Commentary

Annie Bartlett

It is entirely possible that most readers will have been ignorant of community rehabilitation orders with or without requirements of psychiatric treatment until reading the article by Clark *et al* (2002, this issue). It is valuable as an educational article and is applicable to the work of both general adult and forensic psychiatrists.

Clark *et al* address a central philosophical problem in psychiatry, that is the relationship of treatment and punishment, but in the less usual context of the community. At times, historically, it has been possible for psychiatry to indulge in an element of self-delusion. Psychiatrists, with their basic medical training, have seen themselves as responsible solely for treatment. The criminal justice system takes responsibility for punishment and its concomitants – the prevention of recidivism and surveillance. The supposed clarity of this distinction and the reasons for the development of apparently parallel systems of punishment and treatment within Western Europe and North America have been much discussed (Foucault, 1967, 1979; Jones, 1993). It is pertinent that this ideological critique of practices of detention stresses the importance of the State in the creation and maintenance of systems of classification for those who offend in some way against social mores, with 'madness' or delinquency, or both. Contemporary British psychiatrists of whatever persuasion have been forced of late to engage with the political wish for 'transparent' surveillance and risk management of patients and may now be more easily convinced of the link between political will and psychiatric practice than they were 10 years ago (Department of Health, 1998, 1999).

The transformation, outlined by Clark *et al*, of probation orders with or without treatment into the new-style community rehabilitation orders with or without psychiatric treatment allows for a review of the area where punishment and treatment explicitly, rather than implicitly, meet. They suggest that these amalgam orders have not been much used and are not effective; they recommend how they might be used in the future.

Psychopathic disorder and its close friends

The peak use of probation orders with conditions of treatment in the 1970s, and their subsequent relative decline in popularity, cannot be definitively explained. Clark *et al* comment on the emergence of therapeutic pessimism in relation to individuals with personality disorder, who historically constituted the main diagnostic group on treatment orders. This may be true. There is evidence that psychiatrists neither like nor want to treat those with personality disorder (Lewis & Appleby, 1988) and that probation officers are both mystified by and cross about this attitude (further details available from the author upon request). But the Government is committed to increasing in-patient and out-patient facilities for those with personality disorder along the lines of the Henderson model (Norton, 1992), as well as pushing ahead with treatment for so-called dangerous individuals and individuals with severe personality disorder, usually men. It seems possible that there will be pressure put on mental health services to manage the more numerous but less dangerous group in the community in the way that Clark *et al* suggest. If so, the additional burden would fall not on forensic psychiatry but on hard pressed community mental health teams, who might reasonably wonder how they are supposed to take on such a task. The widely held belief that there is little scope for significant change would be unlikely to make this a popular suggestion.

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Dual diagnosis

It is well-known that the numbers of individuals within the prison system with personality disorder are high (Maden *et al*, 1994, 1995; Singleton *et al*, 1998). Property offences, many drug-related, constitute 60% of the offences for which men are imprisoned and 80% of those for which women are imprisoned (Home Office, 1999). Thus, the reservoir of dual diagnosis individuals within the prison system, often serving short sentences, would seem large. The prison system is once again bursting at the seams and prison governors are reluctant to receive prisoners on short sentences. The dual diagnosis group is a candidate for community rehabilitation orders with or without the involvement of mental health services. This group is not mentioned as such in Clarke *et al*'s review of earlier use of probation orders with conditions of treatment. They are important now, economically, socially and criminologically. They may be unwilling or unable to engage in treatment options, but my suspicion is that they are seldom offered this option, as they will seldom be assessed by mental health services (Fiander & Bartlett, 1997).

Assessment of motivation for intervention is crucial, otherwise the floodgates might be opened to large numbers of unhelpable individuals. There is no equivalent of in-patient assessment orders using Part III of the Mental Health Act 1983, despite the fact that the community orders can last much longer than in-patient treatment orders. Assessment for treatment may fall to the addiction services, whose historical interest has been confined to those who really want to change. This position looks both luxurious and dated given the changing political imperatives mentioned above. But to put significant numbers of dual diagnosis individuals on joint orders may simply be setting them up to fail.

Role of future research

It is depressing that in an era of supposedly evidence-based medicine major changes in practice are driven not by the results of research but by political expediency. This has been particularly true in coercive mental health practice (e.g. supervision registers, supervised discharge orders, hybrid orders and the proposals for community treatment orders). It is hard not to conclude from the review of Clarke *et al* that the jury is out on the efficacy of community rehabilitation orders with additional requirements of psychiatric treatment. The research they cite is either old or small scale and apparently limited in scope. It might be advantageous to consider outcome, naturalistically, in relation to both criminal justice and psychological variables. This might not be too difficult since individuals subject to these community orders are in some sense a captive population as they are constrained by the need for regular reporting. In other criminal populations the relationship between treatment success and recidivism is complex (Robertson & Gunn 1987). For supervising psychiatrists this highlights the risks of taking on the psychiatric supervision of those likely to offend. Rather than simply following the authors' prescription for the increased use of the orders, mental health services might be wiser to be cautious and await results from such research.

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