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NOT TO DO
IN MENTAL HEALTH

DO NOT DO mental health

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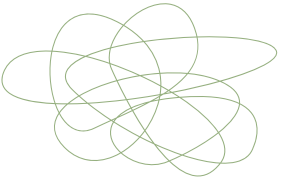

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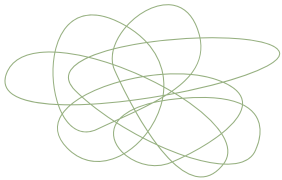

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Prologue

I can see how a mere six months has changed Ángela when she turned up for her appointment. Alcohol had taken its toll: her cheeks are more sunken and hollow than I have ever seen them. Her hair is rough, and she looks unhappy. I fear that if she goes on this way, sooner or later she'll be dead. She wants my help to get back on her feet, she says. I do my best to focus on her, not my computer. I resolve to demand less than ever from her so that she won't throw in the towel yet again. This time I tell myself, I'll keep my mouth shut until she finishes. She has to get everything off her chest, she has to see that in this office time stands still while I listen to her. There's a long pause until she begins: "I've reached rock bottom". I nod quietly and bite my tongue whilst I ponder a B12 analysis and whether I should put her back on olanzapine or Antabus. I think for a long time before I ask her whether she does in fact want to go back on medication, or just wants to talk. I want her to know that I don't just switch automatically to suggesting "What you have to do is..." "You should...", "One every twelve hours..." or even "I told you so".

It is so very difficult to reverse what we've learned in our medical training and practice. Ángela hates the way that medication deprived her of her capacity to cry but I hate feeling impotent, with my hands tied – a failed medic. We are used to sessions where we assess in five minutes, have a diagnosis in 10 and pull out the prescription pad in 15. I have been taught that the way to fight disease and death is through quick responses, interventions and well-practised manoeuvres. That we counter loneliness and despair with loud recommendations and solutions. But death and disease roar on with their own voices: and so does loneliness and despair.

Where did we get it all wrong? This semFYC document with recommendations "What not to do" in mental health teaches us about well-being through waiting, healing that comes from pausing and reflecting – in other

words, thoughtful non-intervention. Nobody is educating us about this approach: Long term isn't fashionable at the moment. We are living in an epidemic of hyperactivity and quick fixes. It has spread beyond the health sectors: it has infected supermarkets and now rages through schools, parks, retirement homes and tourist destinations. It even pervades intimate spaces, family settings – and time alone for reflection. But, as John Berger's *A fortunate man* points out, a physician who does not simply leap to a cure is invaluable.

If only there were more "What not to do" guidelines, because the world outside the clinician's room is exponentially more harried with the demand for quick fixes. We could do with guidelines for taking a slower, more reasonable approach to bureaucracy, the food we eat, our relationships with others, and so on. It has been only three years since the pandemic slowed us down – when the official advice was predominantly about "what not to do" – but has anyone kept to that pace?

Back in my consulting room, I pass the hankies over to Ángela while I wonder how to tailor this appointment to her, to make this a place which won't frighten her off for another six months. I wonder how to block out the keyboard's febrile clatter and stop demanding things of her that she can't fulfil later, that fill her with guilt, things that shut her down. That leave her feeling more alone, if it's possible for her to feel more alone than she is right now. Sometimes we manage to achieve this. And it's not by ramping up the suggestions and demands like an exuberant salesperson. It happens when you manage to create, to let happen, fleeting instants of genuine communication in which you can unbutton your lab coat, put your hands down and be your genuine self. You can be out there, in front of her, courageous, without any barriers, intrigued to get to know her and her truth.

You're not hurrying towards making a next appointment – when she will only come back trying to get you to see into her world. And in those moments, you feel more of a doctor than you have felt in a long, long time.

Dra. Rosana Corral Márquez
Writer and Psychiatrist

WHAT NOT TO DO in mental health

1 Do not use diagnostic labels initially in front of a patient consulting for emotional distress

Diagnosis is a medical procedure that may entail iatrogeny. Its potential benefits should be contrasted with the damage that might be caused in people and groups.

In primary care, due to its accessibility, proximity and the commodification of health and life itself, various consultations related to daily life problems are evaluated (emotional suffering and psychic distress) which in the past were resolved outside the health system.

The diagnostic label lays down a medical-technological interpretative framework, which sets off a cascade of diagnostic-therapeutic procedures that may lead to iatrogeny due to the system's stigma and dependence. It also favours a tailored solution that can hold the individual accountable and dissemble collective solutions set out beyond the scope of the health system. It is, therefore, estimated that one quarter of people referred to mental health centres do not fulfil the diagnostic criteria for mental disorder[1]. However, merely being referred means patients have the impression that their own resources, or those from the community are invalid to resolve their suffering. This does not mean that primary care should not broach the problem: by listening, supporting, guiding and avoiding medicalization/psychiatrization.

In mental health, the so-called label has a huge impact as it hinders the search for or retention of employment, the perception of social or family success and full interpersonal relationships with a marked impact on self-concept itself. There is a risk of giving magnitude and weight to disorders that we purport to relieve as the individual's vulnerability is amplified and his possibilities to recover are even limited. Some studies suggest that the psychiatric model based on diagnosis has not entailed a clear improvement in the prognosis of disorders[2]. For sure, diagnoses can turn into a tool that reduces uncertainty, the feeling of responsibi-

lity and associated anxiety, mobilizes social or work resources such as leaves of absence or disability benefits, activates setting up treatments or raises hopes for improvement.

The first treatment level should care for society as a group, encourage healthy community assets by means of social activism and public policies to improve quality of life and curb inequality. It must also assume a containment function that works as quaternary prevention. Prior to diagnosis priority is given above all to person-focused care and their narratives from a community perspective. Therefore, it is in this context that professionals should adopt a wait-and-see approach by means of leisurely reflecting on those patients who will not benefit from being labelled, treated or referred[3].

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2 Do not tackle mental health problems without contextualizing first the social health determinants to avoid medicalizing issues with a social basis

Broaching a situation of psychic suffering from a mainly individual and biomedical standpoint may turn out to be inefficient, harmful and unfair.

It is obvious that any psychic suffering has its root in socio-economic, cultural and historic conditions, and this manifests in the form of the person's unique symptoms. This expression means it is not always easy to discern what a disease is, because diagnostic categories in mental health are not clearly defined entities; especially in a society that medicalizes suffering and existential difficulties[1]. This tendency to give a medical slant to circumstances that were not treated this way beforehand, with the consequent need for intervention, is a responsibility that falls upon health professionals, patients and our whole society in general[2]. In the mental health field, this means that people consult life's discomforts more often than were previously tackled in other social arenas or with other cultural tools[3].

Discomfort can be understood as an expression of the impact on bodies and lives of dynamic groups with a social, political and economic organization[3]. There is no isolated disorder that has to be accounted for and where the context is an additional influence. Instead, this is an inextricable part of the problem[4]. Therefore, and from our ethics-related responsibility, mental health care has some socio-political implications that we just cannot ignore[3].

The risk of redefining these discomfort demands arising from what are essentially social problems such as mental disorder, which offer an excessively personalized intervention is that of circumventing the context and a collective glance that may help to more fully and usefully account for suffering. However, at the same time people's capacity to tackle daily adversity can be threatened and technical solutions offered such as psychopharmacological treatments or psychotherapeutic management. Are not free from a potential iatrogenic risk[3] and easily impacted

by conflicts of interest[2]. What is more, such management may be an exercise in legitimizing the damage and chronification[4]. There may also be a danger of creating and perpetuating the very mental disorders that we purport to relieve[3].

Despite the clinical context in which mental health demands unfold being intimate and personal, it is inevitable and necessary to broaden the focus beyond a biographical scope. Moreover, this should be broadened to a sociocultural and political context by means of a collective and public health consideration that aspires to transformational bonds from social and active infrastructures in community health.

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3 Do not medicalize uncomplicated pain

Mourning is a normal emotional response in the event of any loss. The fundamental role of healthcare professionals in tackling uncomplicated mourning is feeling accompanied. Attention should be paid to risk factors and circumstances that may condition pathological mourning.

Mourning can be defined as an emotional response to any kind of loss. This is a normal sadness reaction that everybody undergoes at some point in their life. However, it is usually more pronounced when a loved one dies[1]. The Holmes and Rahe stress scale scores the death of a spouse and a close family member among the five most stressful life events. The traditional phases of mourning according to Kübler Ross are denial, anger, bargaining, depression and acceptance. How long the mourning phase lasts is variable; every individual can develop this with a different time line (even on a deferred basis) and sometimes they overlap[2].

A total of 90% of patients manage to overcome the mourning process without complications. Patients will recover, adapt over time and will not require assistance, which is called "uncomplicated pain"[3]. In light of this situation, they will only require the informal support of family members, friends and acquaintances. Structured health interventions targeted at mourners, far from proving efficacy, may even be harmful[4]. However, some cases of mourning may become complicated and prolonged over time. The risk factors to develop a complicated mourning depend, among others, on personal characteristics (age, sex, history of physical or mental disease, personality traits), relationship with loss and the circumstances (sudden expected, etc.) and other social aspects (presence of a support network, etc)[3].

The intervention of healthcare professionals should be minimal when tackling uncomplicated pain. It is suggested to follow the REFINO model during the interview (relationship, easy listener, facilitation, information, normalization and orientation)[4]. However, in the event of complicated mourning we should opt for a selective intervention tailored to the patient's needs. In any case, the opportunity to make contact to ask about their state, needs and answer any queries or doubts should be evaluated. The routine course of the mourning should be notified.

There should also be a normalization of feelings, avoidance of feelings of guilt, advice not to take precipitated and irreversible decisions, ask about possible signs of complication (including suicidal ideas); and leave the door open to any possible future consultation. In short, undertake a process of accompanying the mourner[4].

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4 Do not minimize symptoms and their impact on the mental health of the paediatric and young population

Mental disorders in childhood and adolescence are common. However, at times treatment is only received partially or is incorrect. The presentation of symptoms and specific features of the clinical interview are some causes that can delay mental health diagnosis and treatment of this population.

The WHO estimates that 10%-20% of minors and adolescents experience a mental disorder. Despite the presence of specific diagnostic criteria at these ages, family members, relatives, teachers and health professionals are sometimes slow to recognize the existence of possible mental health pathology in this population. The life and social situation of this paediatric and young population, as well as that of their families, have an impact on their functionality and may constitute pathology.

Although there are investigations that tackle over diagnosis of mental disorders in minors and adolescents, some studies point to difficulties in diagnosis for various reasons: The ambiguity of certain symptoms, atypical forms of presentation in this population, the use of heuristics, not making a broad and correct differential diagnosis or the discrepancy of interpretation in criteria by clinicians[1].

Systematic reviews have concluded that the main cause for young people not seeking out professional help and not accessing this is fear of stigma, shame, lack of knowledge on mental health and the negative perceptions of asking for help[2].

Collaboration between educational centres and the mental health services is essential so that minors, young people and their families can access support within settings that minimize the logistic barriers. Primary care should also offer young people different ways to access help by themselves, including the use of digital tools, which have the potential to facilitate the strategy of asking for help and promoting the autonomy of young people[2]. It is important to educate and promote

emotional intelligence tools to detect and find out about our own and others' emotions, generate an adequate self-esteem, greater resilience and in the long term favour self-knowledge and personal maturity[3].

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5 Do not forget substance consumption in the history of a patient consulting due to a mental health problem

Given the growing frequency of substance consumption in our society and the two-way relationship of mental disorders, it is a priority to correctly identify both disorders to implement the necessary tools for its intervention.

Comorbidity in the same individual, who has at least one disorder due to substance consumption another mental or psychiatric disorder is called "pathology" or "dual disorder". Regardless of their order of onset, dual patients are more severe than subjects who only have one disorder, both from a clinical and social perspective[1] . During the clinical interview it may be difficult to identify them as one of the diagnoses may be hidden when interpreting symptoms that are part of the other diagnosis[1,2].

Whilst in humans the most common addictions associated with mental disorder are smoking, cocaine, heroin and cannabis, in women alcohol addiction and tranquillizers are more prevalent. Moreover, women are more susceptible to suffer from gender-related violence and are more at risk of social exclusion than men[2,3]. Mental health problems associated with more prevalence to these addictions are: social phobia, ADHD, obsessive compulsive disorder, borderline personality disorder, psychosis and other behaviours marked by impulsiveness. Up to 40% of people with dual pathology contemplate suicide[2].

Given the suspicion of mental pathology in the primary care consultation, we should systematically ask about substance consumption. Incoherent behaviours, low adherence to previous treatments, sudden changes in behaviour, absenteeism, loss or excess of appetite, hyperactivity or drowsiness and anhedonia are some indicators of suspicion[2]. Moreover, there are various instruments for diagnostic support, among them MINI (International Neuropsychiatric Interview) and PRISM (Psychiatric Research Interview for Substance and Mental Disorders), short and medium duration structured interviews, respectively[3,4].

The detection of dual pathology is challenging and it is essential to create a doctor-patient relationship based on respect and trust, which avoids value judgements or labels. Taking a detailed history (family history, chronology of the process, symptoms during periods of abstinence and relationship with consumption), use of semi-structured interviews and use of biological markers as support (liver enzymes, urine metabolites, among others), is recommended[4].

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6 Do not omit tackling suicidal ideas in people consulting for depressive symptoms

Suicide is the leading cause of external, accidental or "unnatural" death in Spain. It is essential that the psychopathlogical examination include suicidal or death ideas in the patient with suspected or confirmed depressive symptoms.

According to data from the Spanish Office of National Statistics, suicide is the most common cause of external death (accidents, suicides, homicides and attacks) in Spain. Therefore, it is a public health problem that requires special attention in our promotion and health prevention work[1]. Almost 50% of people who took their life had contacted their family doctor the month prior, of which 25% had attended a primary care consultation the week before[2].

Different kinds of stressful life factors (medical, social, work or family) can lead per se, or in association to psychological or psychiatric pathology, clinical symptoms of anguish that can foster suicidal ideas as the only possible alternative for resolution. For different reasons, it is common that the patient deliberately hides directly stating their purpose out loud, whereby it is essential to pay attention to indirect signs that notify the existence of this stressful factor and its magnitude (increased demand because of non-specific somatic symptoms, request for de novo anxiolytic medication or sadness), as well as suicidal risk factors with the purpose of reorienting the clinical interview and specifically tackling ideas of death[3].

When, through of dialogue and empathy, risk factors for suicidal ideas are observed, clinical practice guidelines recommend asking these patients openly whether they have contemplated suicide. The interview may be held gradually: asking initially about ideas of desperation, death, suicidal ideas and finally, structured ideas. Although not validated in Spain, the SAD PERSONS or IS PATH WARM scales may be useful because of their facility for implementation. The former is comprised of ten items with an affirmative or negative response and according to the results sets out four risk levels that enable scheduling the most

suitable intervention for the patient (from outpatient follow up, referral to mental health or need for admission)[4].

When detecting these risk factors and suicidal ideas, an important prevention barrier is erected by means of framing the suicidal proposal towards other therapeutic options and solutions and adapting this to the patient's life situation. This has the aim of avoiding the materialization of suicide or suicide attempt[4].

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7 Do not diagnose a mental health problem without having previously ruled out organic causes

A basic medical evaluation needs to be performed on patients with psychiatric symptoms to rule out a possible underlying organic origin.

Many organic diseases, both relatively usual and extremely rare, can manifest with psychiatric symptoms (confusion, delirium, hallucinations, cognitive abnormalities, depression, anxiety, euphoria, mania) either as a unique early symptom or as the predominant symptom. The differential diagnosis that has to be considered is broad.

Among other many aetiologies, there are neurological diseases (such as dementia or central nervous system tumours), endocrine (thyroid abnormalities, pheochromocytoma, Cushing syndrome, Addison disease, hypopituitarism), infectious (HIV, syphilis, encephalitis), autoimmune (systemic erythematous lupus, multiple sclerosis), vitamin deficits (Wernicke syndrome, Korsakoff syndrome, B12 deficit), metabolopathies (acute intermittent porphyria, Wilson disease) or electrolytic abnormalities.

Psychiatric symptoms may also present due to the adverse effects of various medicines (such as corticosteroids or antivirals) and recreational drugs.

The percentage of misdiagnosis in patients with organic conditions that present at the start with psychiatric symptoms is unknown. However, it has been reported that the psychiatric patient is more vulnerable to suffering from a negligent diagnosis of a physical disease (studies reveal that 19%-80% of psychiatric patients suffer from an underlying medical pathology that leads to symptoms), whereby it is important that this broad spectrum of differential diagnoses be present in the evaluation made by the professional[1].

A full clinical history, physical examination that includes vital signs and a mental evaluation is recommended. A brief cognitive evaluation that includes attention, orientation, executive functions and recent memory is preferable. There is controversy in regard to the use of laboratory

tests in general. Their study is recommended in patients with an initial episode of psychiatric symptoms, in the elderly and in patients with a clinical history or physical examination that leads to suspecting an organic pathology[2]. Further laboratory and neuroimaging tests in people with qualitatively different or unexpected symptoms, in the immunodepressed or in persons in a situation of social exclusion can also be considered. Nonetheless, further evidence is needed in the literature to set out these recommendations more clearly[3].

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8 Do not use psychotropic medicines exclusively to treat mental health problems

Non-pharmacological treatment (interventions on lifestyles, psychological, social and community support) is an essential pillar in mental health as a treatment of choice in some cases, and as an adjuvant to pharmacological treatment, in others.

There is evidence that psychological, psycho-educational interventions and physical exercise are all effective to prevent and treat the most common mental health problems in primary care. Their effectiveness has also been proven when new technologies are implemented such as self-guided or minimally guided programmes, given that they are accessible, low cost and can be introduced in different contexts[1].

Cognitive-behavioural therapy is the treatment of choice for anxiety, depression, food behaviour and personality disorders, among others. Both behavioural and cognitive disorders can be used in different combinations according to the symptoms to tackle: relaxation and breathing, autogenous training , cognitive restructuring, in vivo and deferred exposure, detained thought or resolution of problems[2]. Community interventions are also effective to improve mental health: social prescription refers the patient to community resources, such as performing tailored physical exercise or nature-based activities (gardening, walking through green or natural areas)[3].

In severe mental illness, early intervention on their lifestyle is important to prevent a deterioration in physical health. Systematic indication of psychological interventions is recommended for patients and their family circle. This favours mutual support groups and fosters a collaborative approach that supports both patients and their carers. Performing interventions on social support networks and interpersonal and occupational relationships is also recommended[4].

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9 Do not prolong situations of temporary incapacity for depressive disorders whilst waiting for a full remission of the symptoms

A correct evaluation of the situation of incapacity to work due to mood disorders includes scheduling going back to work as part of the therapeutic process. This scheduling, in the framework of behavioural activation, encourages the patient's functional recovery.

The processes of temporary incapacity due to common mental disorders are, after musculoskeletal disorders, those that most commonly lead to prolonged work absences. Among them, depressive disorders often lead to long term work absences[1]. A lengthy work incapacity may entail a reduced quality of life for the patient with a deteriorated social, family and work life, higher risk of permanent incapacity and even job loss. Moreover, this leads to public and private socio-health financial costs that try to meet system deficiencies and domestic, family or social supporting expenses arising from the incapacity situation[1,2].

To correctly tackle temporary work incapacity due to mood disorders we need to have full information from primary care on the processes, ascertain the kind of work and undertake a realistic schedule for going back to work as part of the therapeutic plan; within what is known as "behavioural activation of the individual"[1].

Going back to work is positively associated with functional improvement in patients with depression. Tackling the expectations of patients from the onset of work incapacity is an aspect that has to be considered. This may lead to identifying the risk factors for prolonged incapacities[3].

Interventions on the field of work, partial or gradual return or job adaptation should form part of the work reintegration programme. Further interventions are needed, both preventive and early management to prevent prolonged work absences due to common mental disorder and to promote going back to work. Furthermore, studies to investigate their effectiveness are also needed[4].

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10 Do not prescribe benzodiazepines without considering their half-life and the patient's clinical profile beforehand

In the event of prescribing a benzodiazepine treatment, the active substance should be tailored (especially considering its half-life and metabolism) to the patient's profile. Clinical features of elderly patients, those with liver disease, in case of pregnancy or a history of addictions are considered.

Benzodiazepines are medicines with an anxiolytic, myorelaxant and anticonvulsant action. They are used mainly in the scope of mental health to treat insomnia disorders or anxiety. In Spain there is a constant increase in the prescription and consumption of anxiolytics: data from the Spanish Agency for Medicines and Medical Devices (AEMPS) confirm that the DHD (daily dose defined by 1000 inhabitants/day) increased from 50.88 to 58.09 in 2012 and 2022, respectively. To correctly use benzodiazepines, according to their specifications, it is recommended to not exceed 2-4 weeks treatment in case of insomnia, and 8-12 weeks for anxiety disorders, which includes the time to gradually withdraw the medicine. Nonetheless, the latest guidelines recommend to not exceed 4 weeks in both cases, using them in monotherapy (to reduce the adverse effects) and at the minimal effective dose[1].

These medicines can be classified according to their half-life: short (under 6 hours: such as midazolam and triazolam), average (6-24 hours: such as alprazolam, lorazepam, lormetazepam or oxazepam) and long (more than 24 hours, such as clonazepam, dipotassium clorazepate or diazepam). Their main adverse effects are sedation with an increased risk of falls, fractures and road accidents, risk of cognitive impairment, tolerance, dependence and abstinence syndrome[2]. Although all of them have the same adverse effects profile, the active substances with a short half-life entail a greater risk of dependence and abstinence, whilst those with a longer half-life increase to a greater extent the risk of excessive sedation and its consequences[2].

We must bear in mind their metabolization path, especially in elderly patients or those with liver disease. As those metabolized by oxidation are accumulated and their usual dose should be cut by half. In this case, the choice would be those metabolized by conjugation (lorazepam, lormetazepam, oxazepam and loprazolam). During pregnancy, they should be avoided, as they are associated with malformations in the first trimester and abstinence symptoms in the newborn at term[3].

The withdrawal of benzodiazepines should be considered in all patients with prolonged treatments beyond the recommended time, although this process is not always successful[4]. There are different strategies for deprescription, such as gradual withdrawal with the same benzodiazepine (10%-25% reduction in the total daily dose and maintain this over 2-3 week periods) or its replacement with an equivalent dose of diazepam (lower potency, longer half-life and there are more presentations available that facilitate its gradual reduction).

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11 Do not prescribe antidepressants systematically for the initial treatment of mild depressive disorder

The available evidence reveals that it is not very likely for there to be clinically relevant benefits in using antidepressants compared to placebo in people with a lesser depressive episode. Therefore, their systematic use cannot be recommended as a first line treatment in mild depressive episodes.

Unlike moderate and severe episodes, mild depressive episodes, while fulfilling the diagnostic criteria set out, have less of an impact on the individual's functionality. The comprehensive and inclusive clinical interview is the most important tool for diagnosis, which can be based on standardized scales (such as Goldberg, GADS; Hamilton, HDRS 17; Montgomery Asberg, MADRS 10 or PHQ 9) to evaluate the episode's severity.

Most patients with depression are evaluated and treated within the scope of primary care by family doctors. The common use of antidepressants as an initial treatment is well known[1]. However, the available evidence questions this intervention strategy as a first line treatment. Against this backdrop we have both the Spanish guidelines for managing depression in the adult[2] and the NICE Guidelines (updated in 2022)[3]. From the analysis of the scientific bibliography including systematic reviews and meta-analyses with unpublished trials that compare antidepressants to placebo, we can draw the conclusion that the efficacy of antidepressants drugs in most kinds of depression is limited[1,4]. In any event, the benefit is mainly observed in at least moderate-severe presentations. Moreover, the adverse effects of antidepressants, which in some cases may have a significant impact on the quality of life of patients, are well set out.

Therefore, antidepressants are not recommended as a first treatment option for adults with mild depressive episodes, because they have an unfavourable risk-benefit ratio. Their use should only be considered in the event that there is no response to other therapeutic strategies, associated comorbidity or a history of moderate to severe depression[1,4].

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12 If there is no depression do not treat insomnia symptoms with antidepressants that have a sedative profile

Therapeutic management of insomnia should initially be based on non-pharmacological measures. Antidepressants with a sedative profile, such as trazodone and tazapine, are indicated only to treat insomnia in the context of depressive symptoms.

Insomnia requires a tailored and multidisciplinary therapeutic management. The basis of the treatment is non-pharmacological emphasizing sleep hygiene and general measures on lifestyle habits, diet and exercise[1]. Pharmacological treatment may be effective at times. However, it has limitations that have to be considered related to the patient (age, general condition, comorbidities) and the medicines used (adverse effects, polypharmacy, interactions, etc.).

Some antidepressants have a sedative action, although they are not indicated in the specifications to treat insomnia. Trazodone is an antidepressant of these characteristics (with capacity for serotonin reuptake inhibition in the presynapse, blockade of 5-HT2A serotoninergic receptors in the post-synapse and antagonism of H1 and αlfa-1-adrenergic histaminic receptors). Their use as a hypnotic in patients who are not depressed is not recommended. This is because their risk/benefit ratio is unfavourable in regard to traditional hypnotics and leads to tolerance after the first week of treatment[2,3].

Mirtazapine is also an antidepressant with a sedative profile (with a capacity for serotonin 5-HT2 and 5-HT3 and histamine H1 receptor blockade). At low doses it may be useful to treat depression in patients with predominant symptoms of insomnia and who may also benefit from weight gain. High doses, however, lead to noradrenergic stimulation that can counteract this sedative effect[4].

Any pharmacological treatment in the event of insomnia should be tailored to the patient and the authorized indications followed. The risk-benefit ratio, adverse effects, impact on the state of morning alertness and abstinence symptoms should be considered.

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13 Do not underestimate the cardiovascular risk of the patient treated with antipsychotics

Neuroleptic medicines are associated with an increased cardiovascular risk and overall mortality. In patients under treatment there must be close follow up and action taken on those risk factors that can be modified.

The consumption of neuroleptic medicines has increased overall and in terms of treatment of patients with behavioural symptoms associated with dementia. Their use is justified in the event of psychotic symptoms, severe agitation or aggressiveness. However, their potential adverse effects, closely following up patients and acting on those risk factors that are modifiable should be considered.

The adverse effects profile depends specifically on the active substance: traditional anti-psychotics lead more often to extrapyramidal symptoms such as sedation, orthostatic hypotension and falls; for new generation anti-psychotics the increased risk of metabolic syndrome and obesity is characteristic. Overall, these molecules increase cardiovascular risk: a higher risk of venous thromboembolism[1], stroke[2] and sudden death of cardiac origin[3] (especially associated with a prolonged QT interval on the ECG) has been observed in patients in treatment compared to the unexposed population.

The scientific literature concludes that there is an overall increase in mortality in patients treated with anti-psychotics. A meta-analysis estimated that the relative risk or mortality for all causes are approximately 2 (HR = 1.9 - 2.19), dose-dependent and greater in the first six months after treatment is commenced. While there are minor differences in risk between typical and atypical anti-psychotics, this is similar between patients with and without dementia[4].

To conclude, before prescribing anti-psychotics their suitability should be evaluated. The risk-benefit profile should be weighed up and a reassemble decision should be made according to the patient's profile. Their use should be limited to more specific pathologies such as schizophrenia, manic episodes or depression with psychotic symptoms.

During treatment of the dementia patient with behavioural symptoms, non-pharmacological measures should always be prioritized.

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14 Do not continue treatments with psychotropic medicines indefinitely without reviewing the patients' prescription criteria and situation

The increased use of psychotropic medicines in Spain means we must set out strategies that avoid prolonging treatments over time with the aim of improving their suitability and safety.

There has been a significant increase in the consumption of medicines such as benzodiazepines, antidepressants and anti-psychotics in Spain in the last two decades. With the exception of the latter, most psychotropic medicines are prescribed in the scope of primary care[1]. In general terms, the prevalence of polymedicated patients (those who chronically consume five or more medicines) has increased threefold in the last decade. It is not uncommon for these active substances to include at least one psychotropic medicine[2].

In primary care, the psychotherapy used to tackle mild-moderate common mental disorders has revealed an improved quality of life, without the need for medication. In the event of mild depression, the risk-benefit ratio for using antidepressants is unfavourable, and in the event of managing anxiety the causes need to be investigated and the use of relaxation techniques (such as the Jacobson method), breathing and medication should be before recommending anxiolytics. In the event of deciding to use psychotopic medicines a full clinical interview is needed, in which the health professional analyzes the patient's situation, their clinical profile and sets up a partnership and therapeutic plan. At the start of the treatment, expectations should be explored. Possible side effects and interactions should also be explained to the patient making them feel a part of the decision-making[3,4].

Nonetheless, some of the main problems that appear while using psychotropic medicines do not occur at the start of treatment, rather they take place when their discontinuation is considered. Some barriers are the onset of dependence in the event of benzodiazepines or discontinuation syndrome in using long-term antidepressants, which can generate rejection to withdrawal by the patient. This in addition with, among

other issues, the lack of specific guidelines for action in the process of deprescription (which are not fully effective), lead to the treatments being prolonged sine die. A psychotropic medicine should always be withdrawn after a professional evaluation. In the event of sustained clinical improvement, ineffectiveness, low adherence, at the patient's request or in the event of onset of adverse effects[3].

In short, a continuous pharmacological review, a selection of the medicine based on the best available evidence, a shared decision-making and the relationship of trust between the doctor and patient are key points to consider. This is to avoid unnecessary prescriptions prolonged over time or that do not provide a clinical benefit[4].

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15 Do not deprescribe antidepressants suddenly to avoid discontinuation syndrome

When indicated, antidepressants should be deprescribed gradually, especially after prolonged treatments and at high doses.

In the last few years the number of patients consuming antidepresssants has risen significantly. While the indefinite use of these medicines is not justified, the difficulties entailed by their deprescription are one of the reasons that contribute to perpetuating their use. In this sense, a systematic review revealed that 27%-86% of patients had undergone withdrawal syndrome when discontinuing a treatment of this kind, at times with severe symptoms[2].

The so-called "discontinuation syndrome" (or "withdrawal") that occurs when stopping dosage of these medicines is no different from traditional abstinence to a substance. This clinical picture, more common than usually diagnosed, may be confused with a relapse of the symptoms that led to its prescription, which contributes to unnecessarily prolonging its consumption. The symptoms it causes may be non-specific (such as headache, body pain, asthenia, sweating, tremors, palpitations, nausea, abdominal pain, anorexia), neurosensorial (dizziness, paraesthesia, tinnitus, sight abnormalities) or psychiatric (anxiety, sleep disorders, panic attacks, impulsiveness, aggressiveness or even suicidal ideas)[3].

The frequency and intensity of these symptoms depends on the active substance, its half-life, posology, how long treatment lasts and the speed at which the dose falls. While this has been reported in all groups of antidepressants, it has been observed more commonly in the case of paroxetine, duloxetine, venlafaxin and desvenlafaxin[3,4]. It is more likely to occur while using short half-life medicines, at high doses, after lengthy periods of treatment, or when withdrawal periods of under four weeks are involved. A higher risk of onset of this picture has also been observed in women aged 18 to 44[3].

To increase the likelihood of a successful deprescription a gradually reduced tailored regimen should be considered. Some experts suggest that 5%-10% of the initial dose should be gradually decreased over periods of one to four weeks. In practice such gradual reductions may be complex when tablets are used, whereby using oral presentations may be useful if these are available. As a whole, the period to full withdrawal of the medicine should be no less than 10 weeks[3].

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