**BMJ Responses to Assessment and management of self-harm and suicide risk in young people**

Adverse effects of medication were not the focus of this education article. It was based on the new NICE guidance for self-harm, which was primarily focused on psychosocial factors and care rather than pharmacological treatment.

Editors. **Competing interests:** No competing interests

**25 November 2024**

Dear Editor,

I read the article and I understood that it consists in guidelines for practicians or general practitioners to help them dealing with suicides for young people. I could nowhere read any mention of the suicidal risks induced by prescribed drugs, to name but a few: antidepressants, antipsychotics, benzodiazepines, anti-malarial tablets, acne medication and some antibiotics.

This omission contradicts the basic guidelines and recommendations in the labels of these drugs and may have dramatic consequences by making practitioners believe that this risk does not exist. I hardly understand this omission in such a paper.

I come from mathematics. When an important published paper contains mistakes or is incomplete, it is usually amended or retracted. At least all mathematicians in the fields are aware of the flaws.

Accordingly, I would suggest to the authors of the paper and the editor to amend it by adding this crucial information that can save lives: prescribed drugs induced risks should be considered. I think that this should appear either in boxes 1 or 2 of the paper.

Sincerely yours,

Dr Vincent Schmitt

**08 September 2024**

Dear Editor,

Mughal et al ask: How common is self-harm and suicide in young people?

They give examples of self-harm, including ‘cutting, medication overdose, burning or hair pulling’. Acute, intense, SSRI induced akathisia is a medical emergency and a cause of violence to self and/or others.

It has been described by those who have experienced this as an overwhelming, agonising suffering, like ‘being on fire under the skin’.

The medication history is of fundamental importance in diagnosis and avoiding misinterpretation of the extreme agitation, unrelenting pacing, writhing, twisting and absolute inability to sit or be still as an acute psychiatric presentation.

The torment of this form of akathisia is so unbearable that the sufferer may, in a desperate quest for relief, not ‘hair pull’ but frantically tear out all scalp, body hair and all eyelashes. Being unable to communicate what is happening, they are understandably vulnerable to psychiatric misdiagnosis, involuntary detention in a secure psychiatric unit, and forced medication with akathisia inducing psychotropic drugs.

As the situation deteriorates, increased dosing and poly-pharmacy create a risk of Serotonin Syndrome or Generalised Psychotropic Malignant Syndrome. It is recognised that many other prescription drugs cause akathisia.

The patient who is suffering from a life threatening, adverse drug reaction receives a series of severe mental illness diagnostic labels for life, which may negate all future hopes, dreams and aspirations. Iatrogenic unemployment is a sad consequence of following a prescriber’s advice.

Those who have witnessed the above, and have seen the tragic outcome of misdiagnosis may well ask: Why as a profession do we appear reluctant to become more AKATHISIA AWARE?

We could start by amending the question above: How frequently is self-harm and suicidality the result of akathisia following antidepressant induction, dose or drug change, treatment augmentation and antidepressant withdrawal, which may also initiate akathisia?

**09 August 2024**

Timothy R Moss Retired Consultant Physician

Dear Editor

This BMJ article begins “In this practice pointer, we outline how GPs and non-mental health clinicians can assess and manage young people aged 12-25 after self-harm or suicidal thoughts. Our approach is informed by the 2022 National Institute for Health and Care Excellence (NICE) guideline for managing self-harm.” (1).

The ‘Practice Pointer’ authors state that they contributed to the 2022 NICE guidance on the topic.

It is noted that the BMJ specifies (2) that “We commission all our education content” and that BMJ ‘Practice Pointers’ “are practical, often problem-based articles. They should help clinicians who are not specialists in a particular field know “how to” to approach a problem, diagnosis or management better.”

In this BMJ Practice Pointer (and indeed in the 2022 NICE guideline NG225)(1 & 3) it is notable that known serious medication-induced self-harm/suicide risks are underplayed - even omitted? Surely the most urgent information that the primary care physician (or other healthcare practitioner) needs to ascertain is ‘has there been any recent new, or any change of, prescribed medication which might have resulted in an adverse effect which may have prompted the self-harm and/or increased suicide risk?’

As recognised by Wessely & Kerwin in 2004 (4) akathisia is a known adverse drug reaction (ADR) relating to the commonly prescribed serotonin reuptake inhibitor antidepressants (as well as to neuroleptics). In the 2024 context of ever rising primary care antidepressant prescribing (for many indications) over the intervening 20 years this must surely be a vitally important consideration?

Medication-induced akathisia is under-recognised and can lead to self-harm and suicide. When recognized for what it is, appropriate action can be taken swiftly (reducing/addressing the causal factor(s)) to reverse the development of further adverse effects – such as further self-harm and death/suicide. Akathisia is also an ADR of other commonly GP prescribed medications such as certain medications for asthma, acne, nausea and other indications. An informative free course on the topic is available online at MISSD.co (5).

Surely it is necessary for the long-known suicide risks especially when antidepressants (and other drugs) are initiated, or the dose increased/decreased etc. – and during switching or withdrawal - to be openly recognised and for prescribers to be urgently and suitably educated?

As described by Dr Timothy Moss, “Akathisia is vulnerable to misdiagnosis, not only of the original condition. The writhing restlessness, disorientation, intensity of suffering, and inability to describe what is happening may lead to misdiagnosis as serious mental illness (e.g. 'psychotic depression" and 'bipolar disorder') leading to psychotropic poly-pharmacy and increased intensity of akathisia”(6).

If a person is experiencing akathisia, they will be viscerally unable to engage successfully in any form of recommended psychological intervention (per Practice Pointer and the NICE self-harm guidance) (1 & 3) and will need urgent proactive support to address the cause - and reassessment of ongoing care.

The ‘Safer prescribing’ suggestion in this BMJ Practice Pointer surely needs to include proper and necessary education for the prescribers and patients about what ADRs may be possible – a duty to warn - so that the patient and their companions can be alert to changes that may indicate that a prescribed drug is having an adverse effect? (7).

“When a clear body of evidence points to increased treatment-linked risk, patients and healthcare providers should be made aware of these risks. To suggest otherwise both breaches the ancient injunction of primum non nocere (first, do no harm) and is not aligned with the practice of evidence-based medicine” (7).

Marion Brown