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EDITOR'S CHOICE

Austerity, suicide, and screening

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The *BMJ* tries not to get into party politics. But parties have policies, and when those policies become government policies, and where there is evidence that a policy is harming health, we must speak as we find.

The policy in this case is austerity, and new evidence of its associated harm is published in the *BMJ* this week. Building on previous smaller studies, Chang and colleagues have examined data from 54 countries to examine the link between the 2008 global economic crisis and increased rates of suicide (doi:10.1136/bmj.f5239). By comparing the number of suicides reported in 2009 with the number expected based on trends before the crisis (2000-07), they identified over 4000 "excess suicides." Increased suicides were most apparent in Europe and the United States, and in men rather than women. The authors looked for and found a specific "dose response" relation between increased suicide rates and increase in unemployment, especially in countries where unemployment levels before the crisis were relatively low.

In a linked editorial, Keith Hawton and Camilla Haw take this further (doi:10.1136/bmj.f5612). Other evidence, most notably a study published four years ago in the *Lancet* (Stuckler et al, 2009) shows that countries that have adopted austerity measures have seen the biggest rises in suicide and other health problems, and that active programmes to keep people in work or meaningful activity can reduce or counter these harms.

So governments can, if they choose, ameliorate the serious damage to mental health from unemployment, the brunt of which in almost all countries examined by Chang and colleagues was borne by young men. In a second editorial, Jan Scott and colleagues highlight the hidden burden of mental health problems in young men who are not employed or in education or training (so called NEETs) (doi:10.1136/bmj.f5270). Too often, healthcare systems fail to identify those at risk before they descend into the "double whammy" of economic inactivity and severe mental disorder**.**

If this is an important example of underdiagnosis, there is no shortage of examples of overdiagnosis. At the Preventing Overdiagnosis conference in Dartmouth last week (www.preventingoverdiagnosis.net), clinicians and academics who had been ploughing a sometimes lonely furrow within their own specialty found themselves at last in like minded company and able to compare notes across healthcare (http://bit.ly/1a0oX26).

Barnett Kramer, a long-time commentator on the risks of overdiagnosis from cancer screening, was there, and in an editorial this week, he and colleagues focus on the damage done by indiscriminate use of the term "cancer" for lesions that may not progress (doi:10.1136/bmj.f5328). And just published on bmj.com, a new study finds that randomised trials of cancer screening are poor at reporting harms. Of 57 trials identified, only 7% mentioned the risks of overdiagnosis and only 4% recorded false positive results (doi:10.1136/bmj.f5334).

Such concerns will be familiar to those of you who have followed the *BMJ*'s Too Much Medicine campaign (www.bmj.com/too-much-medicine) and our recent series on overdiagnosis, which this week turns to screening for pre-dementia (doi:10.1136/bmj.f5125). Another government policy which, based on this paper, might be summarised as daft and damaging.

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