BJPsych The British Journal of Psychiatry (2016)
209, 446. doi: 10.1192/bjp.209.5.446

From the Editor's desk

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Geopolitics and mental health

Recession and health impacts

Recession is associated with poor health[1,2] and necessitates active policy and political actions to offer better health outcomes.[3] Inequalities worsen at times of recession and affect particular groups, including men, women and ethnic minorities, depending on contexts and country.[4–6] The effects are mediated by unemployment, poverty, and chronic stress leading to greater chronic disease.[7] Recession affects health by impacts on biology through chronic stress (for example, shortening telomere length), social divisions and loss of societal cohesion, more ischaemic heart disease and health risk behaviours such as smoking and alcohol consumption, as well as anxiety and depression.[7,8] The expectation is of higher suicide rates, more common mental disorders, and more antidepressant prescriptions.[1,9]

Public mental health

The adult psychiatric morbidity study (APMS) has just reported data for 2014,[10] showing greater levels of common mental health problems, especially in people living alone, unemployed or in poor physical health. Women have high levels of common mental disorders, self-harm and post-traumatic stress disorder (PTSD) explained perhaps by exposure to violence. More attention to violence prevention is needed in routine care services (see Brooker *et al*, pp. 359–360). The APMS also suggests growing access to antidepressant and psychological treatments for common mental disorders, although some groups such as ethnic minorities appear to be undertreated.[11] In contrast, McCrea and colleagues (pp. 421–426) show that antidepressant prescribing has not increased in the England since 2001, although longer periods of prescribing may reflect better targeting and adherence. Rabinowitz *et al* (pp. 427–428) show that patient-level rather than group analyses do not support the findings of previous meta-analyses that baseline severity of depression has an effect on the drug *v.* placebo difference. The social context is relevant when considering effectiveness of interventions; at times of recession there is a higher risk of greater health inequalities. Delgadillo *et al*'s evaluation (pp. 429–430) of a national programme of psychological therapies suggest these are less effective in more deprived areas, requiring more targeted investment in these areas and at times of recession-related deprivation, if societal health and economic success are to be protected.

Interventions to reduce mortality and morbidity

Murray and colleagues (pp. 361–365) suggest that a 40% recovery without sustained antipsychotic medication following a first episode of psychosis means we should be more cautious about prescribing. If there is no response to clozapine within 6 months, Siskind *et al* (pp. 385–392) suggest an alternative be used, with a lower risk of adverse effects.

Dementia can present with multiple disabling and persistent symptoms of apathy, hyperactivity, depression and psychosis (see van der Linde *et al*, pp. 366–377). Concerns about antipsychotic prescribing extend to people with dementia, leading to more careful management of prescribing.[12,13] Alternatives to medication, for social and behavioural symptoms are still needed.[14] At the same time, we know that effective management of mental illness, including the coordination of care and appropriate medication, can reduce premature mortality.[15] Howard *et al* (pp. 378–384) report that risperidone prescriptions increase mortality in people with dementia only if anti-inflammatory drugs are also prescribed, otherwise there appears to be a lower mortality if there is comorbid depression, and a lower rate of cerebrovascular events in the presence of delusions and depression. Lithium prescription in people with bipolar disorder appears to be associated with a lower risk of cancer, possibly by inhibition of GSK-3 (see Huang *et al*, pp. 393–399). Cardiac anxiety, maybe through the avoidance of exercise, is related to more major adverse cardiac events following myocardial infarction, irrespective of baseline cardiac disease severity or baseline depression (Van Beek *et al*, pp. 400–406). Hedman *et al* (pp. 407–413) show that cognitive–behavioural therapy or bibliotherapy are effective treatments even in the new DSM-5 classifications of somatic symptom disorder and illness anxiety disorder.

Pharmacological interventions can provide enormous benefits; however, the balance between harms and benefits needs better verification and reliable methods of analysis of trial data. These challenges mean we must pursue more effective monitoring to assess population needs, use such data to drive better service design and delivery, and invent new treatment models; we must establish benefits and harms of existing treatments with greater precision. Geopolitical influences, deprivation, conflict, alongside political and financial investment, are all areas of endeavour for better health gains for people using healthcare services and for societal health and success.

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https://doi.org/10.1192/bjp.209.5.446 Published online by Cambridge University Press