

Editor:

I am writing in response to the article on covert medication published by Hung *et al.*¹ in the April 2012 issue of *The Journal*. While the authors raise critically important questions regarding this practice and note some of the ethics pertaining to its use and potential aftermath, I am writing to address what I feel is an important psychodynamic consideration that attends this situation.

Given our particular culture's admiration of independence and autonomy, my perception is that people are often placed in a no-win position when confronted with the choice of taking unwanted medication and of having to refuse it in the interests of appearing autonomous and being the master of their own fate. Unfortunately, this cultural given can run aground when the individual has impaired judgment, as happens in the face of psychosis or many other psychiatric illnesses.

My belief is that covert medication can often allow the individual to save face when apprised of its use later, at a time when he is more psychiatrically stable. It is then possible for the person to say that he was medicated without his awareness, and therefore, he is absolved from having caved in to the demands of others at a time when the illness was at the helm.

While I do not condone covertly medicating people as a routine procedure, I do believe the dynamic account by Hung *et al.* explains why many people, upon learning of the incident, are only momentarily angry or actually may be grateful and receive the news calmly. I would like to hear what others think on this topic.

References

1. Hung EK, McNeil DE, Binder RL: Covert medication in psychiatric emergencies: is it ever ethically permissible? *J Am Acad Psychiatry Law* 40:239–45, 2012

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Editor:

Newton and associates¹ published a retrospective case-control study of patients who committed either

an act of serious violence or three acts of less serious violence during admission to the acute care unit of John Umstead Hospital, Butner, North Carolina. They emphasize in the paper's abstract that, by using easily collected clinical data, clinicians can correctly categorize 80 percent of patients as either having or not having tendencies toward difficult-to-manage violence. Although it is clear that the combination of risk factors they describe can be used to define a group of patients at a significantly increased probability of violence, we would like to make two points of clarification.

First, the proportion of patients correctly classified by a risk assessment tool is not necessarily a helpful measure. For example, a risk assessment that categorizes every patient as at a low risk of violence would be correct 95 percent of the time in a population with a base rate of violence of 5 percent.

The most widely accepted measure of the ability of a risk assessment to discriminate between high- and low-risk individuals is the area under the receiver operating curve (AUC), which is the probability that a randomly selected violent patient will have a higher risk score than will a randomly selected nonviolent patient.² In the footnote to Table 2, Newton and associates report an impressive AUC of 0.881, indicating that the variables they examined could strongly statistically differentiate populations of violent and nonviolent patients. One feature of the AUC is that it is not affected by base rate considerations, which are central to our second point about the recent study. In contrast to the proportion of correctly classified patients and the AUC, it is the proportion of high-risk patients who go on to be violent that is the central test of the clinical usefulness of a high-risk categorization.^{3,4} This proportion, the positive predictive value (PPV), can be calculated by using sensitivity, specificity, and base rate.

A sensitivity of 0.74 and a specificity of 0.85 can be derived from the data reported by Newton and associates. John Umstead Hospital is a very large, state-run mental health facility, and we understand from the authors of the recent paper that the acute unit had more than 10,000 admissions during the study period. Assuming that this figure included more than 2,000 individual patients, the base rate of difficult-to-manage violent patients was below five percent. With a base rate of 5 percent and the reported sensitivity and specificity, a PPV of 20 percent