Editor:

I write in response to two articles in the recent issue of The Journal. In the first, Drs. Shadravan and Bath[1] write importantly of the role of history in our collective bias when it comes to assessing people from different, and historically disadvantaged, cultures. As is commonly said, if we fail to learn history's lessons, we are bound to repeat earlier mistakes. Learning those lessons may help us avoid repeating the errors of the past, but of course we are not guaranteed to do so. One reason there is no guarantee is that so much of what we do is unconscious. Speaking only for myself, I am sure that my own internal biases affect my decision-making, no matter my efforts to be "unbiased."

The second article of most interest to me was Dr. Adshead's response[2] to the interesting piece on shared risk formulation by Drs. Ray and Simpson.[3] Taking a cue from the move toward shared decision-making in clinical practice, Ray's and Simpson's review of approaches that would include the forensic patient in our risk-assessment efforts is fascinating, but it was Dr. Adshead's response that really got me thinking.

How much does our bias toward risk affect our decision-making when it comes to forensic patients? How much is this bias based in the personal history of each individual patient? How much is this bias based in our own past experiences with bad outcomes? Do we even remember the good outcomes?

In my work in Maryland's forensic system, it has always struck me that we knew all about the failures: patients who came back repeatedly, the ones who committed new headline-grabbing crimes, or the individuals whom we couldn't discharge due to refractory illness. But what about the people we discharged who did not return?

In addition to my work in forensic psychiatry, I have worked for more than two decades with On Our Own of Maryland, the statewide consumer network. There, I regularly have the opportunity to interact with the people we serve as peers and friends, not as doctor and patient. I have met people who have come through our treatment system, including some who have come through our forensic system. It is always humbling to hear how they view us and the way in which we make decisions.

I wonder how much our decisions, especially about release, are guided by our own bias regarding the bad act(s) that led the patient into our system, and not by a full assessment of risk and protective factors. Having met numerous former patients who are thriving, it makes me wonder: If our forensic hospitals only see the patients who return, and never see the patients who don't return, how can staff there who must make release decisions truly know the outcome of those decisions? The patient could be dead or in prison, to be sure, but what if he or she is in a long-term sustained recovery? Not knowing that, how can we expect forensic practitioners to make fully informed, unbiased decisions?

Seems to me, we have a lot to learn from our patients.

References

1. Shadravan SM, Bath E: Invoking history and structural competency to minimize racial bias. J Am Acad Psychiatry Law 47:2–6, 2019
2. Adshead GMJ: Talking to forensic patients about risk. J Am Acad Psychiatry Law 47:29–34, 2019
3. Ray I, Simpson AIF: Shared risk formulation in forensic psychiatry. J Am Acad Psychiatry Law 47:22–8, 2019

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