

An American Cultural View of the British DSPD Proposals

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J Am Acad Psychiatry Law 32:124–31, 2004

Members of black and other ethnic minority groups in the United Kingdom have been worried about Britain's new program for the management and treatment of individuals with a dangerous and severe personality disorder (DSPD). These changes to service provision in Britain have evoked commentary in the United States^{1,2} that has criticized the British Government's ideas on a number of fronts. Not surprisingly, ethics-based questions were raised about the British Government's plan to detain preventively certain individuals with DSPD. It was also pointed out that only a few British psychiatrists believed this subgroup of individuals could be treated effectively. In addition, there was opposition to compulsory treatment of the group. A further critique of the service changes centered on the notion that consumers had had little input into development of the proposals. A final substantive criticism was that much of what the Government contemplated was based on the assessment of risk, an arena in forensic psychiatry that is currently fraught with complexity and continues to be the subject of academic review.

Besides these critical comments^{1,2} about the DSPD proposals, black and other minority groups in

the United Kingdom have another clear interest in the program. They are wondering, and legitimately so, whether black people in the U.K. will be adversely affected by this new legislation. It is concern about this central question that prompted the Brent Black African and Caribbean Mental Health Consortium (a London-based organization) to sponsor a conference about the subject in October 2003. The meeting (whose theme was *New Directions in Forensic Psychiatric Policy and Their Impact on Black African and Caribbean Communities in the United Kingdom*) brought together representatives from different constituencies to review the DSPD proposals and to discuss them in light of the concerns they have evoked. The DSPD program is of central importance, as the Government's proposals will have an impact on the care delivered to individuals with DSPD. In addition, the suggested program may transform the mental health care system throughout Britain and may even influence substantially the direction of mental health research at British universities over the next decade. Since, as we shall see, the Government intends for the DSPD proposals to catalyze refashioning of their whole mental health care system, it is entirely logical for concerned citizens to ask how Britain's black population will fare under this proposed legislation.

The British Proposals

In an official document published in 2001,³ the British Government issued a progress report on its DSPD initiative. The Government pointed out that they had two major objectives in mind: protecting the public from very dangerous people in society and

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providing the quality of services to these individuals that would enhance their chances of being reintegrated into the general community.

The British Government outlined the idea that their concern about public safety has increased because of the challenge posed by “the small minority of mentally disordered people; those with a severe personality disorder who, because of their disorder, also pose a significant risk of serious harm to others” (Ref. 3, p 3). It seems evident that the politically sensitive matter of public safety has, at least in part, provoked a governmental response. One dimension of the response is to reform mental health legislation.⁴ The other is to develop “appropriate specialist services for people assessed as DSPD” (Ref. 4, p 3).

In the proposed legislation, the Government has repeatedly emphasized that protection of the public is one of its highest priorities. As a result, clear authority will be provided for the detaining of individuals so that they may be assessed and treated if, as a result of a mental disorder, they pose a serious risk of harm to others.⁵ The Government has acknowledged that these individuals may be known to mental health services, social services, or the police. Consequently, these agencies will be able to refer the individual for an initial assessment and then for a further 28 days of compulsory care and treatment. Beyond 28 days, further care must be authorized by a Mental Health Tribunal. Individuals already incarcerated may also be referred for assessment. The Tribunal or a court, in the case of individuals with DSPD, may mandate care for such individuals.⁵

A review of documents issued by the National Institute for Mental Health in England (NIMHE)⁶ makes clear how the British Government has decided to realign its services under this plan. The Government concluded that there was a “significant disparity in the availability of services for people with personality disorder” (Ref. 6, p 13). They noted that in 2002, only 17 percent of Health Trusts had a dedicated personality disorder service. Forty percent of Trusts provided some service, and 28 percent provided no service.⁶ The report stated that there was no consensus about the need to provide services to this group of patients.

Through its Department of Health (DH), the British Government has suggested developing personality disorder services over the three-year period from 2003 to 2006. These services will be structured in two ways: for general adult mental health services

through the development of specialist multidisciplinary personality disorder teams and for forensic services through the identification, assessment, and treatment of personality disordered offenders at specialized centers. The DH will also provide funds to catalyze new training opportunities for the disciplines that will care for this category of patients.

The DH, in its background texts, went to considerable lengths to buttress its decision to pursue this unique program initiative. It developed a comparative definition of personality disorders, explored the epidemiology of this particular disorder, and reviewed what services existed for individuals suffering from personality disorders, including those in forensic settings. Opinions were also solicited from “service users,” the British equivalent of the American-styled “consumers.” Service users complained that “Personality Disorder” was a pejoratively stigmatizing label. They also claimed that “Antisocial Personality Disorder” was very stigmatizing terminology, and they feared that the “Dangerous and Severe Personality Disorder” label would lead to inappropriate compulsory detention of some individuals.

The DH commissioned studies to explore whether there are effective treatments for personality disorders. The studies concluded, according to the DH, that while more research is needed, “there are real grounds for optimism that therapeutic interventions can work for personality disordered patients” (Ref. 6, p 23). The DH pointed out that “a combination of psychological treatments reinforced by drug therapy at critical times is the consensus view of treatment in personality disorder” (Ref. 6, p 23). It remains a substantive question, of course, whether the general body of mental health professionals on both sides of the Atlantic would agree with such a hopeful view of the treatment of personality disorders. But the British DH believes that one can successfully treat even those in the psychopath group who score high on Hare’s Psychopathy Checklist (Ref. 6, p 27).

With all of this background work done, the British DH have proposed the development of an intricate array of services that will center on the care and treatment of individuals suffering from personality disorders. These services will certainly strengthen what the general mental health service system can offer. But, in addition, the mental health forensic system will expand, offering short-term treatment, longer-term rehabilitation and expert assessment—all of this for the personality disordered offender. The DH has

even promised to dialogue with entities involved in the training of mental health professionals so that professionals will, in the future, be better prepared to manage and treat individuals suffering from personality disorders (Ref. 6, p 48).

Legitimacy of the Question

Criminal Justice

American observers, from their vantage point in the United States, would readily conclude that one ought to consider seriously the concerns raised about the potential impact of the DSPD proposals on black groups in Britain. Certainly, the cultural context of the United States would make it folly to ignore the question of what impact any fundamental change in health policy legislation would have on blacks in North America.

The U.S. situation is unambiguous. With respect to the administration of American justice, Kennedy has noted that “public authorities in the United States have long used race as a signal of an increased risk of criminality” (Ref. 7, p 138). This association of skin color and criminal conduct has been underscored in many different situations. Media took note of it in reporting that the New York City Council released records showing that the percentage of individuals stopped and frisked has consistently stayed around 50 percent for black individuals, which is higher than for other ethnic groups and twice the demographic percentage of blacks in New York City.⁸ Of course, police officials insisted that the skin color of people stopped by the police is consistent with the racial background of violent crime suspects identified by victims. While the argument continues about the meaning of this stop-and-frisk activity—whether it constitutes racial profiling or whether it is inherently racist—the data certainly reflect police officers’ judgments about individuals they encounter. Some observers insist that there is a link between black skin color and criminality. As blacks constitute only about 25 percent of New York City’s population, this elevated stop-and-frisk rate will continue to fuel the discussion about the degree to which police officers in America’s big cities exercise their law enforcement functions in a prejudiced fashion.

A similar media report pointed out that racial disparities are seen as pervasive in American juvenile justice.⁹ The report described a study underwritten jointly by the Justice Department and several foun-

dations. It noted that minority youths were “more likely than their white counterparts to be arrested, held in jail, sent to juvenile or adult court for trial, convicted and given longer prison terms. . .” (Ref. 9, p A1). The report pointed out that blacks represented about 15 percent of the total U.S. population under the age of 18 years. However, blacks under 18 made up 26 percent of those arrested in their age group, 31 percent of those in their age group sent to juvenile court, 46 percent of those waived to adult criminal court, 40 percent of individuals placed in juvenile prisons, and 58 percent of those in their age group admitted to adult state prisons.⁹ Regardless of the causes, the disparities were undeniably obvious. Hence, the report’s conclusion that justice may be only for some Americans.

In another report issued by the United States Justice Department in 2003,¹⁰ it was stated that 12 percent of African-American men between 20 and 34 years of age are in jail or prison. This contrasts markedly with 1.6 percent of white men in the same age group. Just as in consideration of data about the disproportionately high number of black men on death row in the United States, it is not easy to conclude that there is a single simplistic cause (such as racism) for the overrepresentation of blacks in the American criminal justice system. Nevertheless, the data force us to confront the possibility that blacks may not be treated fairly when they seek justice in the United States.

We acknowledge that not everyone will grant such a straightforward interpretation of these U.S. data. Stark¹¹ has, for example, reviewed a number of explanations that suggest broader responsibility for this state of affairs. At least one stereotypical, deficit-based, and conservative model suggests that the disproportionate number of black Americans in the criminal justice system may be related to the dissolution of the black family. This would in turn account for the high unemployment, pervasive drug abuse, elevated pregnancy rates, and the high number of youth dropping out of school and getting into trouble. This model recommends simplistically that blacks take responsibility for interrupting the cycle of their nihilistic involvement in crime, for lifting the low self-esteem of their group, and for diluting the predatory, crime-ridden aspects of their culture. In a reanalysis of data, Stark¹¹ agreed that it is this stereotyped and exaggerated association of blacks and violence that leads to the likelihood of blacks’ receiving

the harsher penalty when blacks and whites commit the same offense.

It is sufficient to state that these American data about blacks and criminal justice do not lend themselves to simple interpretation. Nevertheless, we cannot ignore them either. Reflection on their significance highlights the need for sustained scrutiny of public policy developments that potentially impinge on the autonomy of a country's citizens.

Health Care

From an American perspective, inequities in the delivery of medical care would be an additional reason for concern about how blacks might fare under the DSPD proposals. Particularly in the United States, published research has revealed that blacks and other ethnic minorities receive lower quality health care than whites and are less likely to undergo routine medical procedures than whites.¹² As noted in the recent Institute of Medicine (IOM) Report, these disparities are observed in a variety of medical treatment areas. For example, blacks are less likely than whites to receive cardiac medication, undergo coronary artery bypass surgery, or receive hemodialysis, kidney transplantation, and intensive care services. The IOM Report further highlighted that these disparities between blacks and whites remain even after adjustment for socioeconomic differences and health care access-related factors.¹²

A recently published study¹³ on the rates of knee arthroplasty among Medicare patients in the United States confirmed once again that disparities exist among blacks and whites but also pointed out the complexity of ascertaining the etiology of the disparities. This study assumed that knee arthroplasty (total knee replacement) is an effective alternative to medical management for the relief of pain and improvement of function in patients with moderate to severe articular disease of the knee. The authors also noted that generally there is a higher rate of osteoarthritis among blacks than whites and a higher rate among women than men. In the results, the national rates among women for knee arthroplasties between 1998 and 2000 were higher for whites (5.97 per 1000 women) than for blacks (4.84 per 1000) (Ref. 13, p 1355). Among men, the rate for whites (4.82 per 1000) was much higher than for blacks (1.84 per 1000). The authors acknowledged that geographical location had some impact on the rate difference, although much less for black men. Health status of the

subjects could also account for some of the difference, as could the differences in patients' preferences, and general distrust of the health care system. Therefore, while the reasons for the health care disparities between blacks and whites are not absolutely clear, this study on knee arthroplasty is yet further proof that blacks and whites in the United States receive unequal medical treatment.

In an editorial published in 2000, Freeman and Payne¹⁴ lamented that inferior medical care was being given to black Americans. They emphasized that black Americans have a higher overall incidence of cancer and a higher rate of death from cancer than whites. In addition, black Americans were undertreated for pain from cancer, fractures of long bones, and surgical interventions.¹⁴

In another editorial published in the same journal, Geiger¹⁵ also pointed out that blacks received poorer medical care than whites. Blacks were less likely to receive renal transplants, undergo hip or total knee replacements, or undergo gastrointestinal endoscopy. On the other hand, blacks were more likely to undergo hysterectomy and amputation of the lower limb.

A similar pattern of health disparities has been documented within the mental health and substance abuse arenas. These disparities exist in access, availability, and quality of care between African-American and white populations. Research has shown, for instance, that African Americans are more likely to have a diagnosis of schizophrenia, antisocial personality disorder, or conduct disorder; are less likely to have atypical antipsychotic medications prescribed; and show a greater unmet need for alcohol and drug abuse services.¹⁶ African-Americans are also less likely to use outpatient and community-based services and are more likely to use inpatient, emergency, and primary care services when seeking help for behavioral health problems.¹⁶

Within both the mental health and physical health fields, numerous causes of disparities have been documented, including: (1) cultural distance between the client and the clinician, (2) use of idiosyncratic and biased diagnostic approaches, (3) misapplication of clinical base rates, (4) stereotypes of African-American psychopathology, (5) use of biased diagnostic instruments, (6) employment of treatment approaches lacking in cultural relevance, (7) limited availability of providers of color, (8) client mistrust

of mainstream health care services, and (9) stigma.^{12,16–18}

With all this accumulated evidence now in hand, voices have been raised to insist that there is now a clear need to develop evidence-based initiatives to address each of the possible causes of disparities.¹⁹ All of these disparities so well established now in the United States would recommend a thoughtful approach in Britain to the implementation of the new proposals that may have so profound an impact on the entire mental health care system and on the autonomy of those who seek help within that system.

Debate on Mandatory Treatment

One would expect some advocates to be worried by proposals that infringe on the autonomy and freedom of mental health patients. These advocates are concerned that such governmental proposals usually arise when politicians and others seek solutions to homeless individuals' residing on the streets or the perpetration of unacceptable violence by people seen as mentally ill. Those who advocate on behalf of these individuals have suggested that the simplistic political response is often offered as a pale substitute for the lack of appropriate and effective services provided in the community.²⁰

Munetz and colleagues²⁰ have developed an intriguing model for consideration and analysis of any mandatory outpatient treatment system. Their argumentation seems usefully applicable to the assessment of any mandated care, including programs established for the treatment of forensic psychiatric patients and other mentally ill offenders. The cornerstone of their model is that mandatory treatment should never be employed in place of inadequately funded or poorly structured systems. This point is crucial in the discussion of the British Government's DSPD proposals. Second, no mandatory treatment should be invoked until other less-intrusive alternatives have failed. Third, a dangerousness-based approach is not preferable to a capacity-based approach. An approach centered on the patient's capacity to make decisions about treatment is likely to be more respectful of the patient's autonomy. The dangerousness approach promotes stigma and may facilitate the idea of confinement without treatment. Finally, Munetz and colleagues²⁰ have argued that consumers must be participants in the development and implementation of models that mandate care.

Risk Assessment Difficulties

The British DSPD initiatives focus squarely on the subject of risk to others, assuming the need for and availability of psychiatrists to perform the task of assessing that risk. Our societies seem uninhibited in concluding that it is the duty of psychiatric practitioners to carry out risk assessments. That we have come so far, with so little mindfulness of the dangers of such thinking, makes the call for honest monitoring of these endeavors all the more imperative.

It was just such diversions of our clinical and humanitarian objectives that drove mental health professionals to object to the use of psychiatry to predict dangerousness when such practices were beginning to take hold in the United States in the 1970s. In 1974, Diamond²¹ admonished his colleagues not to permit their professional status to be falsely paraded as expertise on matters in which no scientific expertise existed and that could lead only to hardship for the unlucky subjects of such evaluations.

Stone,²² in 1975, warned that the use of dangerousness as a criterion for civil commitment would deprive traditional psychiatric patients—who are rarely dangerous—of inpatient services as beds were filled with more clearly dangerous individuals.

In 1978, Shah²³ pointed out that there were 15 different ways in which the evaluation of dangerousness was being utilized within the justice system. Among other arguments, he pointed to the scientific problem of a strong societal preference for false-positive errors in risk predictions, and to the ethics problem of unfairly applying preventive detention to the mentally ill. He noted at the time that other more predictably violent groups, such as repeat offenders and drunk drivers, received no such handling, because preventive detention had no place in our centuries of English legal tradition in the United States.

Over the years, our society (and perhaps even the profession of psychiatry) has apparently become immune to such concerns. When the U.S. Supreme Court was confronted in 1983 with significant scientific data that psychiatric predictions of dangerousness were wrong twice as often as they were right, it nonetheless permitted the use of such predictions even in matters as important as the imposition of a death sentence.²⁴ In part, they formed this reasoning because such assessments of dangerousness were carried out all the time by psychiatrists in civil commitment proceedings. So the Court saw no problem in

accepting psychiatric testimony on this issue in other contexts as well. The weight to be accorded to such testimony was just another matter for the fact-finder to decide.

In more recent times, we have seen the emergence of “risk assessment” from the murky depths of dangerousness prediction.²⁵ While this concept has more desirable statistical traits and has been accompanied by more and better scientific study, within the rituals of the criminal justice system, this scientific evolution has been little more than a semantic enhancement. The U.K. has not, for example, adopted legislative initiatives to quantify the assessment of various levels of risk and match them with various levels of intervention. The legislation intends the psychiatric identification of individuals as “dangerous,” with sequestration attendant to the application of the label.

There are many reasons that we should be concerned about the use of psychiatric expertise for such purposes. Increasing accuracy of risk assessment techniques, particularly using well-studied actuarial instruments, tempts us in this direction. Yet, as Mossman²⁶ pointed out, accurate predictions are not the same as “correct” predictions. He demonstrated mathematically that even instruments with accuracies significantly above chance (e.g., an area under the curve (AUC) = .83), fail to sort patients into subgroups with meaningfully different levels of risk. He argued that such clinical usefulness of risk assessment would require instruments that are nearly infallible (i.e., AUC = .99).²⁶

Rogers²⁷ has offered other concerns about risk assessment practices. He observes that our risk literature emphasizes risk factors, ignoring protective factors and moderator/mediator effects. Assessments that take into account only such risk data are inaccurate, biased against forensic populations, and countertherapeutic. For forensic and/or criminal populations, such risk assessments are subject to a “floor effect,” such that a statistically significant level of risk will always be assigned. In societies increasingly intolerant of even small risks, the result is decidedly negative for such populations. He further noted that probabilistic data are easily misused by the courts and that there are problems of applying the correct base rate to any particular evaluation.

It is easy to imagine how the “floor effect” bias carries cultural-racial dimensions given the over-representation of minority individuals within the crim-

inal justice and correctional systems. And can we honestly say that we understand the application of appropriate base rates along the continua of dominant/nondominant group dimensions?

Dvoskin and Heilbrun²⁸ have made the point that even accurate actuarial approaches to the assessment of risk are not helpful to the kind of real-life decisions that face mental health professionals, such as the release of forensic patients. An individual carries his or her history forever, and such history is the basis of actuarial assessment. Risk factors identified on admission are static and thus not amended by such factors as progress of treatment.²⁸

It is just such static, historical factors that influence the labeling of individuals as exhibiting dangerous severe personality disorders. No matter how brilliant the envisioned research, how will we ever treat an individual’s history? And if this new era of legislated scholarly work somehow manages to elucidate techniques for the successful treatment of dangerous personality disorders (a task that has thus far managed to elude more than a century’s worth of investigators and practitioners both in Europe and America), how will that be reflected in our current models of risk assessment?

Mullen²⁹ has drawn our attention to the even more challenging issue of the ethics of mental health professionals who engage in risk assessments. He expressed several criteria for the ethical conduct of these assessments, and argued that empirical evidence must exist to guide the decision-making. Mental health variables must be prominent and directly related to the probability of future harmful behavior. Risk should be expressed as a probability, while stating the limits of such probabilistic determinations. The implications for the subject of the inquiry must be considered, and the inquiry must be motivated by an intention to provide better treatment and care to a patient—as opposed to a motivation to confine or coerce the patient.²⁹ Until we reach a point where the intended research clearly demonstrates the clinical superiority of mandated treatment under confinement over other possible interventions (from the confined individual’s perspective), it seems unlikely that we will temper such ethics concerns.

The unfortunate reality is that in over 30 years of focus on dangerousness and risk, we have created powerful pressures on clinicians to become police; we have provided all the incentive necessary for clinicians to internalize a nonclinical, protective approach

to their work with patients.³⁰ We engage in these rituals in an attempt to salve public anxiety and fear, yet the result has been an increasing association in the public mind between mental illness and dangerousness.³¹ And we have only strengthened the perception that mental health care is about the control of dangerousness—a perception that has seen its logical extension in the initiation of the Dangerous Severe Personality Disorder proposals.

Comment

It is important to note that the British Government, in a recent publication about delivering race equality, has acknowledged publicly their concern that psychiatric patients from black and minority ethnic communities have not had adequate services and health outcomes.³²

The Government has articulated an ambitious plan³³ to effect change in mental health services inside (within its services) and outside (within the communities). The Government has outlined its intentions to reduce and eliminate ethnic inequalities in service experience and outcome by ensuring that community minority ethnic groups participate in service planning, delivery, and evaluation. In addition, all service organizations should have cultural capability and provide excellent service. The Government has also decided that all service organizations should invest in improving diversity. And finally, a crucial part of the Government's plan is to expand the capacity of black and minority ethnic communities to enhance the psychiatric patients' chances of living successfully in their communities. This will be achieved through improved access to housing and employment.

These plans reflect substantial sophistication and an acute awareness of factors that detract from a health system's being culturally competent. If the Government follows through on all its proposals, Britain will likely have one of the most culturally sensitive and effective mental health care organizations in the world. In that case, it seems contradictory that the same system would advance the DSPD proposals or would expect that minority groups—especially blacks—should welcome the proposals.

Indeed, a culturally competent system should have policies in place that ensure the effective and equitable delivery of services for recipients of care. For example, Cross and colleagues³⁴ have defined cultural competence as a set of congruent behavior, attitudes,

and policies that come together in a system or agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations. Questions remain regarding whether the implementation of the DSPD proposals will allow for the fair, effective, and unbiased treatment of blacks in Britain. The recent television exposé³⁵ in which British police trainees bared their most racist thoughts to the television camera was revelatory and unsettling. Those images could not have endeared the police to the black community and could not have put in a good light any governmental proposal that could reduce the autonomy of blacks.

While it is admirable that the British Government has outlined its intentions to reduce ethnic inequalities in the service experience, such efforts geared toward enhancing the cultural competence of service systems inevitably involve long-term, multilevel, and simultaneously occurring interventions. As with any systems change initiatives, such interventions will require continued commitment and resource allocation, which can be challenging for any country.

In the United States, federal, state, and local agencies are currently struggling with creating culturally competent systems of care. It should therefore be evident that Great Britain has an important and complex set of strategies to implement if high-quality and unbiased services are to be delivered in a culturally sensitive and competent manner.

Assuming that the British Government goes forward with the DSPD proposals, it will be incumbent on psychiatrists and other mental health professionals to focus their attention on the ethics dimensions of their practice under the DSPD proposals. Mental health professionals should expect to be asked about their opinions of a patient's dangerousness at the point where consideration is being given to the patient's detention and at the point where the patient is being considered for release. Professionals should deliver such testimony within the boundaries delineated by ethics precepts (such as truth-telling and objectivity) and should not be intimidated by the political need to protect the community from potentially dangerous individuals.

One final troublesome point is that the DSPD proposals encompass an expansion of clinical programs as well as a determined interest in detaining dangerous individuals. The overall initiative will, by any measure, cost a substantial amount of money. Only time will tell whether the Government will

spend the necessary funds to improve mental health services or simply end up with more citizens in detention, a disproportionate number of whom could be black. Mossman²⁵ has reminded us that, after all is said about dangerousness and psychiatric patients, all patients deserve treatments that are good. Consequently, “violence reduction should be a side effect of, rather than a justification for, those interventions” (Ref. 26, p 280).

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