

Correspondence

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Public anti-stigma programmes might improve help-seeking

In their systematic review and meta-analysis on the association between mental health-related stigma and active help-seeking,¹ Schnyder *et al* find that negative help-seeking attitudes and personal stigma are associated with less actual help-seeking. The authors connect these findings to a recommendation for anti-stigma campaigns to 'target these personal attitudes rather than broad public opinion'. However, this recommendation cannot be extrapolated from the types of study they reviewed. Moreover, it overemphasises help-seeking as the key outcome and does not adequately consider the importance of changing wider social acceptance in broader domains related to, for example, disclosure at work or support from family and friends.

Schnyder *et al* reviewed studies evaluating the association between stigma and actual help-seeking at the individual level. They did not assess how public-level attitudes correlated with actual help-seeking in the population, which would have required cluster-level analyses. Their individual stigma–help-seeking association is different from concluding that campaigns targeting the general public are not helpful in improving help-seeking at a population level. Because Schnyder and colleagues did not include evaluations of broad public anti-stigma campaigns on care-seeking, their recommendation against such efforts risks misleading policy makers, healthcare practitioners, researchers and advocates.

In contrast to Schnyder *et al*'s recommendation against targeting public opinion, our work has shown that investment in population-level anti-stigma programmes can address several important challenges. Low levels of public knowledge, negative attitudes and discriminatory behaviour have significant consequences for people with mental illness. Our evaluation of the Time to Change anti-stigma campaign in England^{2,3} has demonstrated improvements in mental health-related attitudes and intended behaviour at the population level and among specific target groups, and this is supported by further reviews of anti-stigma interventions. These changes can foster a positive social context that is more supportive of people with mental illness.

Moreover, Schnyder *et al*'s finding that self-stigma and stigma against other persons with mental illness was associated with limited help-seeking is likely influenced by community-level stigma. Individuals with mental illness internalise the broad socio-cultural environment in which they reside and may experience more discrimination when living in a high-stigma community. Individuals with mental illness and sexual minorities living in communities with higher public stigma have greater self-stigma, lower empowerment, lower chances of employment and greater risk of mortality.^{4–6}

Programmes that reduce public stigma could combat social exclusion and promote social participation of people with mental

illness across several important life domains. Moreover, targeted anti-stigma interventions that improve attitudes of key groups, such as employers, peers at work, law enforcement officers and healthcare practitioners, could foster support for individuals with mental illness and make a significant impact on their quality of life. Improving public attitudes, therefore, can also create a virtuous cycle.

Ultimately, the most effective approaches require multisectorial strategies incorporating persons with mental illness, the general public and key stakeholders. Extrapolating recommendations against public anti-stigma campaigns from studies only assessing associations between stigma and help-seeking at the individual level risks deterring investment from evidence-based approaches.

- 1 Schnyder N, Panczak R, Groth N, Schultze-Lutter F. Association between mental health-related stigma and active help-seeking: systematic review and meta-analysis. *Br J Psychiatry* 2017; **210**: 261–8.
- 2 Henderson C, Robinson E, Evans-Lacko S, Corker E, Rebollo-Mesa I, Rose D, et al. Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009–2015. *Acta Psychiatr Scand* 2016; **134**: 23–33.
- 3 Henderson C, Robinson E, Evans-Lacko S, Thornicroft G. Relationships between anti-stigma programme awareness, disclosure comfort and intended help-seeking regarding a mental health problem. *Br J Psychiatry* 2017; in press.
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Authors' reply: Not considering the broader context, Evans-Lacko and colleagues' critique of our study¹ mainly focuses on a part of a sentence ('target these personal attitudes rather than broad public opinions') in the conclusion of the abstract and understand this as a general recommendation for anti-stigma campaigns. In this generalisation, they lost sight of our paper's explicit focus on the relationship between stigma and help-seeking, which was also stated in the full sentence: 'Campaigns promoting help-seeking and fighting mental illness-related stigma should target . . .'. Unfortunately, when only browsing the abstract, the 'and' might indeed be misperceived as a two-fold recommendation, for campaigns promoting help-seeking on the one hand and anti-stigma campaigns on the other. We are sorry for that and have suggested that the *BJPsych* publish a correction for clarification that reads: 'Campaigns promoting help-seeking by means of fighting mental illness-related stigma should target these personal attitudes rather than broad public opinions'.

Evans-Lacko and colleagues further argued that we overemphasised help-seeking as the key outcome. In light of the authors' own reviews on this topic^{2,3} this is a surprising statement. Just like our meta-analysis, these reviews start from the observation of the negative consequences of delays in help-seeking for mental illness and highlight the importance of better

understanding the reasons for these delays. Of these, ‘stigma associated with mental illness is one such potential influence.’²

This makes help-seeking one important outcome in stigma research. All the more, as early help-seeking might prevent the development of severe social disability and the need for intensive treatment that were both reported to abet stigmatisation and discrimination. Our principal finding was that the connection between stigma and active help-seeking varies according to type of stigma and that, in particular, a person’s own attitudes towards mental health help-seeking and towards persons with mental illness are associated with their help-seeking behaviour. Thus, we suggested that these findings might be considered in planning, evaluating and implementing campaigns with the aim of promoting help-seeking.

We certainly admire the work of Evans-Lacko, Thornicroft and colleagues in stigma research. We especially acknowledge that population-level anti-stigma programmes are helpful in reducing negative and stigmatising attitudes and enhancing the public’s knowledge about mental illness. We also acknowledge that different stigma types (such as perceived public attitudes and self-stigma) are interrelated and can influence each other (see the Discussion section of our study¹). It is important to point out that we understand personal attitudes towards persons with a mental illness as a part of the broader term of public stigma (see the introductory section¹).

With this, we hope to have clarified some initial misperceptions of Evans-Lacko and colleagues.

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Suicide risk assessment tools do not perform worse than clinical judgement

The study by Quinlivan and colleagues¹ could be interpreted to suggest that clinician and patient ratings are better than actuarial tools in predicting self-harm after an emergency hospital presentation with self-harm. However, we would argue that this is an incorrect interpretation.

First, the clinical evaluation appears to have occurred after these tools were completed by the same clinician, and, although the clinicians were masked to the overall score, the clinical impression will therefore have been strongly informed by the items in these suicide risk assessment tools. In fact, the study does not appear to be a comparison between actuarial tools and a distinct, unstructured clinical judgement, but a comparison between actuarial tools and what is called a structured clinical judgement approach (where structured questions about relevant risk factors are asked, and then a clinical judgement is made about an individual’s overall risk level). Clarification of the exact procedure used is important for interpreting the findings.

Second, the authors correctly point out that, on the basis of ROC curves, risk assessment tools performed no better than clinician ratings. The other way of looking at this, however, is that clinician ratings performed no better than risk scales. In particular, the Manchester Self-Harm Rule,² a 4-item tool, performed just as well. Importantly, the authors found no evidence of between-hospital heterogeneity for this tool’s performance. Clinician ratings, on the other hand, showed substantial heterogeneity between hospitals, with specificity ranging from 58% to 82%. The lack of variability in the actuarial tools could be argued to be an advantage when performance between clinician rating and assessment tool is no different. Furthermore, tools like this will be considerably quicker, leaving more clinician time for risk management (as opposed to assessment).

Third, the clinicians were based in teaching hospitals (Brighton, Bristol, Derby, Manchester and Oxford) with long-standing research interests in self-harm. Whether the reported predictive accuracy of clinician ratings is generalisable to non-specialist centres is an empirical question.

Fourth, the patient rating may also have been influenced by the questions asked by the tools (which tend to be categorical and therefore it is easy to work out what constitutes a risk factor). In a sense, then, the patient rating is a form of structured judgement.

Comparing risk tools with clinicians may not be informative, or even feasible, as clinical interviews already include many of the items used in risk tools. Instead, future research should compare actuarial scores with or without additional clinician input. In other words, if clinicians disagree with the risk level provided by actuarial tools, does this reclassification lead to an improvement in predictive performance? As the AUCs for the tools in this study ranged from 0.55 to 0.72, there may be considerable room for improvement by incorporating novel and modifiable risk factors, as has been shown in violence risk assessment in patients with severe mental illness.³ Ultimately, randomised studies will be required to establish the effects of different approaches to risk assessment on patient and service outcomes.

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- 2 Cooper J, Kapur N, Dunning J, Guthrie E, Appleby L, Mackway-Jones K. A clinical tool for assessing risk after self-harm. *Ann Emerg Med* 2006; **48**: 459–66.
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Authors’ reply: We thank Professor Fazel and Dr Wolf for their thoughtful letter and interest in our article.¹ Well, at least we agree on one thing: randomised controlled trials could help to clarify the role of risk assessment scales in the management of people who have harmed themselves. However, we do not think that future research should investigate scores ‘with or without additional clinician input’. Risk should not simply be a score or a colour on a traffic light system. In isolation, such ratings may be worse than useless, especially if they distract clinicians from engaging with their patients. An alternative design might be to investigate what risk scales add to ‘assessment as usual’.