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Highlights of this issue

By Kimberlie Dean

The impact of inequality and discrimination on mental health outcomes

While the prevalence of obsessive–compulsive disorder (OCD) has been found to be similar in different countries and, within Western countries, between different ethnic groups, concern has been raised about the potential for differential equity of healthcare access for this patient group. Fernández de la Cruz *et al* (pp. 530–535) found that individuals with OCD from minority ethnic groups were underrepresented in the secondary and tertiary mental health services of one London catchment area. The authors found that the disparity was greater than that found for a comparison patient group with depression and they comment on the need for further research to focus on understanding the specific reasons for the identified inequality in service use. Also focused on differential patterns of healthcare access, Ran *et al* (pp. 495–500) have examined the outcomes of treated and never-treated patients with schizophrenia, in a study based in rural China. Over a 14-year follow-up period, those with schizophrenia who did not receive antipsychotic treatment were found to have poorer outcomes across both mental health and social domains. The authors argue that their findings challenge the notion that outcomes for those with serious mental illness are better in low- and middle-income countries.

In an editorial focused on the inequalities of physical health outcomes for those with mental illness, Shiers *et al* (pp. 471–473) call for more coordination between primary care, secondary care, and public health to address the poor physical health and mortality outcomes for individuals diagnosed with psychosis. The authors highlight a number of available resources designed to improve coordination of care with the aim of reducing the morbidity/mortality gap associated with psychosis. Another editorial in the *BJPsych* this month, by Taggart & Bailey (pp. 469–470), further highlights the excess mortality associated with serious mental illness in England by describing a mental-health-specific *Atlas of Variation*, which presents relevant life-course data by region. The authors call for inequity of healthcare access to be targeted in order to reduce the stubborn mortality gap.

Reported discrimination among people treated for depression is addressed in a cross-national study by Lasalvia *et al* (pp. 507–514), as part of the ASPEN/INDIGO international study. Of the 34 countries included in the study, people living in countries identified as having a very high Human Development Index (HDI) reported higher levels of discrimination than those in medium/low HDI countries. Examining the impact of individual and contextual factors in explaining differences and considering the public awareness approaches taken in high-income countries to date, the authors propose a move away from stigma-reduction campaigns focused on the biological aetiology of mental illness to a focus on competence and inclusion.

Focusing on recovery

Three papers in the *BJPsych* this month address different aspects of recovery in mental health. Williams *et al* (pp. 551–555) evaluated the Questionnaire about the Process of Recovery (QPR) instrument and compared the 15- and 22-item version in two samples with longitudinal data. Both versions of the instrument were found to have satisfactory psychometric properties but the authors were able to recommend the shorter version as being slightly more robust and less burdensome. Using latent class growth analysis techniques, Hodgekins *et al* (pp. 536–543) identified three types of social recovery profile in a sample of individuals with first-episode psychosis followed up for 12 months, with 66% being classed in the low stable group. Such poor social recovery was predicted by male gender, ethnic minority status, young age at psychosis onset, increased negative symptoms and poor premorbid adjustment. From measurement and outcome prediction to development of an intervention to increase mental health team support for personal recovery, Slade *et al* (pp. 544–550) describe the process of evidence synthesis which led to development of REFOCUS, an empirically supported manualised intervention which will be evaluated in a multisite cluster randomised controlled trial. The authors highlight the active and free availability of developed materials from the project.

Criminal justice pathways and victimisation experiences

In the context of presenting to services with a first episode of psychosis, Bhui *et al* (pp. 523–529) found that criminal justice pathways were more common in violent presentations, where psychopathy levels were greater and where drug use was present. A first presentation to services via the criminal justice system was also more common among Black Caribbean and Black African patients to an extent not fully explained by other factors. The authors call for more qualitative hypothesis-generating and quantitative hypothesis-testing research to focus on understanding these findings.

Patients with severe mental illness (SMI) are known to be more likely to experience victimisation than those in the general population. In a Dutch study by de Mooij *et al* (pp. 515–522), almost a quarter of individuals with SMI reported violent victimisation compared with almost 10% of controls. Victims with SMI were more likely to be assaulted by someone known to them and, within the patient group, in-patients were the most likely to report victimisation.

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