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Supporting help-seeking across the ages by reducing our use of stigmatising labels

Mitchell and colleagues¹ provide a helpful commentary bringing out many key issues regarding help-seeking for mental health support among young adults. I suggest most of their proposals are relevant to all ages; also that we need to tackle head on the problem in clinical practice of dichotomising at the individual level into those needing and not needing help according to whether a 'disorder' is present.

The evidence they provide that it is young adults who are less likely to gain support is limited.² In our study, recently accepted by the *BJGP*,³ 20–24-year-olds are the age group most likely to be referred and to access psychological therapy. Estimated prevalence of common mental health problems (CMHPs) according to the Adult Psychiatric Morbidity Survey starts at 13.8% for 18–19-year-olds, rises to 15.3% for 20–24-year-olds, peaking in 45–49-year-olds (20.6%). In contrast, annual referral rates to IAPT psychological services, as a proportion of CMHPs, peak in 20–24-year-olds (23.0%) and then decrease gradually from this point until 65–69 (9.7%); 18-year-olds (8.4%) are much lower and comparable with those 70–74 years of age (6.0%).

Mitchell and colleagues discuss stigma and self-reliance, but in my view they do not go far enough in addressing the current

'best practice' of designating individuals as either having or not having a 'disorder'. This is a particular problem when considering the role of the GP, both in our roles at the interface between lay and medical worlds, and in promoting better mental wellbeing. We need a way of providing a range of support for stress and reduced function, which is more flexible: one that recognises specific problems such as irritability, low mood, social anxiety, and consequent problems such as study performance, arguments, avoidance, and substance use, without the need for a diagnostic label. In this way general practice can be an important part of the crucial public health challenge of preventing and alleviating mental distress and suffering, in ways helpfully suggested by Mitchell and colleagues, without having to always arbitrate between those who are 'disordered' or not.

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Dead unequal

As a GP with an interest in palliative care my eye was drawn to your January 2017 briefing entitled 'Dead unequal'.¹ Referring to Graham Watt's 'Deep End' work in Scotland, you highlighted the economic differences between rich and poor that contribute to differential morbidity and mortality.

Just as in life there are postcode inequalities, in death there are equally significant inequalities. As well as a postcode lottery, there is a diagnostic lottery. Much better to have cancer than a non-malignant condition. Support to help people with cancer at the end of life is better resources and is more accessible than other conditions.

Despite the Scottish End of Life Strategy 6 years ago highlighting this diagnostic iniquity as a key target, there is still so much to do. Indeed, the 2016 Scottish strategy again has this as the number one priority: to identify more people with non-malignant disease for end-of-life care. Charities, such as Marie Curie, have now doubled their non-malignant effort, but the differential is still great as care models are so cancer-centric. So, in the end, you would probably benefit more from the right diagnosis even more than the right postcode.

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Correction

In the article by Robson J *et al*. NHS Health Check comorbidity and management: an observational matched study in primary care. *Br J Gen Pract* 2017; DOI: <https://doi.org/10.3399/bjgp16X688837>, the Discussion section 'Comparison with existing literature', third paragraph, stated '... a not unsurprising result because only 35% of those randomised to invitation actually attended'. This should state '... a not unsurprising result because only 52% of those randomised to intervention attended at baseline and only 35% completed the study at 5 years'. The online version has been corrected.

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