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## Editor's choice

### Wellbeing and the lingo of mental 'health'

What's in a name?

'Wellbeing' is now the duvet to cover all distress; our local IAPT service even use it to describe their therapeutic offerings. Allied to its pillow-partner 'mental health problem'. I've had depression on and off since 1986 and I certainly don't regard it as a 'common mental health problem'; I reserve that description for my overall state when my luggage goes missing at the airport.

It's hell when depression kicks in and I have no reason to doubt its physical nature any more than any other physical symptom from which I and thousands of others have 'suffered'. And, oh look, there's another weasel-word — replaced now by the far more calming 'lived experience'; and how exactly could we acquire experience without living it?

It gets worse too; the other day I was reading a CCG mental 'health' document and it referred to a 'mental health illness'. What a farce as right royal as any. It's high time for those of us who've got the 'mental illness' T-shirt to wear it with pride; after all, we don't call diabetes a 'common pancreatic health illness' or a beta-cell wellbeing problem?

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### Predicting relapse of depression in primary care

I am interested in the work Moriarty *et al* are doing to predict and prevent relapse of depression in primary care in the current *BJGP*.<sup>1</sup> It makes me think about

all the years I worked as a GP and the difficulty I had with making the diagnosis of depression as a specific disease entity in individual patients with all their own unique stories and experience of low mood, low self-esteem, self-worthlessness, and who struggle with suicidal thoughts.

In my old age I now volunteer at a suicide prevention charity, Maytree in North London. We offer people struggling with suicidal thinking, with or without acts of attempted suicide and or self-harm, an opportunity to talk about, share, and try to understand their distress during a 5-day residence. The atmosphere is one of calm safety with non-judgemental listening.

People come with a variety of diagnoses and treatments, which are acknowledged but largely put aside during their stay so that they can be encouraged to be themselves and tell their stories in their own words. In this way there is a sense of people reconstructing their own identity and regaining their self-belief.

They leave with strategies to avoid actual suicide in the future and with the hope of making constructive, fresh use of ongoing sources of help, therapy, and support.

For me now as a retired clinician I am released from having to make diagnostic decisions and concentrate on listening to people with their own special, unique stories with a view to offering hope to escape from the prison of recurrent depressive thinking and the ultimate solution of suicide.

Suicidal thoughts are always associated with the classic symptoms of depression one way or another and their exploration with those who are struggling is surely a way forward towards resolving them in the longer run. The aim of Maytree is to prevent actual suicide and, in the context of the *BJGP* leader, to build the hope that relapse of depressive episodes can be predicted and prevented in the longer run by increased self-awareness, self-care, and self-belief.

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#### REFERENCE

1. Moriarty AS, Castleton J, Gilbody S, *et al*. Predicting and preventing relapse of depression in primary care. *Br J Gen Pract* 2020; DOI: <https://doi.org/10.3399/bjgp20X707753>.

DOI: <https://doi.org/10.3399/bjgp20X708977>

### Mental health in diabetes: a response

Thank you for your letter and thoughts about the editorial.<sup>1,2</sup> I couldn't agree more with all the points you make. The Cartesian split between mind and body means we are always playing catch-up on the issues mentioned in the article and your letter, and the issues are of course much broader than diabetes alone.

Our piece was written from the perspective of GP leaders in diabetes and a psychiatrist working in diabetes rather than a psychiatry focus, hence the diabetes lens. The same issues exist in all LTCs and multiple conditions, but the rich detail we were able to describe has come from our experience in the diabetes work we have been doing. I guess the point was to start to talk about whether this learning is transferable.

I sympathise with your view about this being back to front as an approach. My experience has been that it is easier to get the attention of people who hold the purse strings if the issue is aligned to one condition and relate it to their agenda, for example, some KPI that they are working towards, and then expand outwards. Mental health funding is getting more attention now than ever before, but we still don't have parity of esteem for it and so the sad fact is that piggy-backing onto a physical health condition agenda gets it more attention.

I am pleased that many mental health providers are training their staff and looking at providing a much more trauma-focused approach to care delivery, but I think it will take time. The main point of this article was to highlight the service gap at what we call level 4, which is not diabetes specific at all, but needs addressing.

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2. Ambury T. Mental health in diabetes: can't afford to address the service gaps or can't afford not to? [Letter]. *Br J Gen Pract* 2020; DOI: <https://doi.org/10.3399/bjgp20X708365>.