Letters

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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*.[1] 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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Mental health in diabetes: a response

Thank you for your letter and thoughts about the editorial.[1,2] 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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Assisted dying survey

It is extraordinary that the Royal College of General Practitioners (RCGP) has chosen to continue to oppose a change in the law to enable assisted dying when the majority (51%) of its polling members supported either a change in the law to enable assisted dying or a wish for the RCGP to accept a neutral position. Quite apart from wilfully ignoring the result of its own survey, this decision displays the sort of establishment paternalism that should have no place in an enlightened society.

By maintaining such opposition the College has demonstrated unbelievable hubris and scant regard for patient choice, liberty, and autonomy. I urge College Council members to think again, delve deep into their consciences, and tell the overwhelming majority of the UK population why they are wrong in seeking a change in the law to enable assisted dying for those for whom one cannot provide a dignified death.

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Language matters: indeed it does

This February 2020 edition of the *BJGP* contains topics that are more closely interrelated than first appears, and the relationship is crucial for GPs to recognise.

As you say, language matters and *'The chances of a successful outcome are less good when … the consultation includes topics such as common mental health disorders and the highly contested territories of persistent but "medically" unexplained symptoms and maladaptive responses to commonplace adversities'*:[1]

- 'Predicting and preventing relapse of depression in primary care'[2] — *'There has been a shift in the understanding of depression as a discrete or episodic illness to being considered a long-term relapsing-remitting condition with possibly incomplete recovery between episodes …'*
- 'Anxiety and depression in adolescents and young adults'[3] — *'Of particular concern is the alarming apparent rise of these problems in girls and young women. A 2017 UK practice-based study of self-harm showed a 68% rise in incidence in girls aged 13–16 years between 2011–2014.'*
- 'Patients' descriptions of the relation between physical symptoms and negative emotions'[4] — *'Primary care guidelines for the management of persistent, often "medically unexplained", physical symptoms encourage GPs to discuss with patients how these symptoms relate to negative emotions.'*
- 'Medically unexplained symptoms'[5] — *'Most GPs labelled the presented symptoms as medically unexplained soon after the start of the consultation.'*

Taking into account the recent report on the 2018/2019 Public Health England review of prescribed medicines associated with dependence and withdrawal,[6] the links become clear. Many patients who may suffer 'common mental health disorders', and those who suffer economic hardship and commonplace adversities, are prescribed drugs for 'depression', 'anxiety', 'trauma', etc. — which carry underplayed risks of dependence and withdrawal. Many such patients go on to experience all manner of distressing 'unexplained' physical and psychological symptoms. Some of these 'unexplained' symptoms can be very severe indeed, including drug-induced akathisia, which can lead to self-harm and suicide. Antidepressants (and other prescribed medicines) can cause akathisia — especially at certain times of dose change or even after withdrawal — and this serious adverse drug reaction is frequently misdiagnosed as 'anxiety' and 'restlessness', with sometimes tragic consequences.[7]

Language matters very greatly.

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Urgent referral of SSNHL to ENT

The paper from ENT in Gloucester makes slightly depressing reading by advising that GPs should ignore the NICE recommendation to refer sudden hearing loss urgently to ENT because ENT departments can't offer this service.[1]

I would strongly recommend reading the full NICE Guideline[2] section 11, pages 137–174, in particular sections 11.2 and 11.3, which show the extensive evidence surveyed and debated by the committee. Evidence was scarce, especially for oral steroids, which made it difficult to draft a recommendation for routes of administration.

A key issue is that five studies showed clinical benefit from intratympanic (IT) steroids for patients refractory to oral or intravenous steroids.

When administration of both oral and IT steroids was compared with either route alone, the committee commented on the clinical benefit of dual administration for recovery, PTA scores, and speech discrimination scores. There was uncertainty about the optimal route and timing (first or second line) owing to the limited number and quality of the studies.

It noted that practice varies considerably between centres and expressed concern about any delay in offering treatment.

Oral steroids are certainly the current favoured first-line treatment, and GPs should not delay starting them. I believe it is advisable to then contact their preferred ENT department as soon as practicable to agree a plan of action for follow-up and possible IT therapy in the event of failure of oral steroids.