**Recent GP consultation before death by suicide in middle-aged men**

I thank Mughal et al for their research on death by suicide in middle-aged men.1 My colleagues and I carried out a regional review of suicides in South Yorkshire and Bassetlaw (2018–2019) (paper in preparation) and found similar rates of GP consultation in the 3-month period prior to death (54%). We also found around half of these consultations were mental health related (48%). Suicidal thoughts were mentioned in a third of cases at this consultation.

Given that these individuals would go on to die from suicide within ≤3 months, the proportion of consultations that were not mental health related or had any mention of suicidal thoughts is striking. Contemporary models of suicide, such as O’Connor’s IMV model, imply that a number of predisposing factors are present in the period leading up to suicide.2 Given the pressures facing general practice and the impact on continuity of care, it is easy to see how the opportunity to identify and enquire about some of the factors may be compromised. We know that middle-aged men are less likely to consult with their GP;3 making these consultations of great value for opportunistic screening. Perhaps it is time to adopt an approach similar to that taken in the identification of domestic violence/abuse and make routine enquiry into suicidal thoughts in all middle-aged men who consult with GPs or other health professionals.

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**DOI:** https://doi.org/10.3399/bjgp23X732621

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**Withdrawing from SSRI antidepressants: practical help is needed**

As a person who has endured a lengthy and complicated withdrawal process from an antidepressant, I am delighted to see this issue gaining recognition. I thank the authors for their work.1

We are starting to move from a position where antidepressant withdrawal is seen as rare and self-limiting, to one where we can acknowledge that, for a proportion of people, the withdrawal process can be extremely difficult. Further, some people will continue to have problems long past the point that they got off the antidepressant. Some psychopharmacologists believe this is due to the adaptation that the brain has made to the drug. Examples of this are often seen in online fora where some people report difficulties for months or years after tapering.

While I welcome this work, more needs to be done to practically aid both prescribers and patients in safely stopping antidepressants. As noted in other letters, liquid forms are available for some drugs but not all, and they tend to be expensive.

The Netherlands has led the way in developing tapering strips that can provide a precise and reliable way to gradually taper. In the UK, we should be learning from such groundbreaking work, and I got the chance to speak with Professor Wendy Burn, the then President of the Royal College of Psychiatrists, about this issue.2

Some readers might be interested to know about tapering strips and how they can aid the prescriber in guiding patients safely and slowly off their antidepressants.2

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**DOI:** https://doi.org/10.3399/bjgp23X732633

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**Managing withdrawal symptoms using tapering strips**

In their acclaimed article, Palmer and colleagues question how GPs should deal with those who experience withdrawal symptoms.1 In the Netherlands tapering medication has been developed to help GPs and other practitioners to do precisely that.2 Tapering strips and stabilisation strips enable them to flexibly prescribe and adjust personalised gradual and hyperbolic tapering schedules, based on shared decision making and proper self-monitoring. This tapering medication has been prescribed to more than 10 000 patients, allowing us to investigate whether and to what extent they have benefited from it. Because 60% of them had tried unsuccessfully to stop using an antidepressant in the past when they experienced severe withdrawal symptoms, it was possible to make within-subject comparisons between stop attempt(s) without and with the use of tapering strips.3,5 These comparisons showed that about 70% of patients who were not able to stop in the past when they suffered from severe withdrawal were able to stop when using tapering strips, the use of which resulted in much less withdrawal. Tapering strips and stabilisation strips can also be prescribed to and used by patients in the UK (www.taperingstrip.com).

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**Competing Interests**

PC Groot was involved in the development of tapering strips and both authors research tapering strips. Neither author is involved in any way in the production or sale of tapering strips.

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Learning from experience

It is welcome to see this advice on withdrawing from SSRI drugs published.1 I congratulate the authors and the BJGP. The Royal College of Psychiatrists (RCPsych), 4 years ago, published a position statement on antidepressants and depression,2 so I had expected similar advice to be published in the equivalent journal for psychiatry. This has not yet happened.

The BJGP article states that ‘Inaccurate guidance on antidepressant withdrawal has resulted in many patients experiencing distressing, debilitating symptoms’ and in ‘Take-home messages’ [Box 1] that ‘GPs should educate patients on withdrawal’. Box 1 reminded me of when I was training in psychiatry. At this time, a 5-year-long ‘Campaign’ was underway to ‘Defeat Depression’. I recall the ‘key messages’, for example, in the article ‘Lay people’s attitudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. BMJ 1996; 313: 856–859.3

The campaign is why there are currently 10s of 1000s of antidepressant discontinuation studies. Br J Psych 2016; 212(4): 341–345.4

Cumberlege J. First do no harm: the report of the Independent Medicines and Medical Devices Safety Review. DHSC, 2020. DOI: https://doi.org/10.3399/bjgp23X32657

Step change in guidance on withdrawing antidepressants

Palmer et al’s article aiming to translate recent change in NICE guidance to GPs is timely and useful.5 Some GPs may have a negative response to the article and understandably, given how big a shift the updated NICE guidance on stopping antidepressants represents from previous guidance.

Double-blind randomised controlled trials demonstrate that 53.9% of patients who stop antidepressants will experience withdrawal effects.2 The minimisation of these effects in guidelines for decades has meant that withdrawal effects are commonly misdiagnosed as relapse.6 This is why there are currently 10s of 1000s of English patients seeking advice on how to stop antidepressants on peer support sites,7 rather than from their doctors.

Though it was considered thirsty to avoid prescription of liquid versions of medications, a shift in policy has been signalled by NICE specifically recommending to GPs: ‘Slow tapering cannot be achieved using tablets or capsules, consider using liquid preparations if available’.8 At present, 8 out of 10 of the most commonly used antidepressants are available as liquids; sertraline is available in liquid form as a ‘Special’.9

GMC guidance is clear that doctors are permitted to prescribe medications off-licence when ‘the dosage specified for a licensed medicine would not meet the patient’s need’. The Specialist Pharmacy Service for the NHS has a dedicated webpage to explain how to make up antidepressant tablets into suspensions,1 and manufacturers of antidepressant liquids allow for dilution with water for easier measurement of small doses.8

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Competing interests

MA Horowitz has been commissioned: a) by Health Education England for a module on how to safely stop antidepressants using hyperbolic tapering for NHS staff on the SCIRPT website; b) to write the Maudsley Deprescribing Guidelines, Wiley-Blackwell. He is a Collaborating Investigator on the RELEASE trial (Australia) investigating supported, gradual, hyperbolic tapering of antidepressants; a member of the Critical Psychiatry Network; an associate of the International Institute for Psychiatric Drug Withdrawal; and co-founder of Outro Health, which helps people who wish to stop unnecessary antidepressant medication in Canada and the US using gradual, hyperbolic tapering.

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DOI: https://doi.org/10.3399/bjgp23X32665