

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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Nina Schnyder, MSc, University Hospital of Child and Adolescent Psychiatry and Psychotherapy, University of Bern; **Radoslaw Panczak**, PhD, Institute of Social and Preventive Medicine, University of Bern; **Nicola Groth**, Dipl Psych, **Frauke Schultze-Lutter**, PhD, University Hospital of Child and Adolescent Psychiatry and Psychotherapy, University of Bern, Switzerland. Email: nina.schnyder@kjp.unibe.ch

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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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Seena Fazel, Wellcome Trust Senior Research Fellow, **Achim Wolf**, DPhil Student and Research Assistant, Department of Psychiatry, University of Oxford, Oxford, UK. Email: seena.fazel@psych.ox.ac.uk

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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'.