of the prisoner's history and presentation whether an assessment of psychopathy/personality disorder is present, and which particular assessment tool will yield the most helpful results. Only in exceptional cases, or where there is a clear justification in the circumstances of the case, should a specific assessment tool be instructed.

8.14 Sometimes a wide-ranging report is appropriate and wording such as *"a comprehensive Psychological/Psychiatric assessment is required, including a structured risk assessment"* may be appropriate.

8.15 For specialist reports on specific issues, it may be necessary to specify a professional with particular expertise[20], i.e*., "a specialist psychology report from a psychologist with expertise in the assessment of learning disability/autistic spectrum disorder/X".* However, panels should not name a specific person in their direction.

8.16 For specialist reports and reports completed by a hospital clinical team for a prisoner transferred on section 47/49 of the MHA, please refer to the Parole Board Guidance on Restricted Patients and the Mental Health Act.

Step Three: Decide what the report should address

8.17 For each type of report, provide detailed instructions on what the report should address. The more specific and targeted the direction, the greater the likelihood of receiving an appropriate report to provide the required information. Panels may wish to include within their directions that an *Executive Summary* should be included within the report.

8.18 Below are examples of **directions for psychological risk assessments:**

To provide a comprehensive assessment of the risk of further sexual offending and to identify appropriate risk management approaches that take into account that the prisoner denies their offending. To include what, if any, impact the denial of the offence has upon future risk management.

To provide a comprehensive risk assessment of further violent offending. To include an assessment of personality disorder and to comment on how any such traits impact upon risk.

[20] For more advice on which professionals should and should not prepare reports in line with the Anthony Rice review, please see paragraphs 6.15 – 6.23.

To update the assessment of risk of further offending given that the prisoner has completed X treatment in hospital/prison.

To provide the panel with an assessment of risk of further fire setting with consideration to how the prisoner's psychological functioning impacts upon risk.

8.19 Below are examples of **directions for psychiatric reports**:

Healthcare Report (Professional evidence)

The Mental Health In-Reach Team is directed to provide a health care report, in accordance with HMPPS GPP Policy Framework, on [prisoner name] who is currently in receipt of treatment in HMP [prison name]. In addition to the items in the recommended SPR-F report template the report should provide guidance on the following:

- *Does the prisoner have a mental disorder as defined by classifications systems such as ICD-10?*
- *What treatment are they receiving for that disorder?*
- *What has been the response to treatment?*
- *Have they cooperated with that treatment? Comment on their engagement with the team.*
- *How stable is their current condition, including desistence from drugs/alcohol?*
- *What factors might lead to destabilisation in the Community if released?*
- *What level of aftercare should be provided to the prisoner if released by the Parole Board and likely compliance with aftercare? Who will provide that aftercare?*
- *Who will provide that aftercare?*

The Board considers that this report falls within the remit of the HMPPS GPP Policy Framework and therefore will not require additional clinical assessment and hence will not require specific funding.

Psychiatric Risk Assessment (Expert evidence)

The Parole Board directs a psychiatric risk assessment report from a suitably qualified consultant forensic psychiatrist. In addition to a full assessment of mental health and risk, the report should provide an opinion on what contribution to risk of future repetition of the index offence involving violence with weapons arises from the interaction between [prisoner name]'s diagnosis of schizophrenia, alcohol misuse and enduring abnormal personality traits/disorder. The report should provide the panel with advice on long-term management in the community and after-care arrangements for that treatment in the event of [the prisoner] being released. This information must be informed by discussion with the responsible service provider and confirm their undertaking to be involved in the prisoner's aftercare.

8.20 Where a panel sets a direction for a complex assessment (or set of assessments) which may cut across a range of specialisms it may be more manageable and cost effective to formulate the assessment in stages. This is particularly helpful where there are distinct areas of specialism to explore, and it is unlikely that one professional will be competent to address them all. For example, to illustrate this, a complex direction could be broken down as follows:

- Assessment by a suitably qualified psychologist to undertake an assessment of intellectual capacity and acquired brain injury to determine the degree of learning disability;
- Assessment by a suitably qualified psychologist of ADHD and ASD;
- Forensic psychological risk assessment to take account of all of the above.

This may assist HMPPS to comply more easily by completing some of the elements inhouse where they have the expertise and only outsourcing the parts that they need.

8.21 There may be cases where a direction for a report will also need to cover the prisoners anticipated future mental health treatment needs and how these would be met if they were to be released. These can be completed in conjunction with the COM and in connection with the catchment area services.

9 Conflicting Reports

9.1 Where multiple professionals have produced reports, it is possible that there may be differences in their assessment of risk and/or recommendations for progression. In these instances, often arising between an HMPPS Psychologist and a psychologist commissioned by the prisoner or their representative, a further joint report may be useful in some cases. If the panel composition includes a specialist member, they will be able to advise the panel on any discrepancies between reports and a joint report may not, therefore, be necessary. In some cases, the discrepancies may be clearly articulated, and it will be clear why two different views have been arrived at and a joint report is not required.

9.2 If a joint report is considered necessary, it may be that instead of a narrative report, a grid/table outlining the discrepancies and similarities between the reports can be requested. These joint reports, in whatever format, will need to be led by one of the reporting parties but discussed and agreed between both professionals. This can usually be achieved through a phone call between them and does not necessitate a face-to-face meeting. A joint report should be a concise overview of the submitted specialist reports.

9.3 The presence of reports by multiple professionals does not automatically mean that a joint report is necessary. Accordingly, it would not be appropriate to make such a direction before the reports are received and have been considered or when there is agreement between report writers.

9.4 Where a direction for a joint report is made, the reasons for such a direction need to be clearly stated. For many cases, exploring areas of agreement and disagreement can be suitably addressed within an oral hearing itself, where one is directed.

10 Directing updates to reports

10.1 It is important to be aware of time limitations in the validity of psychological and psychiatric assessments. If there is an assessment in the dossier that is over 12 months old, then the assessment may not be valid (although this will depend upon the specific validity relating to the tool employed, for example OASys/ HCR-20/ RSVP are valid for 12 months, ERG22+ is valid for 6 month). Please refer to the Guidance on Risk Assessment for more detailed information on assessment validity timeframes. Where panels consider an update is needed, these can be provided in a brief format if, following review, limited changes to the case have been made that impact upon the overall assessment.

10.2 It is not appropriate to direct an update to a report that is still within the validity timeframe unless there have been significant developments (for example, completion of a programme or a deterioration in behaviour) or the tools used in the assessment specify that they should be re-administered over a shorter timescale.

11 HMPPS Practical Arrangements

11.1 HMPPS reports produced by forensic psychologists will be managed and funded directly by HMPPS Psychology Services Group (PSG). HMPPS has a Framework that involves a number of different external providers who will be responsible for providing specialist forensic psychology reports to the Board in addition to HMPPS directly employed staff. When a report is directed by a panel and PSG cannot provide a report within a reasonable timescale, the report is put out for tender to providers under the terms of the Framework and allocated to the successful tender. Specialist forensic psychological reports commissioned externally are to be completed by Registered Forensic Psychologists, and this can cause delays.

11.2 Commissioning and funding psychiatric reports is more complicated. Healthcare reports from the prison's MHIRT are governed by the HMPPS GPP Policy Framework and do not require specialist commissioning or funding. Risk assessment and other specialist expert psychiatric reports are commissioned by the prison on a case-by-case basis and require specific funding. With the exception of Prison Healthcare reports, expert psychiatric reports to courts, including the Board, are not covered by the NHS contract. Consultant psychiatrists who undertake such work do so outside of their NHS contract and will claim an appropriate fee for work carried out.

11.3 Prisons are required to fund psychiatric reports but these come from unfunded resources which can create a challenge for prison establishments and they may need to escalate the request to their Prison Group Director for resolution. HMPPS has produced guidance for HMPPS staff on this issue.

11.4 Where there is a dispute concerning the commissioning of a report or catchment area services that cannot be resolved, the case manager may be asked to escalate this with PPCS to resolve.

12 Responsibilities & expectations

12.1 As noted above, mental health difficulties, including personality disorder, are common among prisoners. It will not be appropriate to direct reports on all prisoners with mental health difficulties. Panels and professional witnesses are expected to have sufficient expertise to assess risk for the majority of prisoners.

12.2 The remit of the Board is to determine the level of risk and to assess the robustness of any risk management plan, which may include management of mental health difficulties. Unless the content of a specialist report is likely to change the panel's mind about the feasibility of a progressive move (release or suitability for open conditions), it is not appropriate to ask for it. It is not the Board's role to help prisoners progress; hence directing a report because a prisoner is "stuck" is not appropriate unless it links to the current assessment of risk for progression.

12.3 It is also not the role of panels to direct 'how' a prisoner will reduce their risk for example by attendance on a particular programme or through work with a psychologist (i.e., one to one work). Such matters are HMPPS internal sentence planning issues and the responsibility of the Secretary of State. Directions must be confined to the purposes of the current parole review and must therefore relate to the preparation of the case or assist in the determination of the issues before the panel. Directions should not be made in relation to the management of the prisoner's sentence, including but not limited to security or transfer issues, re-categorisation, treatment needs, and sentence planning.

12.4 Specialist reports are costly both in time and money and can result in a significant delay to the prisoner's parole review. A typical risk assessment report may require five days of work as a minimum, more complex cases can take longer. In addition to the cost of that report and any costs associated with the author of the report likely giving evidence at an oral hearing, there is an opportunity cost as that time will not be available to other prisoners who may have greater need. It follows that great care must be taken in directing specialist reports to avoid unnecessary use of resources and unnecessarily delaying cases.

12.5 At times a prisoner may wish to commission their own specialist report. Panels can *invite* the disclosure of such reports but cannot direct them, it is up to the prisoner whether they wish to disclose and rely on the report they have commissioned. If the prisoner does commission a report and intends to rely on it, the panel can direct that the report is disclosed within a reasonable timeframe to prevent delays.

12.6 In order to secure funding for a prisoner commissioned report, whilst applying for legal aid, legal representatives can complete a supplementary form that allows space for additional information to be added to support

their request. This might be necessary when a report of an unusual specialism is required that would be categorised as out of the 'norm'. In such circumstances, panels may be asked if they could issue a supporting direction for the legal representative to commission the report, which could be referenced on the supplementary form and strengthen the application. Whilst this can be agreed to and be referenced in directions, panels must be of the view that the report is necessary.

13 Consent

Engagement in the assessment process

13.1 The matter of prisoner consent is discussed and agreed at the outset by the professional undertaking the assessment when they make their first engagement with the prisoner.

13.2 The understanding is that consent relates to asking the prisoner to be part of the process once they have a good understanding of what it entails and how their information will be used etc. This is an agreement and consent to engage in the assessment process.

13.3 Consent is not being sought to ask for their permission for a report to be completed and submitted to the Parole Board.

13.4 In some cases, a prisoner may initially give consent but then later withdraw it i.e., the prisoner initially gives consent and begins engagement but then decide to discontinue with the process.

13.5 In some instances, the prisoner may decline to engage in the process from the outset.

13.6 Issues around consent to engage can be related to the prisoner's responsivity factors (and/or current difficulties), litigious nature and/or previous experience with professionals. Withdrawing from the process does not mean that a report cannot be completed and submitted.

13.7 In either of these instances, if a report is deemed necessary in order to assist with the risk assessment, the professional can still undertake a report using other routes, for example make use of partial engagement of the prisoner, rely on other historical or current reports, or other collateral information. Whilst not ideal and this approach has limitations, it is a potential option. The report should highlight the circumstances and the potential limitations relating to how the assessment was made.

Disclosure of the Assessment Report

13.8 Consent to disclose the assessment report to be shared with the Parole Board is a separate matter.

13.9 The prisoner should be made aware that the assessment report will be provided to the Parole Board and consent should be obtained in advance, wherever possible.

13.10 However, if a prisoner declines to give consent, the report must still be submitted, given it is being provided in response to a judicial direction. A judicial direction (made under powers deriving from Parliament) is binding and the exemptions under the Data Protection Act (DPA) relevant to courts and tribunals will allow the data to be processed.

13.11 The HCPC's guidance around consent states that registered professionals:

> "*… have a legal duty to keep to orders made by the court*". The Royal College of Psychiatrist's Good Psychiatric Practice guidance states "*A psychiatrist must participate in hearings and tribunals, and other similar activities that protect the rights of the patient, in a timely and appropriate manner, ensuring adherence to mental health legislation relating to consent to treatment and detention. The psychiatrist must provide written reports as required*."

13.12 The Royal College of Psychiatrists sets out in CR193 Responsibilities of Psychiatrists who Provide Exprt Evidence to Courts and Tribunals[21]:

> *"Reports should not be disclosed without the assessed person's consent and/or consent of their legal representatives,* ***or unless directed by a court****, other than in exceptional circumstances…"*

13.13 The overriding principle is the duty the professional has to the court (in this instance the Board) and from a public protection perspective, and therefore they would submit the report but highlight that the prisoner has not agreed to it being shared.

13.14 The above principles apply to other documents such as Mental Health Tribunal reports, hospital reports, and documents relating to section 117 (s117) of the Mental Health Act 1983 (MHA 1983) aftercare plans. Consent from the prisoner is not required.

14 Specialist Panel Members

14.1 Panels should consider how the expertise of a specialist member (a psychologist and/or a psychiatrist) could enhance the panel's approach and what it could contribute to risk assessment and determination. Careful consideration should be given as to whether deployment of specialist members is warranted and whether a specialist member is needed to provide relevant help to interpret the information put before the panel in order to make a safe and fair assessment of risk.

14.2 The earlier the need for a specialist panel member is identified, the more likely one can be available and the chances of delay in listing the case can be reduced. Specialist members are in short supply and should, therefore, be deployed wisely.

[21] *CR193 Responsibilities of Psychiatrists who Provide Exprt Evidence to Courts and Tribunals*

14.3 Psychiatrist and psychologist members have specific knowledge and skills which are described below. There is, however, more overlap than distinction in the areas which they can contribute, and, in most cases, a psychiatrist or psychologist may be equally appropriate. Therefore, simply specifying a 'specialist member' would be sufficient.

14.4 Where a panel believes that a specific discipline or expertise is needed in order to make a fair and rigorous risk-based decision they may wish to consult with a specialist member (see section 15). However, when setting a direction, the panel should still only specify a "specialist member" but record any additional information for the attention of the Listings Team and future panel.

Requesting either a psychologist or psychiatrist member

14.5 It is appropriate to simply request 'a specialist member' without specifying the discipline further, for cases when:

- There are mental health concerns or evidence of psychological distress with an identified or suggested link to the prisoner's risk of re-offending or harm (e.g., substance misuse, anxiety, depression or self-esteem issues) but these have not been such as to require transfer to hospital for treatment during the sentence, nor does follow up mental health care need to be arranged ahead of release;
- Personality disorder or psychopathy has been identified or suggested and the OPD pathway will contribute to future management;
- There is a learning disability, developmental disorder/neurodiversity e.g., autism, Asperger's Syndrome, attention deficit hyperactivity disorder (ADHD) or a brain injury; or
- The case has complex or serious risks issues e.g., the prisoner has exhibited a range of offending behaviour, offending involves multiple victim types or sadistic behaviour, the motivation for the offence(s) is unclear and the prisoner denies some or all aspects of their offence.

Requesting a psychologist member

14.6 It is appropriate to request a psychologist for cases when:

- There is current psychological evidence e.g., a psychological assessment, psychometric tests or psychology report which need specialist interpretation (standard psychometric tests completed prior to or following an offending behaviour programme are unlikely to routinely require interpretation);
- There are two or more differing psychological opinions e.g., a Prison Service psychological report and a prisoner commissioned psychological report;
- There are questions with regards to a prisoner's response to interventions due to issues such as motivation to change, levels of psychopathy, personality disorder or learning difficulties.

Requesting a psychiatrist member

14.7 It is appropriate to request a psychiatrist for cases when:

- There are issues relating to the prisoner's major mental disorder such as schizophrenia, and increasingly in the ageing prison population of dementia, and in some cases physical illness, which may have a bearing on risk;
- During this sentence, the prisoner has been, or is currently, detained in hospital under the Mental Health Act;
- Licence conditions are proposed which require involvement of specialist mental health services, for example in relation to continued specialist prescribing of depot medication or clozapine monitoring, or provision of section 117 aftercare;
- Where there is current psychiatric evidence about the prisoner e.g., a psychiatric report or substantial evidence from a prison MHIRT which requires interpretation, or the Judge's Sentencing Remarks emphasise the importance of the pre-sentence psychiatric reports in determining sentence.

When neither a psychiatrist nor a psychologist is required

14.8 *It is not appropriate to request ether a psychiatrist or a psychologist when:*

- Although research studies have highlighted the prevalence of mental health difficulties in prison/secure hospitals, in most cases, where there is no history of specialist mental health treatment, as opposed to offending behaviour programmes, and the specialist assessments are limited to a PRA then a panel may not need to include a specialist member.

- Panels should be confident in asking:

  - the author of a PRA to explain their assessment, to describe the inference regarding risk from the factors set out in the assessment schedule, to be able to comment on the level of confidence on the assessment and to make a professional recommendation;
  - representatives of an MHIRT to comment on their contact with a prisoner, compliance with medication, and any links made with primary care (GP) services to continue the aftercare of a prisoner on common drugs for anxiety and depression which are usually managed in general practice;
  - authors of reports on substance misuse about the engagement of a prisoner with substance misuse services in prison, to comment on their commitment to addressing substance misuse difficulties and to advise on handover to community substance misuse services if appropriate.

14.9 When MCA panels are directing that a case goes to an oral hearing, and the case includes significant psychological, mental health, or substance misuse evidence, it is good practice to make explicit that the need for a specialist member has been considered and, that one is required (as per the current MCA template), OR that a specialist member is not considered to be

necessary and similarly to provide reasons why not. This may assist the panel chair in subsequent review of the dossier.

14.10 As noted below, there are specialist members who are available to discuss issues with panels ahead of hearings if a particular case causes concern, and to advise on whether a specialist member would be preferable in a given case.

15 Consulting a Parole Board Specialist Member

15.1 Where a specialist member has not been added to a panel, there is the option to consult a specialist member on a particular issue or question relating to their area of expertise. The specialist member can also provide information and advice in relation to directing specialist reports. This pool of specialist members is made up of both psychologists and psychiatrists. Panels may approach these specialists for a short consultation on an ad hoc basis. The list of specialist members within this pool and their contact details can be found on SharePoint and can be provided by the case manager.

15.2 Specialist members consulted under this process do not become part of the panel and do not take part in decision-making but may offer information/guidance on technical specialist issues. Examples of when a panel may wish to consult with a specialist member include:

- Deciding if a specialist report (and what type) or update should be directed;
- Assisting with the wording of a direction for a specialist report;
- Understanding a particular mental health/medical condition that is unfamiliar;
- Understanding the intervention/risk reduction work completed in prison and/or hospital;
- Deciding if a specialist member is needed on the panel;
- Evaluating the risk management plan where release on the papers is being considered and the prisoner has a mental health condition or there are concerning conduct issues;
- Discussing a point relating to a particular area of expertise that needs unpicking; and
- Advising on licence conditions and/or case progression.

15.3 This resource is intended for a brief consultation of up to 30 minutes to assist the panel in their deliberations. The panel should be able to summarise the case and issues to the specialist member and full consideration of the dossier by the specialist member is not required. If more in-depth input is needed, it may be more appropriate to direct the case to a multi-member panel at MCA, or oral hearing with a specialist member on the panel (please see section 14 above for more information).