Correspondence

Venous thromboembolism prophylaxis – beware of potential risks

Van Zyl *et al*'s study[1] highlights the importance of increased awareness of venous thromboembolism (VTE) in mental health services for older people. However, it is also important to be aware of the risks of thromboprophylaxis within this setting. The authors claim that the incidence rates of VTE in old age mental health services were comparable with those in general hospitals. However, it does not follow from this that the same approaches for VTE screening and thromboprophylaxis used in general hospitals should be applied, particularly with respect to the risks of thrombocytopenia and bleeding from prophylactic low molecular weight heparin,[2] which may be exacerbated in mental health in-patient settings, where the average length of stay is likely to be longer than in an acute medical unit. In fact, recent meta-analyses have questioned whether such risks outweigh the potential benefits even within the general hospital setting.[3] Further evidence should be sought before such VTE prevention strategies are widely implemented in mental healthcare settings, lest they lead to patient harm.

1 van Zyl M, Wieczorek G, Reilly J. Venous thromboembolism incidence in mental health services for older people: survey of in-patient units. *Psychiatrist* 2013; **37**: 283–5.

2 Wang TY, Honeycutt EF, Tapson VF, Moll S, Granger CB, Ohman EM. Incidence of thrombocytopenia among patients receiving heparin venous thromboembolism prophylaxis. *Am J Med* 2012; **125**: 1214–21.

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doi: 10.1192/pb.37.11.372

Venous thromboembolism risk assessment in old age psychiatry

Venous thromboembolism (VTE) risk assessment for patients admitted to old age psychiatric units has been a neglected area.[1] Both the National Institute for Health and Care Excellence's and the Department of Health's guidelines[2,3] recommend that every patient admitted to hospital be assessed for VTE and managed appropriately. The failure to adequately screen and prevent VTE is believed to cause annually between 25 000 and 32 000 potentially avoidable deaths in the UK.[4]

During my 6-month rotation in old age psychiatry, we completed an audit looking into VTE risk assessment for elderly patients. The results were quite alarming: 13% of patients developed deep vein thrombosis (DVT). We then looked at DVT risk factors retrospectively and this revealed a mean of 3.4 risk factors for patients admitted to our unit. Not one patient had been assessed for VTE or treated on admission with pharmacological prophylaxis or graded compression stockings. Old age psychiatric units do not seem to have policies in place to recognise and manage patients accordingly, in contrast to general hospitals, where every patient undergoes a VTE assessment on admission and is commenced on appropriate prophylaxis immediately.

Unfortunately, both the risks of thrombosis and those associated with prophylactic treatment are increased in frail older people, and this means that careful risk assessment to weigh up the risks and benefits in each patient is essential. A more standardised national approach and greater awareness of the Department of Health's risk assessment tool for VTE[3] may be needed.

1 van Zyl M, Wieczorek G, Reilly J. Venous thromboembolism incidence in mental health services for older people: survey of in-patient units. *Psychiatrist* 2013; **37**: 283–5.

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3 Department of Health. *Venous Thromboembolism (VTE) Risk Assessment* (Gateway reference 10278). Department of Health, 2010.

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doi: 10.1192/pb.37.11.372a

Diverse response from psychiatrists to CTOs

I thank Dr Lawton-Smith for his comments on our paper on community treatment orders (CTOs).[1,2] I find it necessary, however, to emphasise that we never implied that all psychiatrists like the new CTOs. In fact, we merely pointed out that they have been used much more than the Department of Health anticipated. In that sense they have been popular with practising psychiatrists.

We are fully aware that many psychiatrists in England and Wales are uneasy with the legislation. I also agree that the recent Burns *et al* paper[3] may well cause a reduction in CTOs used.

1 Lawton-Smith SH. CTOs – use with caution (letter). *Psychiatrist* 2013; **37**: 308.

2 Lepping P, Malik M. Community treatment orders: current practice and a framework to aid clinicians. *Psychiatrist* 2013; **37**: 54–7.

3 Burns T, Rugkåsa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, et al. Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *Lancet* 2013; **381**: 1627–33.

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doi: 10.1192/pb.37.11.372b

The risk in risk assessment

Szmukler *et al*[1] should be warmly congratulated on their clear, authoritative critique of the recent developments in the law of

England and Wales concerning mental health. Their analysis of the assessment of risk is particularly telling: 'Rare events are virtually impossible to predict with any degree of accuracy. ''False positives'' will overwhelm the number of ''true positives'' [. . .] if the rate of suicide in the year post-discharge were, say, 1 in 250, only 1 in 100 of patients judged to be at ''high risk'' using a risk assessment instrument would complete suicide.'

These number-based risk assessment instruments lack the necessary sensitivity and specificity to be useful, and can be harmful in the ways described in this article. Our judiciary, policy makers, coroners and others, conducting inquiries or giving expert evidence, should all take note.

1 Szmukler G, Richardson G, Owen G. 'Rabone' and four unresolved problems in mental health law. *Psychiatrist* 2013; **37**: 297–301.

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doi: 10.1192/pb.37.11.372c

Look back in anger: flaws in the retrospective evaluation of risk assessment

The team from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness recently posted a report on quality of risk assessment prior to suicide and homicide.[1] The report describes an un-masked retrospective survey of the risk assessments found in the case notes of 42 suicide victims and 39 homicide perpetrators. The authors suggest that in about a third of cases poor risk assessment might have contributed in some way to those deaths. However, the assumptions made in the report and the interpretation of the results raise serious concerns.

First, the study did not examine whether risk assessments that were classified as inadequate were more common in the notes of suicide or homicide cases than in the notes of other comparable patients with a non-fatal outcome. In fact, there is no evidence to show that raters who are masked to the eventual outcome can correctly identify the notes of patients who have died by suicide[2] or perpetrated homicide.

Second, there is no empirical evidence to suggest that risk assessment is of any use in preventing rare events such as suicide and homicide.[3] The low base rate of these events means that for every correct prediction there are inevitably a very large number of false positive predictions, reducing the possibility of arranging any practical intervention to prevent the adverse outcome. The low proportion of true positives means that any intervention that follows from a high-risk categorisation with the aim of preventing a rare outcome must be sufficiently effective and benign to warrant treating so many false positives, and must be efficient enough so as not to result in the excessive diversion of healthcare resources from low-risk patients, including the proportion of false negative categorisations. The lack of sensitivity of risk assessments means that they miss about half of all homicides[4] and as many as 90% of all suicides.[5] Hence, if there are benign life-saving interventions that are suitable for high-risk patients, they should be offered to so-called low-risk patients as well, obviating the need for a risk assessment.

Hindsight will always allow us to identify clinical decisions that might have prevented an adverse event, like the action replays of goals in football matches. However, when viewed prospectively, clinical decisions involve a level of uncertainty and the requirement that the clinician accepts a level of risk in order to respect the patient's wishes and ration the resources that are available. Perhaps the reason that a third of risk assessments were thought to be of poor quality was because those clinicians were aware of the futility of trying to predict a rare event, and were just getting on with doing what is possible, which is a comprehensive assessment of the individual patient's treatment needs, followed by ethical and compassionate evidence-based treatment of every patient.

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Declaration of interest

M.L. and O.N. have both received speakers fees from AstraZeneca.

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doi: 10.1192/pb.37.11.373