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ANTICIPATING HARM IN THE CONTEXT OF MENTAL DISORDER. LOOKING AT ITALY FROM ENGLAND AND WALES

Sommario: 1. Introduction. – 2. Context. – 3. The case of Jonty Bravery. – 4. The approach of sentencing courts. – 5. Clinical involvement – recommendations and gatekeeping functions. – 6. The REMS approach and its prospects. – 7. Conclusions.

Abstract: This chapter examines some of the issues concerning the harm caused by and to offenders suffering from various forms of mental distress; and, in particular, anti-social personality disorder. It takes one notorious case and questions why the case was resolved in England and Wales with a custodial sentence and questions how the case might have been dealt with under the Italian system with its new therapeutic REMS system. The chapter considers some of the imponderable dilemmas that such offenders pose to all jurisdictions.

1. *Introduction*

A casual observer comparing the arrangements for the care and treatment of offenders with a range of mental disorders in England and Wales with those pertaining in Italy could be tempted to describe the former as medieval. Over the last half century Italy has forged ahead with progressive de-institutionalised care for those suffering mental distress (Basaglia-Tranchina 1979) with 'Basaglia Law' in 1978 leading to the closure of mental hospitals in Italy [1]. In 2017, further legal developments led to the closure of the Ospedali Psichiatrici Giudiziari, the six large forensic hospitals managed by the Ministry of Justice for the care and detention of mentally ill offenders (De Ambrogi 2017) [2]. Such offenders

[1] Legge Basaglia, Legge 180, 13 Maggio, 1978.

[2] Legge n. 9/2012 prescribed the closure of the OPGs.

were thereafter to be accommodated in the REMS, a residential model of care based in small secure residential units in the community[3]. Thirty or more such units - taking no more than 20 patients - with high staff ratios and employing only clinical personnel are now in operation across Italy (Di Lorito et al 2017). In stark contrast over that period, in England and Wales the focus was on law reform, rather than fundamental system reform: hence, there was the *Mental Health Act 1983*, which was ultimately amended by the *Mental Health Act 2007*. Whilst the 1983 Act has been rightly portrayed as introducing greater legal protections for patients, the 2007 Act arguably extended the ambit of psychiatric control over those offenders with mental distress, by reducing the existing restrictions on the legal definition of 'mental disorder'[4]. Moreover, other developments during this period placed a greater policy emphasis on offenders with dangerous and severe personality disorder (O'Loughlin 2014; O'Loughlin 2019). The use of compulsory detention under the *Mental Health Act 1983* also increased as the more security focussed approach took hold (NHS Digital 2016; NHS Digital 2020).

This chapter examines whether these distinctions are as stark as they appear at first sight, using as a vehicle one recent notorious case. This straddles the divide between the punishment of offenders with mental disorder in the criminal justice system and the diversion of such offenders into a therapeutic environment under various provisions of the *Mental Health Act 1983*. The difficulties of making decisions about the sentencing and disposal of offenders suffering from mental disorder are acute, particularly where sentencing decisions can have implications for future release. But the decisions about disposal also have consequences for the individual well-being and trajectories of those sentenced. The chapter looks briefly at the relevant law in England and Wales, but also makes reference to some research looking at the difficulties practitioners face in these cases. It also tries to remain cognizant of the possibilities of an alternative 'Italian-style' future and of the enduring problems inherent to any system dealing with the challenges posed by those who have offended with mental disorder.

[3] Legge n. 81/2014 required the establishment of REMS (Residenze per l'Esecuzione delle Misure di Sicurezza) in each of the twenty Italian regions by 31st March 2015.

[4] Under the *Mental Health Act 1983*, as amended by the 2007 Act, s.1(2) «"mental disorder" means any disorder or disability of the mind».

2. *Context*

Evaluating risk in the context of mental disorder, where a crime has occurred, is fraught with imponderables (Peay 2011). First, were the crime and the mental disorder related? Causation and correlation are almost impossible to unpick in individual cases. If the crime and the disorder were unrelated then the mental disorder may only count as a mitigatory factor for punishment and/or a determinant of disposal. In those contexts there are issues around whether the mental disorder was active at the time of the offending (albeit not related to it), active at the time of sentence and thus relevant to disposal, or merely part of the offender's history. Second, if the mental disorder and the crime are linked, issues arise as to whether the disorder (or disorders, as many offenders present with co-morbidities) is or was so severe as to have had a bearing on fitness to plead and take part in a criminal trial. Or whether criminal responsibility can even be properly attributed because of mental disorder at the point of offending, in essence through use of some 'insanity' defence. Third, there are parallel issues – which may be treated differently in different jurisdictions with respect to 'unfitness' or 'insanity' – as to whether the disorder is treatable, and whether that treatment is likely to be successful, either in tackling the disorder, or in reducing the likelihood of future offending. Finally, there are questions about whether future criminal behaviour is susceptible to a re-occurrence of the disorder or whether any re-occurrence of the disorder is simply indicative of a health-based need. Given all of those issues pertaining to risk to others or harm to the offender, there are then questions about what space or scope is left for a penal intervention based on deserved retribution, or public protection. Or whether a mixed therapeutic – penal approach is advised, with either the penal element or the therapeutic intervention coming first. Or indeed whether a punitive response is precluded and only a therapeutic intervention is lawful. In England and Wales all of these issues have been subject to recent scrutiny, and guidance has been published following the deliberations of our Sentencing Council. These came into force on the 1st October 2020[5].

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[5] See Sentencing Council (2020) *https://www.sentencingcouncil.org.uk/overarching-guides/magistrates-court/item/sentencing-offenders-with-mental-disorders-developmental-disorders-or-neurological-impairments/.*

3. *The case of Jonty Bravery*

Jonty Bravery was sentenced to detention for life in a custodial setting, with a minimum period of 15 years of detention, for the attempted murder of a 6 year old French boy on the 4th August 2019 [6]. The offence came to public attention because of its horrific and utterly bizarre nature. Bravery had gone to the 10th floor viewing platform of Tate Modern – a major art gallery – in London, and once there had seized the boy, who was with his family, and immediately threw him over the railings of the viewing platform. The child fell 100 feet; remarkably, he survived the fall but suffered catastrophic and life-changing injuries. Bravery pleaded guilty to attempted murder and was sentenced in June 2020.

For the offence of attempted murder in England and Wales the Crown has to prove an intent to kill. Even had Bravery not pleaded guilty this would, in the context, have been easy to prove. There was no issue raised that he was unfit to plead, nor that he was 'not guilty by reason of insanity'; indeed, there was evidence that the offence had been carefully researched and planned by him. Bravery had autism, and he had researched before the offence what effect his autism would have on his sentencing. In England and Wales, autism falls under the definition of mental disorder in the *Mental Health Act 1983* [7]. Whilst the latest White Paper (Department of Health and Social Care 2021) considering reform and modernisation of the *Mental Health Act 1983* does propose removing autism from the ambit of the civil sections of the Act, autism will remain as a relevant diagnostic threshold for those involved in criminal proceedings [8].

The evidence of four psychiatrists was considered by the court [9]. Notably, at the time of sentence, Bravery was held at Broadmoor Hospital. His treating clinician recommended a hospital order with restrictions; this is a therapeutic order which would have had the effect of continuing his treatment at Broadmoor. As an offender he was regarded as vulnerable

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[6] *https://www.judiciary.uk/wp-content/uploads/2020/06/Bravery-sentence-002.pdf.*

[7] Mental disorder is broadly defined in s.1(2) as «any disorder of disability of the mind». The *Mental Health Act* Code of Practice (2017: para 2.14) is specific in including autism spectrum disorders, albeit it is recognised that autism alone is likely only very rarely to constitute grounds for detention. *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF.*

[8] The government published its White Paper, a consultation document, on 13th January 2021 Reforming the Mental Health Act - GOV.UK (*www.gov.uk*).

[9] One dealt only with the fitness to plead issues.

in a custodial institution [10]. The treating psychiatrist was supported in her opinion by another psychiatrist. The final clinician recommended custodial detention, to better protect the public, with the option of transfer to hospital (and transfer back to prison where necessary) if the special unit in detention where it was hoped he would be located could not cope with his needs. Ultimately, the judge favoured this latter custodial option and rejected the recommendation for a therapeutic order.

Why had these disagreements occurred and what part did future risk play? Bravery was only 17 when the offence was committed, so there were arguments about developmental issues. But the clinicians agreed that his autism did not explain the offending. They also agreed he had an overlapping personality disorder; the considered violence in which he had engaged was suggestive of 'psychopathy' to the psychiatrist not recommending a hospital disposal. The risk posed to the public was agreed as 'grave and immediate' and all thought it was likely that he would spend the greater part, if not all, of his life in detention of some form. So the disagreement stemmed from assessments of where he could be best treated or managed (he was obviously vulnerable in a prison environment); where the best prospect of rehabilitation might occur; and, critically issues about future risk.

In England and Wales two different systems of release apply to those leaving hospital and those leaving prison. For those on restriction orders in hospital, release can be via a decision of the Secretary of State or by a Mental Health Tribunal; with annual reviews being a statutory entitlement before the Tribunal [11]. Decisions about continued detention are governed in law primarily by the persistence of a qualifying mental disorder – albeit this is defined very broadly – and the protection of the patient or others. Recall from release into the community is on the basis of deterioration in an offender's mental health such as to meet the criteria for hospital readmission [12]. For those in prison, release is via the Parole Board, whose decisions are governed by a different statutory regime [13] and the risk of

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[10] *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/893374/safety-in-custody-q4-2019.pdf.*

[11] See *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/670679/MHCS_Tribunal_guidance_-_restricted_patients_v1.1_Dec_2017.pdf.*

[12] See generally s.72 and s.73 *Mental Health Act 1983* (on power of the Tribunal to discharge a restricted patient) and s.42 *Mental Health Act 1983* (on the power of the Secretary of State to recall a conditionally discharged restricted patient).

[13] *The Parole Board is empowered to direct the release of life sentenced prisoners «if it is satisfied that it is no longer necessary for the protection of the public that the prisoner should be confined» Crime (Sentences) Act 1997*, s. 28(6)(b) *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843522/Decision_Mak-*

future offending is the key criterion; with recall on the basis of an increase in that risk of offending. No reviews take place until the tariff-based punitive element of the sentence has been completed: in Bravery's case, a period of 15 years. Arguably, therefore, the public looks like it is better protected by release from prison via the Parole Board, than from hospital by the Tribunal or Secretary of State.

However, matters are not that simple. Clinicians understandably argue that the overall risk with a hospital disposal is reduced; first, because of the treatment that offenders in hospital will have received for their disorders before any release is deemed appropriate; and second, because the quality of supervision in the community enables rapid recall if an offender's mental health begins to deteriorate (Beech et al 2017). After some years of dispute in the courts, the position on sentence has now been achieved whereby, in essence, each case is to be treated on its own merits when anticipating potential release regimes (O'Loughlin 2021) [14]. Neither scheme is deemed preferable.

So why in the case of Bravery did Mrs Justice McGowan reject the recommendation for a hospital disposal and sentence Bravery to custody? Neither autism nor personality disorder are obviously treatable, but the recommendation had been made that Broadmoor would be better able to 'educate' Bravery to manage his personality disorder and control his violent behaviour. Tellingly, a distinction was drawn in the evidence (given by the psychiatrist not favouring a therapeutic disposal) between reactive violence (which might be better controlled) and considered violence (manifest in the specifics of the attempted murder, where Bravery had pre-planned the offence). Mrs Justice McGowan concluded that with the prospects of rehabilitation not being high wherever Bravery was sent, the role of public protection and the requirement for punishment must play a greater role. Marking the terrible act that Bravery had committed took precedence in that context over supporting the more limited prospects of rehabilitation. Even in the context of his overlapping mental disorders his culpability was regarded as high; meriting the description of him as 'callous'.

The choice was stark between a solely hospital-based disposal and a custodial sentence with the possibility of temporary transfer to hospital should the need arise at some point in Bravery's sentence. However, this again reflected the particular features of the offender. There is a third hybrid choice between the two options; namely, a hospital and limitation direction.

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ing_Framework_Public_Document.pdf October 2019. See also para 66 of the 2018 'Warboys' judgment https://www.judiciary.uk/wp-content/uploads/2018/03/dsd-nbv-v-parole-board-and-ors.pdf.

[14] *R v Fisher* [2019] EWCA Crim 1066.

These orders were introduced in 1997 into the *Mental Health Act 1983* and are known as section 45A hybrid orders (Eastman-Peay 1998; Delmage et al 2015). This disposal allows the courts to order a sentence of imprisonment, but direct that the offender first be sent to a psychiatric hospital for treatment of any mental disorder. In essence, it permits the courts to 'hedge their bets' with respect to their own perception of future risk against a current need for treatment. The orders have been little used, even after the time in 2007 when they were extended in their application so that they applied not only to offenders suffering from psychopathic disorder (as it was then known) but also to offenders suffering from any mental disorder under the *Mental Health Act 2007*. And the latest figures suggest that, for 2018, there were 31 hybrid orders made by comparison with 252 hospital orders with restrictions. Moreover, the 'hedging of bets' element stems from the fact that ultimate release from these orders will be via the Parole Board rather than by the Mental Health Tribunal, and can therefore take account of criminological factors which might affect the risk of re-offending, rather than focussing primarily on the offender's mental health status.

However, the orders are limited to those who are eligible for 'a sentence of imprisonment' and therefore apply only to those offenders aged 21 and over. Bravery was 18 at the time of sentence, and whilst he was sentenced to detention for life, this was not *per se* a sentence of imprisonment. He would serve the first part of his sentence in a Young Offender Institution, where the emphasis is on training, rehabilitation and education. Of course, with the tariff of 15 years, Bravery will inevitably spend the bulk of his life-sentence in an adult prison, albeit, as the psychiatrists hoped, he should be held in a specialised unit.

Three further features of the case are pertinent. First, in January 2020 during his stay awaiting trial at Broadmoor Hospital Bravery assaulted a nurse, for which he was given a 14 week sentence on two charges of common assault in December 2020 [15]. By this time he had, in fact, received his sentence of detention for life and was being held at Belmarsh Prison. Second, his appeal against the length of the tariff (15 years) applying to his primary sentence of life was unsuccessful. Counsel had argued that his mental health and his age had not been given sufficient mitigatory allowance, but the Court of Appeal disagreed, noting that they were satisfied that the sentence was neither manifestly excessive nor wrong in principle [16]. Third, Bravery, according to his Counsel, had settled into the regime at Belmarsh. The psychiatrist at Broadmoor who had supported a hospital

[15] *https://www.bbc.co.uk/news/uk-england-london-55411786.*

[16] *https://www.theguardian.com/uk-news/2020/dec/09/tate-modern-attacker-loses-appeal-against-sentence-jonty-bravery.*

order with restrictions had, in the light of the new evidence of Bravery's situation in Belmarsh Prison, changed her view and no longer supported a hospital disposal. Hence, Bravery's Counsel withdrew the appeal against the nature of his sentence [17].

4. *The approach of sentencing courts*

All this means that there is a complex picture when considering the evaluation of risk in the context of mental disorder. In recent judgments the courts have approached these decisions in the following way; with the penal elements of a sentence being given considerable significance. To paraphrase the judgment in *R v Edwards* at para 34 [18], which has guided the Judges as to the appropriate decision-making process:

I. Is a hospital order appropriate?

II. If so, consider all sentencing options including a s.45A order.

III. In deciding on the most suitable disposal remember the importance of the penal element in a sentence.

IV. Assess (as best he or she can) the offender's culpability and the harm caused by the offence. The fact that an offender would not have committed the offence but for their mental illness does not necessarily relieve them of all responsibility for their actions.

V. A failure to take prescribed medication is not necessarily a culpable omission; it may be attributable in whole or in part to the offender's mental illness.

VI. If imposing a hospital order under s.37/41 explain why a penal element is not appropriate.

VII. Release on licence from a s.45A order and from a s.37/41 order are different, but the latter does not necessarily offer a greater protection to the public. Each case turns on its own facts.

This decision process focusses on the choice between a purely therapeutic order and a hybrid therapeutic-penal order. And, of course, it remains open to a judge to order a purely penal sentence where the offender's culpability is high, even in the context of a treatable mental disorder. In all

[17] *https://www.theguardian.com/uk-news/2020/dec/09/tate-modern-attacker-loses-appeal-against-sentence-jonty-bravery.*

[18] *R v Edwards* [2018] EWCA Crim 45, but see also the preceding case *R v Vowles and others* [2015] EWCA Crim 45 and the subsequent cases, which have taken a more 'Edwards' type approach: *R v Fisher* [2019] EWCA Crim 1066 and, more generally and with a focus on offending mentally disordered children, *R v PS and others* [2019] EWCA Crim 2286.

these choices, the issue of how the subsequent method of release should affect the initial imposition of a purely therapeutic order, or a hybrid penal-therapeutic order, has given the courts special difficulty. Having stated in *Edwards* a seeming preference for the s.45A order, the subsequent case of *Fisher* notes [19]

> «we do not consider that the life sentence imposed does enhance the protection of the public, and a restricted hospital order will ensure that any release and aftercare is properly focused on the mental health condition of the applicant and importantly is supervised by the responsible clinician. It will, as we have described, also reduce delays in release and indeed, if necessary, any recall»

Here is not the place for a detailed analysis of the nuances of the case law. Suffice it to say both therapeutic and punitive themes can be discerned in the various judgments. A compelling analysis can be found in the recent work of O'Loughlin (2021), together with the important ramifications of Articles 2 and 3 under the European Convention on Human Rights as a restraining feature on any imperative to send offenders with mental disorder into prison environments where they may encounter harm. It is also worth stressing that the Government's latest White Paper, consulting on reforms to the law in England and Wales, does acknowledge that the concept of harm to the offender can also include the harms caused to him or her by their offending: and that, accordingly, reducing offending by any given individual is in their best interests [20].

5. *Clinical involvement – recommendations and gatekeeping functions*

For clinicians advising the courts, becoming involved with a disposal that invites a penal disposal is inherently problematic. However, research has shown that clinicians' opinions as to the ethics, merits and disadvantages of hybrid orders are complex (Beech et al 2019). In general, clinicians in this small research study only favoured using these orders in limited cases and largely where a psychotic illness was characterised by short periods of psychosis and there were prominent features of personality disorder and/or substance misuse; or where treatability for a primary personality

[19] *R v Fisher* [2019] EWCA Crim 1066.

[20] Reforming the Mental Health Act - GOV.UK (*www.gov.uk*).

disorder was unclear; or where the mental disorder was not considered wholly responsible for the offending and that accordingly some culpability warranting punishment was appropriate. Tellingly, the clinicians were significantly aware that, at some point in the future, decisions about release would likely have to be made. Denying themselves the option of influencing release under a psychiatric supervisory regime was problematic. Release by the Parole Board was thought less effective for all sorts of reasons; including the risk of harm both to the offender and the public where community psychiatric care was not pre-eminent.

A number of the features of the approach in England and Wales, and the interaction between the clinician's role and the court's role, are worth highlighting. First, clinicians can only advise the courts; the ultimate decision on disposal is for the sentencing judge. But this relationship is further unbalanced by the realities of mental health resources and the inclinations of particular practitioners. Thus, a sentencing court may be inclined to a hospital disposal, but in the absence of recommendations from clinicians and available beds such a disposal would be legally and logistically impossible. Equally, clinicians may favour a hospital disposal and be willing to offer a bed, but a judge may regard the offender's culpability and future risk as being too high to take up such recommendations. Second, there is a provision under the *Mental Health Act 1983*, in cases where clinicians and sentencers are uncertain as to which course of action is best advised, for what is called an interim hospital order to see how the convicted offender-patient responds to a therapeutic regime[21]. However, this provision has been little used and further actively discouraged by the Court of Appeal, where the administrative burdens entailed in its use seem to have outweighed the good sense the order embodies[22]. Third, the hybrid order, s.45A discussed above, has proved controversial with both clinicians and lawyers (Peay 2016); a controversy which should have been heightened by the Wessely Review (2018) of the *Mental Health Act 1983*. Notably, in a consultation carried out by the Forensic Psychiatry Faculty of the Royal College of Psychiatrists, no psychiatrist came forward to commend the hybrid order[23]. Yet these orders continue to be made, suggesting that at least some psychiatrists see merit in them, if only as a temporary diversion of a mentally disordered offender from a custodial regime[24]. Moreover, a further potential problem remains:

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[21] S.38 *Mental Health Act 1983*.

[22] *R v Vowles* [2015] EWCA Crim 45.

[23] See Taylor et al (2021) *BJPsych* editorial.

[24] Albeit only in small numbers: see *https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2019-20-annual-figures.*

namely, that when offered a sentencing disposal that favours security and safety, courts often prove remarkably keen to adopt such orders. The use of Imprisonment for Public Protection (IPP sentences) in England and Wales typified this. These were indeterminate sentences with a time-limited punitive tariff, but which ran-on thereafter on grounds of risk. Although now abolished they created a huge backlog of offenders in prison on such sentences; yet, they were never designed for widespread use (Annison 2015).

One of the features of the hybrid order when it was first introduced, was that it was intended for adult offenders suffering from what was then known as 'psychopathic disorder'. Indeed, only offenders with this diagnosis were eligible for this mixed therapeutic-punitive order. The problem of how services should respond to those suffering from personality-type disorders has bedevilled numerous jurisdictions in terms of their mental health legislation. Such convicted offenders often have considerable needs and vulnerabilities, but they also commonly retain capacity. The problem has been made more acute where such patient-offenders are either resistant to treatment, or, as likely, where no effective treatment has been verifiably established (or, some would argue, is likely to be established). Yet these offender-patients can continue to pose a risk of further offending both after release, and within the institutions where they are being cared for and held.

Although Bravery's primary diagnosis was one of autism, this was not thought to account for his offence in any meaningful way. The overlapping diagnosis of personality disorder, with elements of psychopathy, was much more likely to have been associated with the offending. The fact that he continued to be aggressive in Broadmoor Hospital in the early stage of his pre-trial remand might be a further indication of this; or it might equally be a failure of whatever treatment was available to have become effective in the early months after his offence and remand. The nature of his offence was so terrible and so bizarre that it is tempting to think that the public would simply have categorized him either as mad, on the grounds that anyone would have to be mad to do such a thing, or as irredeemably evil for choosing such a course of action. These two opposing spectrum ends crudely, in essence, capture the familiar Lombrosian-Beccaria divide (Newburn 2017). But such stark appraisals belie the complexity of human behaviour, and in particular, of those with personality disorders.

In England and Wales the prolonged 'pilot' period under the dangerous and severe personality disorder regime (O'Loughlin 2019), in which offenders with personality disorders were distributed either between the Dangerous and Severe Personality Disorder (DSPD) units in hospital, or those in prisons, was finally eased out. Such offenders are now largely placed on a 'rehabilitative' pathway that takes them through prison rather than hospital. In this context, the contrast with the REMS is notable.

6. *The REMS approach and its prospects*

As an outsider with only a limited understanding of the minutiae of another country's psychiatric services it would be foolhardy to comment beyond the broad brush. However, it is worth stressing that a number of the features of the REMS are very appealing (and in some limited respects parallel the former DSPD hospital units in England and Wales). There is very high staff provision, the units in Italy are admirably small, they are locally-based enabling patients to retain family contacts and geographical resonances, they are newly built, patients' bedrooms are unlocked during the day enabling interaction within a secure perimeter, restrictive practices are discouraged and those experiencing an acute incident will be transferred to a general hospital. A series of activities in the REMS and outside in the community are encouraged to promote well-being and agency, and, critically, there is a limit on the total length of stay governed by the length of the prison sentence for their index offence (Di Lorito et al 2017).

The extent to which personality disordered patients – and in particular those with anti-social personality disorder or psychopathic traits - have become part of the population of the REMS is unclear. It is clear that there is no legislative bar on their inclusion. It is also admirable that part of the ethos of the REMS is that the aggression of such patients is better managed in a therapeutic and less restrictive setting. In contrast, Broadmoor Hospital, whilst therapeutic in its design, is a hospital with very high security measures in place. Indeed, it has frequently been argued historically that the regime at Broadmoor, like the OPGs, saw some patients being detained seemingly indefinitely on grounds of risk, where their underlying mental disorders largely only provided the legal justification for continued detention in that setting (Peay 1989). And a variant of this, the white-life sentences or Ergastoli Bianchi, is referenced by Di Lorito et al (2017).

However, issues of security and the safety of staff working in the REMS remains a real one, despite the laudable aspirations embodied in the shift from the security-focussed OPGs. The danger with new initiatives, also experienced by the DSPD units, is that initial enthusiasm amongst a group of dedicated staff can weary as the problems the patients pose prove difficult to resolve. This can lead to a degree of ossification and frustration amongst staff and patients. This arguably is one of the reasons why having an absolute limit on the period of detention fixed according to the relevant criminal sanction is welcome, albeit, any very lengthy sentence will still risk ossification. Ensuring that there is a safe environment for everybody has to be a priority. Indeed, the fear is that if such safe environments are not realisable, then more offenders with mental disorders will inevitably

shift back into prison populations where community services are deemed, understandably, inappropriate (Hopkin et al 2018).

There will also always be issues of capacity, as the population deemed to merit accommodation in REMS fluctuates. With the DSPD units there were initially problems with recruiting individuals who did not meet the established criteria in order to populate the units. In time, this was followed by difficulties moving patients on from the units with the result that those who needed places were accommodated elsewhere in arguably inappropriate conditions. The situation in the REMS, reported by Di Lorito et al (2017), noted that whilst there had been a significant reduction in the total numbers of offender-patients held in the REMS vis-a-vis the OPGs, a number of patients were being held in prisons awaiting admission; and some, where risk was low, had been moved from prison to community facilities, still awaiting admission to REMS. Thus, the problems of matching resources to need are longstanding and the restrictions that very small units create paradoxically exacerbate this. In turn it makes the roles of the gatekeepers to those resources critical.

With the management of the REMS passing from the judicial system to the health professionals, decisions about leave and discharge fall to those professionals. In England and Wales, decisions about transfer between institutions and leave for those patients deemed sufficiently risky to have received a hospital order with restrictions still remain the exclusive domain of the Secretary of State for Justice[25]. That such a member of the executive should be legally responsible for these decisions (even if advised by an in-house specialist unit at the Ministry of Justice, HMPPS Mental Health Casework Section, who in effect make the decision under an approved delegated authority), and potentially thereby subject to political considerations, looks strange through most eyes. But these arrangements probably border on the indefensible through the eyes of an Italian familiar with the REMS system. Again, the reality of the situation is that the in-house unit invariably follows the recommendations of the treating psychiatrists, albeit this has historically entailed lengthy delays[26]. But on the surface, the system in England and Wales is greatly in need of long-delayed reform, now under active consideration with the publication of the White Paper (Department of Health and Social Care 2021).

Di Lorito et al (2017) also report that the system of referral to the REMS is problematic. Whilst it seems that referral by a magistrate is on the basis of forensic psychiatrists' appraisals, the experts seem to be distanced from

[25] S.37/41 of the Mental Health Act 1983.

[26] Reforming the Mental Health Act - GOV.UK (*www.gov.uk*) suggests that the backlogs involved in these decisions have largely now been cleared.

those running the REMS, who are presumably the clinicians best able to say whether a patient's needs can be addressed by the REMS. And urgent referrals, in essence a provisional placement in a REMS, represented the bulk of admissions in the early days of the REMS. Again, structuring decision-making in contexts where there is pressure to 'do something' can lead to a population in a REMS with very diverse treatment and security needs. Dealing with patients with clear anti-social personality traits and/or substance addiction can challenge both staff and other patients in small units. Moreover, community acceptance of such units can be made more difficult when the population of patients who will be admitted, and ultimately discharged into the local community, includes a number of those suffering with assorted personality disorders. Fears can be raised that make the building of new REMS – needed to accommodate the demand from the system – problematic. As Di Lorito et al (2017) observe, coping with the demands of those with more criminologically challenging behaviour can be to the detriment of those whose needs are less pressing in terms of risk, but more urgent in terms of self-motivation.

On the other hand, if treating clinicians within the REMS have exclusive control over entry, what happens to the potential patients with different needs and who are likely to impose different demands on a specific REMS? Are these 'unattractive' patients simply to become the preserve of the prison system? These are age old dilemmas. The REMS developments have crystallised the critical interactions between clinicians' assessments of what they can legitimately offer, patients' expectations of and preparedness to engage in therapy, and the court's embodiment of the need to ensure 'justice'. These factors, together with the proper use of resources and managing the community's understanding of these complex issues, create a nexus of imponderable dilemmas. We in England and Wales have much to observe, and most certainly to learn, from these initiatives.

7. *Conclusions*

In England and Wales there is an array of sentencing options for offenders with various forms of mental distress or disability which necessarily determine the ultimate method and circumstances of release back into the community. It is clear that a penal approach will always remain an option, and in some cases it is perceived as the only appropriate option. The position of offenders under 18 who have complex mental health needs who have offended seriously is not as well-provisioned as for adult offenders. Nonetheless, forcing a choice between a wholly therapeutic option and a

penal option (with the possibility of transfer to a therapeutic environment on a temporary basis) can be problematic for the courts.

It is also important to recognise the constraints on decision-making in these contexts. The law in England and Wales provides a structure; clinicians advise and judges decide (at least in so far as to which mechanism will apply to which offender-patients at some point many years later). In addition, clinicians' views about what resources should most appropriately be used will structure judicial decision-making in all but the most egregious cases. But there are also sometimes absolute bars which the law imposes – and this can create difficulties. Hence, a law that was designed in 1997 for one category of mentally disordered offender – those with psychopathic disorder – where it may have made sense to limit its application to those over 21, looks ill-suited when it is extended to all categories of mental disorder, including autism, by another Act of Parliament (the *Mental Health Act 2007* which amended the 1983 Act)[27]. The framers of the 2007 Act had clearly not thought sufficiently deeply about the limitations of its implementation for young offenders, given the consequences of simply extending the 1983 Act's definition of mental disorder.

With respect to the Italian position, there are clearly many laudable features of the REMS approach. But how would a REMS respond to the needs of an individual like Jonty Bravery? Would the response simply be that this is an offender, albeit a young, vulnerable and needy offender, who simply has to be accommodated in a prison environment and not a therapeutic one? To respond that an individual like Jonty Bravery is so rare that it would be foolish to design services around him would be to adopt the common legal adage that 'hard cases make bad law'. This can be contested. First, those with anti-social personality disorders are not a rare occurrence in forensic populations. Second, personality disordered patients are also commonly co-morbid; should such offender-patients be the exclusive preserve of criminal justice measures? Third, the intersections between extreme ideology, mental health and domestic terrorism are likely to present a growing problem[28]. If poor mental health is one of the factors that leads individuals to be vulnerable to radical ideology, and then onto acts of extreme violence, then mental health services can have a preventive role: both, ideally, before offending and after release from treatment or punish-

[27] On the 13th January 2021 the government published a White Paper outlining its plans for reform of the Mental Health Act 1983, which would include removing autism as a basis for civil detention for treatment under the Act *https://www.gov.uk/government/news/landmark-reform-of-mental-health-laws.*

[28] *https://www.theguardian.com/uk-news/2021/jan/11/reading-attacker-khairi-saadallah-given-whole-life-prison-sentence.*

ment. Careful thought needs to be given by both jurisdictions as to how this can best be achieved.

Whilst the hybrid order approach in England and Wales has been rightly criticised for mixing philosophies, ethics and working practices it has been one, albeit flawed, legislative attempt to reconcile the mixed needs that offenders with mental disorder present to services. The alternative approach, of building humane and, ideally effective, treatment-oriented services via REMS may inevitably encounter the problems of resources and security issues if patient allocation were seriously to address the cohort of patients with assorted personality disorders. Perhaps the answer lies not in providing treatment per se in prisons. First, because the prison environment is inherently problematic where questions of consent properly inform any treatment issue, and a coercive environment can make obtaining valid consent simply impossible. And second, because holding out the possibility of treatment in prison may simply undermine an effective therapeutic approach elsewhere. Surely the answer lies in ensuring that custodial services provide a standard of care during confinement, for all offenders for whom custody is truly a last resort. This standard would need to significantly exceed what is currently offered, and certainly what is offered in the prison system in England and Wales, where self-harm, assaults and suicides are rife (Ministry of Justice 2020).