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THE ROLE OF THE MENTAL HEALTH PROFESSIONAL IN THE SENTENCING PROCESS

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Introduction

The public in many western countries have demanded laws that protect them from those from whom they feel at risk. They have demanded longer sentences, driven from a time when offence rates were rising, but continuing when offence rates in most western countries are static or falling. Courts have been given less discretion, as well as a greater range of issues to consider at sentence, including issues of risk of reoffending, and mental health treatment interventions that may ameliorate that risk.

These requirements have meant that parliaments have asked courts to seek the opinions of mental health professionals to assist in making such determinations. Often this is under the catch all phrase such as to assist the court in determining ‘the type and nature of any sentence to be imposed’. Some legislation requires mental health professionals to address specific criteria, especially in relation to determining issues such as discretionary life sentences [referred to as preventive detention in New Zealand]. There are also increasingly complex sentences available, such as hybrid prison and mental health disposition, and new criteria such as dangerous and severe personality disorder, sexual predator laws or special risk related dispositions. Further, there is evidence that perhaps 15% of new receptions into remand prison have a significant current mental health problem [Brinded et al, 2001; Fazel and Dinesh, 2004] justifying the input of a mental health professional if mental health needs are relevant to the offending and need provision in any sentence imposed.

We also seem to be at a phase of international politics, where respect for principles of due process [be it procedural or substantive] is being run over, by the development of extra constitutional detention, or increasingly intrusive powers of the state over citizens. Examples include the detention of illegal immigrants, asylum seekers, covert monitoring of citizens extra judicially. Trends in penal policy show less concern with whether this particular individual presents a risk, but is increasingly aimed at detaining this ‘class of individual’ to reduce the crime rate. Attacks on constitutionality for the needs of communitarianism, if you will [Hudson, 2001]. Further, we are in an era when being clear where ‘public health psychiatry’ and ‘crime prevention’ begin and end, is very unclear (Eastman, 1999).

So what issues emerge when a mental health professional, trained in clinical ethics, is asked to become involved in these processes? What is the basis for their involvement? Is it an extension of health care ethics or *parens patriae* duties of the State, to ensure the protection of the vulnerability of the offender? Or is it for the protection of others, to help the court muster the coercive power of the State against the interests of the individual? Should the presence of mental abnormality, which may mitigate responsibility, also mitigate sentence? Or if it increases risk of reoffending, does it act as an aggravator at this point of sentence?

Mental health professionals are thus involved in sentencing from multiple purposes including addressing treatment and dispositional issues for mentally abnormal

offenders, and assisting with assessment of risk in mentally normal offenders thought to be of high risk. We may be involved for the wellbeing or welfare of the offender, or for the interests of justice or to protect the public [Adshead and Sarkar, 2005; Kennedy, 2005]. This paper will address issues that emerge from each of these functions, and note some of the issues in ethics, efficacy and public policy that arise for mental health professionals. I do so as a doctor, psychologists have a slightly different perspective on these issues, as only some are trained in clinical ethics, others in social or organizational psychology which represents a different perspective.

Roles of Mental Health Professionals

Forensic professionals have always been aware that their world has a rather more complicated set of ethical challenges than that covered by clinical ethics. In court there is also the interest of justice to be served, and thus tensions of dual agency. As Verdun-Jones (2000) notes, such issues pervade ‘every nook and cranny’ of forensic mental health practice. So it is not possible to be ‘purist or unworldly’ from a mental health professional perspective about our participation in this process. It is clearly a public good to have mental health professionals involved in the sentencing process, as there are clearly some issues where expertise can be brought to the issue which will enhance fairness and public wellbeing from the sentencing process [Adshead and Sarkar, 2005]. But we need to come to this process with our eyes open to the tensions that exist between what is ethical, what is expert, what is desired by courts and the requirements of new legislation.

It is important to note that this is not a normal medical role. Normal medical roles are primarily focused on developing a therapeutic relationship with a patient, for their interest primarily or exclusively, based on the development of trust and empathy, most particularly in psychiatry [Bloch, 2005]. Development of that type of relationship in a pre-sentence report context may well be very misleading. The mental health professional is there to provide as good and clear opinion on the issues that the court requires to be addressed, not to provide treatment. The failure to realise the importance of this difference may be ethically fatal.

Psychiatrists and psychologists appear to have come to the court expert role from 3 different motivations (Simpson and Evans, 2005). First, as citizens concerned with the desire to protect the public from those who may victimize others, they were prepared to share their skills to detain such people. Second, they came as therapists interested in trying to work with people who they see variously as troubled, maladjusted, deviant or ill, who they may be able to help for the person’s own sake as well as for others. Finally, they came with a desire to study such people, to understand more about how to help them, and thereby be better therapists and predictors, to achieve better treatment and more focused detention.

Psychological and psychiatric techniques are founded on the study of inner or hidden aspects of the person, private space as Franzen (2000) refers to it, what Rose (1990) would describe as the soul or the psyche. The mental health assessment processes of description, observation, classification and measurement of aspects of persons were developed to enhance therapeutic interventions, on the basis of improving outcomes for

that person over that which would take place if no intervention occurred. Thus for evidence based therapeutic practice, one must be able to predict course and outcome for groups of people. The differentiation between the psychological make up of groups of people [for example the psychopathic, antisocial, or paedophilic] for treatability purpose, also serves to define future risks to others of interest to courts at sentence. Thus health technologies based on examining the private space, or the soul, for appropriate therapeutic motivations, could now also assist criminal justice needs of prediction, and prevention by detention. Thus clinically derived skills, developed with clinical ethics in mind, can now serve a justice or community protection function. Does this change the ethical landscape? Does the justice system provide adequate protection for defendants in this process?

The criminal justice system is not blind to the rights of the person. It protects the person against self incrimination, incompetence and provides for the right to silence. However, therapeutic based skills are designed, because of their use for the well being of the person, to by-pass resistances and encourage self revelation that the criminal justice rules protect people against. In other words, the cloak of therapeutic possibility that a mental health professional brings to the assessment provides for the hope that an offender will tell a doctor more than they will tell a detective. If that was not the case, the court would employ criminologists and leave clinicians in their hospitals!

This allows the criminal justice system access to a rich vein of information of the person's inner self, otherwise unavailable to it. Are mental health professionals properly aware of this dynamic? Are courts thoughtful about what they are asking of us?

This debate is not new. In one of the more fascinating medico-legal exchanges, Professors Alan Stone and Paul Appelbaum engaged in a debate over a decade regarding the role of the forensic psychiatrist as expert witness. In 'The parable of the Black Sergeant', Stone describes his ethical unease when he found himself employing his clinical skills in a military court which worked against the interest of his patient. Stone described this as unethical because when he was engaging in expert testimony he used skills derived from clinical training in a manner which could not be covered by a general release from confidentiality given to the defendant. The psychiatrist-as-expert used clinical skills to access information that only they could, not for the good of the patient, but for the needs of justice. Appelbaum agreed this was an ethical difference, and coined a new term, forensicist, for this special psychiatric role.

A forensicist, according to Appelbaum, is a psychiatrist or psychologist working as expert witness. He distinguished the different ethical requirements, namely instead of having the primacy of respect for persons, confidentiality, beneficence and non-maleficence, a forensicist has primary obligations to tell the truth, to be objective and to assist the court. These principles became the basis of the American Association of Psychiatry and Law's ethical principles for experts, but have not settled the ethical tensions for many. Stone continues to refer to this as 'truth without consequences'. Many British forensic psychiatrists have grave concerns about carrying over clinical skills from the welfare interests of the patient into a justice framework [Eastman, 1999].

Efficacy

Regardless of whether it is ethical, though, one must consider whether or not one is expert. The US Supreme Court in *Daubert v Merrell Dow Pharmaceuticals, Inc.*, (1993) stated that expert testimony must be demonstrated, by a preponderance of the evidence, to be scientifically grounded as well as relevant and relevant to the issues presented by the case. This requires that this expert has the requisite scientific, technical or specialist knowledge, and second, that the testimony assists the finders of fact to decide the issue (Cunningham and Reidy, 2002). Thus it is always important to ask whether there is scientific evidence that can address the question being asked. It is thus vital that where experts cannot address the question raised by the court, we let the court know the degree to which one can and cannot assist.

Societal Context of Sentencing Persons with Serious Mental Illness [SMI]

The increasing number of mentally ill offenders appearing before the courts has resulted in the development of legal mechanisms to accommodate their needs. The courts have been seen as one of an increasing number of points where leverage can be brought to bear on a person with SMI to adhere to treatment, abstain from drugs of abuse and remain in contact with services [Monahan et al, 2005; Ross and Lawrence, 2005]. For instance in the US, large numbers of people with SMI are subject to court imposed coercive interventions outside a civil commitment paradigm, via probation orders or financial controls. In parallel have been a range of new legal mechanisms for the mentally abnormal offender, including hospital disposition and hybrid orders. Courts require treatment and risk related guidance about when to employ such sentences.

Linked to this general trend has been the development of specialist courts, such as drug courts and mental health courts. These courts have been a development aimed at a particular group of offenders for whom traditional court processes presented limited value.

Given that these processes aim at treatment interventions that will improve the wellbeing or welfare of the person, as well as meet the interests of justice, the issues for mental health practitioner are reasonably close to clinical ethics, and expertise exists from clinical practice to define treatment needs for SMI and addictions. Thus both ethical and Daubert criteria are reasonably met in relation to this type of sentencing activity.

Sentencing context: risk related evaluations

The public intolerance of risk has brought a range of sentences that require or seek mental health professional input which are primarily or wholly risk related decisions, irrespective of treatment needs. These include preventive detention, dangerous and severe personality disorder, and sexual predator laws [Simpson and Evans, 2005]. For instance in the UK, the Criminal Courts [Sentencing] Act 2000 requires that if a longer than commensurate sentence is to be imposed the courts should seek a psychiatric report prior to sentencing. Similarly in New Zealand, if the court is to impose an order of preventive detention [in effect a discretionary life sentence] 2 ‘health assessors’ reports must be sought prior to sentence (Simpson, 1998). Queensland recently enacted

preventive detention via imprisonment at release, again requiring the reports of 2 psychiatrists to explicitly determine risk [Keyzer et al, 2004]. These sentences present challenges in efficacy and ethics.

In these contexts, the court requires mental health professional input about a clinical issue, risk of future violent or sexual behaviour, which is of course also a legal issue, and directs clinical assessment in a manner constrained by legal demands. For instance, New Zealand case law requires that the issue of the offender's remorse is assessed in relation to preventive detention. Lack of remorse increases your risk of receiving a sentence of preventive detention, even though research evidence does not show that the presence of remorse lowers the long term risk (Hanson and Brussiere, 1998). Remorse, though, is important to victims, but its inclusion fails Daubert criteria.

Further, pre-sentence reports assessing risk of reoffending upon release many years in the future may also fail Daubert criteria as many factors relevant at the time of release must be unknown, such as responses to in prison treatment programmes (Simpson, 1998). Thus the structure of legal tests may make it very hard for clinicians to respond to the court with expertise, even if the wider interests of justice may seek it. Under these circumstances, it is vital that the expert informs the court of the limitations of the assistance one can provide. This should not frustrate the wider needs of justice.

The Wider Interests of Justice

One of the trends related to the desire for public protection has been the development of what is referred to as the 'new penology'. The new penology has shifted the emphasis from punishment of individuals for what they have done, to detaining the group of people who may place others at risk [Hudson, 2001]. The aim here is to imprison at risk populations to reduce the crime rate. So it is sufficient to say this person comes from a population at risk of reoffending, and not necessarily find that this particular person will offend. This has become an increasingly dominant paradigm in the use of imprisonment for public protection (Hudson, 2001) and relies on the presentation often of what is essentially grouped, not individualized, outcome data. Grouped statistical data is commonly presented in federal capital sentencing in the US (Cunningham and Reidy, 2002). Most commonly this is the use of the PCL R, a psychological assessment tool, which is increasingly used as a predictive tool. This is inadequate for a mental health professional and is, frankly, a criminological or sociological philosophy, not a health related one. Health related evaluations are person specific, guided by grouped or actuarial data, but not a slave to it. Criminological analysis is satisfied with grouped decision making. This unsaid difference of philosophical assumptions lies at the heart of tension between the mental health professional and 'modern' sentencing laws.

A further issue emerges in being clear about what issue is it that the mental health professional is addressing? Courts may use information gathered for one question to assist them in resolving another. For instance, Solomka [1996] found in the UK that courts sought a psychiatric report for determining whether or not a mental health disposition was appropriate. If the court concluded it was not, the courts have then used the same report to assist in the imposition of a longer than commiserate sentence. Appeal Court decisions held the court could use the material to answer other questions

such as the risk the offender posed and thus whether the longer than commiserate sentence should be imposed. Thus it appears that regardless of the issue the psychiatrist thinks (and presumably the defendant thinks) their report is addressing, the court may use that information in whatever particular way it sees fit.

Relationship dynamics

As noted, the law provides certain protections including Bills of Rights, Miranda type warnings against self incrimination and the right to silence. Rules around the protection of vulnerable defendants or suspects have emerged from recognition of miscarriages of justice from interrogation of incompetent defendants. Further, information provided for the purpose of health care delivery is usually subject to qualified privilege. In New Zealand, the Evidence Amendment Act provides such protection, making it quite clear that information gained by a doctor or psychologist in a treating relationship cannot later be used by them in a sentencing context. This makes it clear to the professional that one cannot move from a treating role to a court expert role for the same defendant.

The reason is obvious. As Bloch (2005) points out, it is the establishment of trust and empathy that is central to a clinical relationship. Using trust and empathy to obtain information from a defendant that is then shared with a wide variety of people outside such trust and empathy is clearly in breach of that relationship. Thus the mental health professional performing a court report must be meticulous in ensuring that the defendant is aware of the nature of the relationship, its purpose and what will happen to the information gathered. Given the length of court related mental health assessments, the power imbalance between the assessor and assessee, emotionally charged nature of the process and the use of clinical skills, it is imperative that this warning about the relationship is made repeatedly during the assessment.

It is not only the assessee who must be aware of the tensions. The assessor may exceed ethical or expertise limits because of eagerness to please the Court, instructing counsel or the payer of the bills (Simpson and Evans, 2005) or concern for one's reputation. It is easy to get drawn past what is ethical or expert by the powerful forces that act, especially in high profile offences.

Towards a tentative synthesis

Slobogin and Fondacaro (2000) have suggested that the traditional legal doctrine for the use of state deprivation of liberty, being police powers and *parens patriae* powers, might be better replaced by punishment (or sanction for blameworthy behaviour), prevention of harm [via either deterrence or incapacitation] and protection (to develop or restore autonomous decision making). The advantage of this structure is that it makes clearer the functions of the deprivation of liberty, all of which are relevant to pre-sentence decision making and clinical ethics. Noting that forensic assessment ethics have, within some boundaries, a different scope to clinical ethics, I have attempted to map out the interaction of these categories in Table 1.

Table 1: A Tentative Synthesis?

Slobogin and Fondacaro	Parens Patriae Powers	Police Powers	Clinical Ethics	Forensic Assessment Ethics
Punishment	No	Yes	No	No
Prevention Deterrence Restraint	No At times	Yes Yes	No Very rarely	No A qualified Yes
Protection	Yes	No	Yes, for those of lowered capacity	Yes

One can see that *parens patriae* and police powers form overlapping but distinct justifications, but that traditional clinical ethical roles are confined to protection of the person through restoration of competence. Very occasionally, clinical ethics may allow involvement in prevention via restraint of the individual, particularly in public health for instance in relation to persons with infectious diseases. In forensic assessment ethics, due process protections for the involvement of the defendant and clear separation of treating and assessing roles, allows input from the mental health professional in both protection and prevention via restraint categories. This is particularly so if the prevention via restraint contains rehabilitative opportunities, and thus the possibility of benefit for the person also.

These protections [Miranda warnings, clear separation of therapeutic and assessing role, assessment for treatment purpose in part] acknowledge that the origin of the skills needed to perform these assessments derives from the large body of skill and knowledge obtained for meeting health needs, which is now being sought for public security needs. Maintaining reference back to health needs is thus important. Clearly, we have no role in punishment, as this is a moral issue for which we lack any specific expertise, and prevention via deterrence, which is a public policy, not a clinical issue.

With this guidance in place, Courts could accept mental health professional involvement to an important but limited degree. In my view, the purpose the court envisages using the report for should be clearly stated in advance, so the report author, defendant and their counsel can approach this assessment in an informed manner. Courts should be aware that clinicians should always relate their opinions to interventions that may ameliorate the situation, and recommendations regarding risk should be carefully considered at sentence. Finally, courts need to be aware that mental health practitioners are limited in their ability to assist them, as courts have a mandate for wider interests of justice than are clinicians as experts. Some questions the court considers, we cannot.

Conclusion

Courts need to act justly, and to do so need full, accurate expert information. But Courts need to be clear about what it is asking and why, so the mental health professional can address the defendant and court knowingly and ethically. The professional can address

issues only if treatment needs for defendants with clinical conditions and lowered competence, and in risk related areas that link to treatment interventions, not to issues of punishment or deterrence.

There will always be tension, risk, ethical and role distortion possibilities. As has been observed, ethical mental health professionals must ‘feel the tension’. Courts need to be respectful of it.

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