illness. Examples included bringing people with and without mental illness together to work towards a common goal, and opportunities for members of the general public to have one-on-one conversations with people with mental illness about their experiences. Future efforts should use the findings of this Article, and the Time to Change campaign in general, as a foundation for building campaigns aimed at treating the cause, and thus eradicating the symptoms, of public stigma towards people with mental illness.

Timothy R Campellone
Department of Psychology, University of California, 3210 Tolman Hall, Berkeley, CA 94720-1690, USA tcampellone@berkley.edu

I declare that I have no competing interests.

4 Campellone TR, Caponigro JM, Kring AM. The power to resist: the relationship between stigma, power, and negative symptoms in schizophrenia. Psychiatry Res 2014; 215: 280–85
8 Gaebel W, Zaske H, Baumann AE, et al. Evaluation of the German WPA “program against stigma and discrimination because of schizophrenia—Open the Doors”: results from representative telephone surveys before and after three years of antistigma interventions. Schizophr Res 2008; 98: 184–93
For instance, within domestic violence, various risk factors have been identified that place victims at increased risk of related homicide (eg, perpetrator’s previous use of weapon, previous threats, and fear of being killed). Screening tools, such as the Lethality Assessment Screener, have been informed by research and are being disseminated among law enforcement agencies for use with victims of domestic violence. Furthermore, because a third of patients who were victims of homicide were killed by other patients, understanding of the risk factors for engagement of mental health patients in violent behaviours, and potential interactions across risk factors for each of these groups, should be improved. For example, are there any unique differences between victims who were mental health patients and victims who were not (eg, demographics, previous history of victimisation, or relationship to perpetrator)? Perhaps in cases in which both victim and perpetrators were mental health patients, examination of the interaction between victim and perpetrator characteristics would be worthwhile.

Research suggests that risk factors among patient victims such as substance use, low socioeconomic status, type of psychopathology, and engagement in behaviours that increase risk could be targeted. Further exploration of these individual characteristics, their interactions, and their contribution to the risk of homicide is necessary. However, a full understanding of risk factors for homicide will be difficult to achieve in view of the potential effects of individual, situational-level, and community factors. Research must be undertaken to inform the development of a more comprehensive model to address the multifaceted manner in which individual and environmental characteristics contribute to risk.

### Balancing care for patients at risk of death by suicide

In The Lancet Psychiatry, Isabelle Hunt and colleagues present a report comparing the number and rate of deaths by suicide among patients under the care of crisis resolution and home treatment (CRHT) teams in England with those of inpatients and people receiving care by other community teams. From 2003 to 2011, the mean number of suicides doubled for patients under the care of CRHT teams, from 80 in 2003 and 2004 to 163 in 2010 and 2011, whereas the mean number of deaths by suicide among inpatients halved over the study period, from 163 in 2003 and 2004 to 76 in 2010 and 2011. Using episodes of care as the denominator for CRHT, suicide rates seemed higher in patients under the care of CRHT teams than for inpatients (14.6 per 10 000 episodes vs 8.8 per 10 000 admissions) and for people receiving other types of care in the community (7.8 per 10 000 people in contact with mental health services). From 2003 to 2011, suicide rates declined by about a third for admissions, by a fifth for patients under the care of CRHT teams, and by a quarter for people cared for by other community mental health services. From the findings of Hunt and colleagues, it is difficult to ascertain specifically how CRHT teams have fared over time, because patients’ characteristics are likely to have changed fundamentally between 2003 and 2011, owing to the expansion of CRHT services; furthermore, trends of symptom levels among patients in CRHT care are not reported.