IIPDW Italy
GUIDELINES FOR DEPRESCRIBING PATHS

Introduction

The Italian network that drafted these Guidelines is currently composed of approximately 160 persons who play an active role in the field of mental health in our country. It includes mental health professionals (psychologists, psychiatrists, nurses, psychiatric rehabilitation technicians, professional educators, as well as social workers, pharmacists, doctors of other specialties, sociologists), survivors, family members, representatives of national and local associations, researchers and others.....

The Italian network was set up in Milan in February 2020, in the wake of the participation of some of us in a first meeting of the international network, in Gothenburg, which gave rise to the International Institute for Psychiatric Drug Withdrawal (IIPDW, see www.iipdw.org for further information on the network and its initiatives). On the one hand, the international network has promoted a critical reappraisal of the evidence on the relationship between the benefits and risks of drug treatments for the main classes of psychotropic drugs, especially in the long-term use. On the other hand, the network has valorised all the available information on de-prescribing pathways in psychiatry, including both the scientific evidence and the information collected by members of international groups such as Will Hall (The Icarus Project), Laura Delano (The Withdrawal Project), and Adele Framer (www.survivingantidepressants.org), to name but a few.

This document was thus born as the result of a dialogue between the various actors in the Italian mental health field. It aims to open (not wishing to consider it as exhaustive) a phase of re-assessment of the treatment practices offered by public Italian Mental Health Departments. In the opinion of all the members of the Italian network, these practices have seen a progressive prevalence of pharmacological options over “non-pharmacological” proposals. This slide towards the constant centrality of drug treatments has made the promotion of concrete prospects of “empowerment” (in terms of reduction of decision-making asymmetries between professionals and those directly concerned) much more difficult. De-prescription pathways are an integral part of “recovery” practices (i.e., the recovery of an authentic capacity to make autonomous decisions about one's own existence).

We believe that professionals who adhere to recovery-oriented mental health care principles should be well aware and informed on indications and operational tools to promote de-prescription pathways, although with the necessary caution and gradual tapering.

General premises

1. The constitutional right of every Italian citizen to decide on his health and on the treatments that concern him (reiterated by Law 219/2017) - in a **responsible and informed manner** - must be considered.

2. A key element of Franco Basaglia's proposal was, and remains, **the centrality of the subject/person rather than the disease**. A subject/person should be considered a bearer of rights but also a bearer of a personal and family history, and of a context. On the other hand, the centrality of the drug is often supported and accompanied by a predominance of the disease

dimension, with the actual risk of slipping from subject to object (of specialized medical intervention).

3. **Comprehensibility of all experiences of mental suffering** (mild and severe), with the need to accompany the deprescribing path with non-pharmacological interventions that can provide tools for managing new possible phases of psychological distress and that allow exploring the biographical story of the subject. In addition to the psychotherapeutic interventions (both individual and systemic, including Multifamily Psychoanalysis and Dialogical Practices), the non-pharmacological options may comprise holistic non-conventional medicine techniques, if proposed by the person (e.g., yoga, meditation, Qi Gong, Tai Chi, Rei-ki) The centrality of drug treatment is in tune with the biological theories that are based on the principle of incomprehensibility of most of the experiences of mental suffering.

4. **Experiences of reduction/withdrawal of subjects treated with psychotropic drugs** (Will Hall – Icarus Project; Laura Delano – The Withdrawal Project, and many others, also in Italy) suggested that some strategies should be adopted to avoid deprescription/withdrawal paths that are most likely to fail. The importance of a request that comes in a clear form from the person concerned (i.e., who is actually taking the drugs) must be emphasized. This request indeed prefigures a path of "self-knowledge," aimed at activating (almost inversely proportional to the drug to be reduced) one's own resources, followed by an increase in self-esteem, sociability, self-determination, rediscovery of one's own talents, and resumption of the "true life."

5. Proved existence of **significant side effects** and high health risks (cardiological, metabolic, neurocognitive, early mortality, etc.) of the main classes of psychotropic drugs, especially in case of long-term use.

6. **Economic and social costs** of long-term drug therapies as well as of all physical and functional disabilities that may result from them.

7. Demonstrated **increased use of psychiatric drugs** in pediatric age groups, in youth groups, and in the elderly population (with a peak during the pandemic).

8. **Lack of training, and refresher courses,** on optimal deprescribing strategies, but also on the proven effectiveness of "shared decision making" (i.e., fully shared decisions after discussing the pros and cons of the available options). These paths must be provided for all psychiatrists in the Italian NHS Mental Health Departments and residents of the Schools of Psychiatry, Child Neuropsychiatry, and Pediatrics, but also for General Practitioners (where the deprescription has already been proposed, especially in the case of polytherapy in elderly subjects).

Specific premises for prescribers

1. Available evidence on **withdrawal syndromes** (both in acute and protracted form) for antidepressants, benzodiazepines, and antipsychotics (especially in case of abrupt withdrawal, which should always be avoided and discouraged).

2. Adherence to reduction models according to the **hyperbolic formula**, which minimizes the risks of a withdrawal syndrome.

3. Adherence to the indications of international guidelines that suggest **monotherapies** as preferential options (with consequent management of polytherapy, in this direction).

4. Knowledge of **Ulysses' Contracts** and, more generally, of all already proposed models of "advanced crisis planning," which are the basis for the concrete methods of involvement and accountability of all the key figures to be included in the deprescription paths (with a a full respect of informed consent).

5. Knowledge of the **implications in daily care practice of Law 219/2017** (in case of presence of a personal support administrator; in terms of potential exclusion of judicial risks for prescribers; as a basis for negotiating the transition from depot to oral therapies; etc.).

6. Preference for the prescription of **formulations in oral liquid solution** of the active ingredients in order to make the deprescribing path easier.

7. Willingness to offer (as an MH service) or to report specific local resources for **agreed non-pharmacological interventions** (e.g., self-help groups, psychotherapists, or art therapists, etc.) and, if possible, to promote the involvement of a small network (including professionals and key persons), according to the dialogical practices and principles.

8. Promotion of the participation of **survivors as active partners** in the definition of deprescribing paths (and, in general, support to the participation in self-help and mutual support groups).

9. Specific attention to the **objectives of any therapeutic pathway**, given the possible, frequent distance between the objectives of the professionals (mainly relapse prevention) and those of the key persons (improvement of the quality of life and functional recovery).

Operational proposals for individuals/families who start a deprescription process

1. Need for a careful assessment of **personal, relational, and contextual conditions** in which to start a deprescription process. Among them, the constraints linked to the possible loss of economic benefits, such as the disability pension, must also be considered.
2. The deprescription path must be **promoted and shared with the person under drug treatment**, from the very beginning.
3. The **active involvement of all components of the family and/or friend context** is desirable, especially when the Ulysses Contract is going to be adopted. The Ulysses Contracts provide for the identification of possible warning signs of psychological distress as well as the definition of coping strategies that are shared in advance to be more easily respected and adopted when distress reaches critical levels.
4. The active involvement of **all involved professionals should be considered preferential**, especially when drafting Ulysses contracts.
5. The **active presence/participation of survivors** or representatives of local users' associations is also preferable.
6. The initial proposal should preferably provide for the definition of **reduction targets**, with a subsequent shared evaluation of the opportunity to reach a full withdrawal in the agreed time and manner.

Proposals for local and regional administrators and central bodies defining policy lines in the Health and University sectors (including Scientific Societies and national Users and Family Associations)

1. Promotion of initiatives **to train or refresh psychiatrists**, child neuropsychiatrists, pediatricians, and general practitioners on the correct methods of deprescribing and the withdrawal syndromes.
2. Inclusion of at least one **university training course** dedicated to deprescribing in many medical specialties (including psychiatry, child neuropsychiatry, and pediatrics), as well as the inclusion of a specific course in the main Schools of Psychotherapy (given the tendency of many psychotherapists to actively promote the need for drug treatments).
3. Activation (by the Scientific Societies concerned) of **research initiatives** for the assessment of the mid-term and long-term outcomes of the deprescribing paths, with a specific focus on the specific strategies adopted in all cases under examination.
4. In parallel with one or more quantitative research, support should be offered for the collection and active promotion (also in training contexts for prescribers) of **individual narratives** that may have relevance and media dissemination.
5. Promotion (by Associations and Scientific Societies) of **awareness-raising initiatives** on the issue of the right to informed consent and active participation in health decisions that affect all citizens (in the light of Law 219/17), as well as on all issues (such as the withdrawal syndrome) linked to the deprescription practices.

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