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.[10] 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.

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I declare that I have no competing interests.

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Understanding risk of homicide among mental health patients

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When we contemplate the association between violence and mental health, caution is warranted before we make assumptions or generate opinions, because of the stigma of violence in mental health; the vast majority of people suffering from mental health difficulties are not violent.[1] Unfortunately, inaccurate beliefs about violence and mental health lead to stigma and even discrimination.

In *The Lancet Psychiatry*, Cathryn Rodway and colleagues[2] examine the characteristics of a national case series of victims of homicide across England and Wales, specifically the characteristics of homicide victims who were mental health patients. One of the most striking findings of this study is the fact that mental health patients are twice as likely to be victims of homicide than are people in the general population. Furthermore, a third of patient victims were killed by another mental health patient. These findings raise the question as to why these rates were increased in this population. In particular, which factors (both individual and within relationships) put mental health patients at increased risk? Although findings from this study will improveawareness of potential contributing factors, the study was not designed to examine risk while controlling for various factors such as demographics or other types of victimisation. Knowledge within the scientific literature about victimisation has improved understanding of risk factors associated with particular types of crime (eg, sexual assault and domestic violence)[3] generally, but not necessarily for homicide and especially not for homicide victims who are mental health patients.

Why is this distinction important? Identification of risk for homicide within mental health populations, which are clearly vulnerable and often underserved, could lead to the development of improved screening approaches and prevention strategies that can be implemented within mental health services. Screening for other types of behaviours that confer health and violence risk among mental health patients is common practice, but screening for risk of patients becoming a victim of homicide or other types of crime is not standard practice. Although outside the scope of Rodway and colleagues' study, comparisons of potential risk factors between mental health patients who have and have not been victims of homicide might improve clinical risk assessments and offer guidance on developing such screening.

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).[4] Screening tools, such as the Lethality Assessment Screener,[5] 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[6,7] 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.[8] 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.

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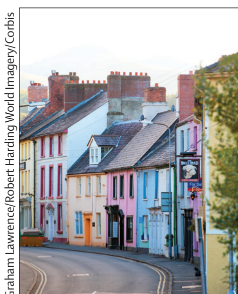
Balancing care for patients at risk of death by suicide



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In *The Lancet Psychiatry*, Isabelle Hunt and colleagues present a report[1] 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. This decline in rates suggests that suicide prevention improved similarly across care settings; CRHT teams followed this general trend, doing no better or worse than other types of mental health care. 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.