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Withdrawal from Prescribed Psychotropic Drugs

(New and updated edition)

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Peter Lehmann & Craig Newnes

Foreword

Before writing the preface for this new work about withdrawal from psychiatric drugs, I started by reading Peter Lehmann's book *Coming Off Psychiatric Drugs* first published in 1998 with a 4th English E-edition in 2020. I had not known of Peter Lehmann and I was also not aware of his work on psychiatric drug withdrawal. His book was filled with powerful first-person accounts of heart-rending personal trials and tribulations within the world of psychiatric drugs with a focus on the oft-ignored issue of drug withdrawal and with reports of professionals, working in psychotherapy, medicine, social work and natural healing how they help in the withdrawal process. It led me to resources I was also unaware of such as the International Institute for Psychiatric Drug Withdrawal (IIPDW), and the many people internationally grappling this issue. Peter Lehmann's summary chapter was a serious and well researched attempt to provide an overview of the various categories of psychiatric drugs, withdrawal practices and resources. Then I reviewed the proposed table of contents for his new work and its expanded individual chapters on the various categories of psychiatric drugs, the look at professional and self-help strategies, and various approaches to the multitude of problems that can occur in an attempt at drug withdrawal. There is still a dire need for education and the provision of both avenues of support and specific tools and approaches to this complex issue. I applaud Peter and Craig for their efforts.

But first, who is Dr. Caligari?

I am a Board-Certified Psychiatrist (American Board of Psychiatry & Neurology), who went to The New York

University School of Medicine, graduating in 1970. I then did an internship and Psychiatric residency in Northern California. After working in a community clinic (La Clinica De La Raza) for many years, I started working for Kaiser-Permanente (among the largest non-profit Health Maintenance Organizations in the USA) in Northern California as a psychiatrist/psychopharmacologist from 1992-2008. From the mid-1970s and onward, to be a psychiatrist meant you managed the prescribing of psychiatric drugs, and the therapy was left to lowered paid mental health professionals. This trend has only sped up to the present day, so a psychiatrist practicing only psychotherapy is a rare bird indeed in the USA. Thus, there are many pressures subtle and not so subtle to prescribe, not to Not prescribe.

Since my retirement I have kept my medical license active on a volunteer basis only and besides being my neighborhood emergency coordinator (earthquakes, wildfires and now Covid19), I have not practiced psychiatry since 2008. It was in 1970 while doing an internship at San Francisco General and also volunteering at a "free clinic" that my wife Sherry Hirsch and I first connected with Wade Hudson, Leonard Frank and others and started *Madness Network News* (MNN) "All the fits that's news to print". The name is a reference to Ronald D. Laing's and David Cooper's Philadelphia Association of London and their "Network Newsletter" which I experienced in London in 1969 as they were trying to create alternatives to the psychiatric establishment with therapeutic places like Kingsley Hall – see *Two Accounts of a Journey Through Madness* by Mary Barnes and Joseph Berke. We published "The Madness Network News Reader" in 1974. We then also founded NAPA (The Network Against Psychiatric Assault). NAPA was based on our mutual experiences and concerns about psychiatry and its real potential for abuse,

from the point of view of patients, professionals, and family members. The name was a play on the Napa, California state psychiatric hospital of the same name.

I started to write articles for MNN in 1971 about psychiatric drugs and drugging under the pen name Dr. Caligari from the classic German silent film. In the film Dr. Caligari is either a mad scientist with his somnambulist Cesare (comparable to a drugged patient) carrying out violent acts at Caligari's behest or the benevolent "Alienist" (the nineteenth century term for psychiatrist) director of a psychiatric hospital. One aspect of the articles I wrote had to do with withdrawal from psychiatric drugs. In 1984, MNN published my "Psychiatric Drugs" booklet and I wrote an unpublished manuscript "Tranquilizing Madness". During my career as a practicing psychiatrist/psychopharmacologist I faced the Sisyphean task of trying to care for and help people while *Doing No Harm*. I worked hard to educate people, to look head on at the difficult decisions in using or not using psychiatric drugs in order to help manage the complex personal, familial, cultural, life and human problems at hand, and to be as compassionate, caring and understanding as I could be. It's also important to not just stereotype all psychiatrists and mental health professionals as Dr. Caligaris or nurse Ratched's (the tyrannical nurse in "One Flew Over the Cuckoo's Nest"). Most are serious professionals trying to help people however misguided their ultimate effects might be.

There is so much that could be said about starting, not starting, stopping psychiatric drugs. Withdrawal can occur or be needed for many reasons including: a serious adverse reaction, significant and disturbing effects, lack of effect, avoiding long term damaging effects, trying to figure out if a drug is really needed or if an acute problem has passed, and the list goes on. The use of psychiatric drugs entails

the withdrawal reactions of various types as well as the unwanted effects, adverse reactions, potentially life-threatening problems like antipsychotic induced neuroleptic malignant syndrome (NMS), and long-term risks of antipsychotics like tardive dyskinesia.

One rule of thumb was that the faster a drug is absorbed and then metabolized and excreted the more likely a withdrawal reaction (the drug half-life). Examples include minor-tranquilizer/sedative-hypnotic/benzodiazepine drugs like Xanax (alprazolam), or the antidepressant Effexor (venlafaxine). However, there are very significant individual differences, genetically determined and involving the liver's enzyme systems for drug metabolism. When I was practicing there was no way to test for those who might be slow or rapid metabolizers. Lithium is the exception as an inorganic element which is not metabolized and it is the kidney that regulates the excretion and removal from one's system. There are now genetic tests available (not cheap) that can determine these individual genetic differences. I don't know how widely used they are, but they can help to determine a person's unique profile and affect potential starting doses. In an ideal medical world, anyone potentially going on a psychiatric drug would be tested before medications are started.

However, unlike an antibiotic affecting a relatively simple organism, and where everyone will get the same standardized dose; when it comes to human brains there is an enormous variability in one's response to any psychoactive drug. And this is above and beyond simple liver metabolism and blood levels of the drug. So, whether it is alcohol, narcotics, cannabinoids, psychedelics, psychiatric drugs, etc. there is no simple way to predict a person's sensitivity and the drug's ultimate effects. Only by an actual trial of the drug, using a test dose in your own biological system can you begin to figure this out.

There are also the effects of age, gender, and ethnicity. The adage for older people had always been "start low and go slow" as far as drug dosing, but I think it is applicable still today for all who might use psychiatric (or any psychoactive) drug even if one gets genetic testing of drug metabolism. Ask anyone who has ended up with problems or an emergency room visit after using edible marijuana products to begin to appreciate individual response patterns and the potential for unanticipated outcomes. Know the drug, know your own responsiveness as much as you can and yes, start low and go slow.

Reading Peter Lehmann's book *Coming Off Psychiatric Drugs* will give you many first-hand accounts of the many problems that I also saw occur with psychiatric drugs. The withdrawal reactions were potentially horrendous (a non-medical term, however, still apt) and often led to a cessation of any attempt to continue the withdrawal. It soon became obvious that for such drugs extremely slow and individualized drug tapers were needed with a great deal of structure, patience and individualized titration of progressively smaller and smaller doses with a systematic trial and error process a necessary component after an initial withdrawal schedule. And given the common practice of polypharmacy (using multiple psychiatric drugs), there is also no simple formula for which drug to begin withdrawal from when multiple meds are being consumed.

In my MNN Dr. Caligari writings and the 1984 drug booklet ("Dr. Caligari's Psychiatric Drugs"), I outlined a 10% generic formula for drug withdrawal schedules. Of course, 10%-steps are not to be understood as a rule, but only as a proposal. In essence when considering withdrawal, with whatever dose a person is on, start by reducing the dose by 10% and then after, say, 1-2 weeks or longer, evaluate any problems. Separating drug withdrawal from any return of prior problems or a brain

supersensitivity and related symptoms created by the use of the drug and exposed during drug withdrawal is not necessarily easy, to say the least. Going as slow as a person needed (weeks, months or even years), returning to the last dose when feeling stable if problems emerge before re-starting gradual dose reduction, etc. were all strategies. At times it required the mechanical process of going to the lowest dose of the drug manufactured and then cutting pills into quarters, and other such unorthodox ways to individualize progressively smaller doses. Dealing with tablets with hard coatings, capsules, etc. and limited dose ranges manufactured were among the problems.

I was glad to read in Peter Lehmann’s book and other sources about ways now being used or suggested to manage this better such as tapering strips or working with pharmacists to tailor small drug doses and decrements. Another option was converting such a short acting drug like Xanax with a short half-life to a drug with similar properties or nearly identical properties but with a much longer half-life that would by its chemistry leave the body and brain much slower such as Klonopin (clonazepam). That is not to say this obviated all problems, which it didn’t, as prolonged or just "long" enough use (which can vary enormously from one person to the next) and physiological dependence are never simply solved for all kinds of reasons.

This is just one, albeit a very important, aspect of drug withdrawal, but all drugs in many different ways regardless of their half-life have by their nature an impact on the neurotransmitter systems of the brain (serotonin, dopamine, norepinephrine, etc.) and use over time can create problems when discontinued and by how they are discontinued. And all of this is occurring in the complex context of human beings and the human condition. Given all of this, the need for education, support on many levels,

cooperative problem solving, etc. becomes a needed part of the entirety of helping someone to enter the process of withdrawal. I am glad that people like Peter Lehmann, organizations like IIPDW and others have been attempting to rectify what has been an enormous vacuum.

Today, even though I have not actively practiced medicine since 2008, I do follow the medical-psychiatric literature from a distance and in fact not much has changed in the world of psychiatric medications. More "me too" drugs (drugs that are derivatives of the same basic chemical formula and with similar or identical drug effects and properties) in almost all categories of psychiatric drugs; aside from the use of ketamine for treatment-resistant depression – to say nothing of tools like transcranial magnetic stimulation (TMS), not to be confused with ECT (electroconvulsive therapy / electroshock) which should be relegated to the dust bin. We can do better!

During my years practicing as a psychopharmacologist I constantly faced the conundrums and difficult decisions inevitably present around the use of psychiatric drugs and did my best to care for people. But there is no cookie cutter approach in this arena. You can’t just say 'No' to any and all use of psychiatric drugs as the way to avoid concerns like dependence and withdrawal. Not everyone has necessarily been damaged by psychiatric drugs and like any tool it can be used constructively or destructively but looking at the balancing scale of constructive vs destructive for any person is not just a simple objective evaluation (much more could be said about this). What is the legitimate use of lithium, atypical antipsychotics, antidepressants, psychostimulants, sedative-hypnotics? What about cannabinoids, psychedelics, substituted amphetamines like MDMA, ayahuasca, mescaline? There is no simple answer, but one can go just so far towards optimizing health and

wellbeing and managing life’s problems with any exogenous substance.

David L. Richman M.D.
Berkeley, October 18, 2020

Editors’ Preface

All over the world doctors, including psychiatrists, prescribe antidepressants, neuroleptics ("antipsychotics"), mood stabilizers, tranquilizers and psychostimulants, and, in most cases, without providing information about the risks of taking them and problems when stopping, for example, adverse effects, tolerance formation, bodily and psychological dependence and withdrawal symptoms. Nor they tell people about ways to avoid or minimize the risks.

This volume presents a collaboration of users and survivors of psychiatry (ex-patients), professionals, researchers, lawyers, and academics around the world committed to helping people understand the potential harm (including drug dependence) that prescribed psychotropic drugs can cause and how to safely reduce or stop taking them. The chapters include individual accounts of people who discontinued their prescribed psychotropic drugs, information about withdrawal groups, research data (especially about antidepressants and neuroleptics) and a commitment to relatively safe withdrawal that will offer hope to many people; those who want to help and those who want to withdraw.

David Richman reminds us in the foreword that in 1984 he was the first doctor in the world to critically report on the possibilities of risk-reducing discontinuation of prescribed psychotropic drugs. Almost 40 years later, he reflects on the urgent need for education and the provision of support and specific approaches to discontinuing prescribed psychotropic drugs. Reforms in the psychosocial field around the world continue, but the dominance of biologically oriented psychiatry persists in both the Global

North and the Global South. Knowledge about how to reduce and discontinue psychotropic drugs with less risk and how to help with the withdrawal process is poorly promoted – as Paulo Amarante from Brazil says in his introductory remarks. In the industrialized north, the situation isn't much different – only rudimentary mention is made by manufacturers and psychiatrists of drug dependence risks and professional help to withdraw is hard to find. Thus, many doctors and psychotropic drug takers discontinue treatment far too quickly, confuse withdrawal symptoms with relapses and prescribe or take psychotropic drugs again instead of using different ways to cope with their problems, as Markus Kaufmann and Peter Lehmann explain. Fernando Freitas and colleagues demonstrate in their chapter that there is a distinct lack of scientific knowledge in mainstream psychiatry about drug dependence, withdrawal symptoms and especially safe and effective withdrawal techniques.

Reasons for reducing and discontinuing prescribed psychotropic drugs, especially antidepressants and neuroleptics, are the topic of the first section. Antidepressants and neuroleptics including the newer antidepressants and the so-called atypical neuroleptics cause major physical and emotional problems. Antidepressants and neuroleptics are the focus of this book. The problems of withdrawal symptoms and dependence on prescribed psychotropic drugs have been known for a long time, as Peter Lehmann points out. In its report to the General Assembly of the United Nations, even the Human Rights Council's Working Group on Arbitrary Detention demanded assistance for those withdrawing from prescribed psychotropic drugs. As with benzodiazepine tranquilizers until the 1980s, withdrawal problems with antidepressants and neuroleptics have been denied, ignored or redefined as patient discontinuation problems

by most mainstream psychiatrists. The Mental Health Self-Help Network Rhineland-Palatinate in Germany points out undesired effects of antidepressants and neuroleptics – reasons for their discontinuation – in their information sheets, designed with the more responsible directors of psychiatric clinics. The Network suggests alternatives and, like most of the authors of this book, approaches to reduce withdrawal problems. While antidepressants and neuroleptics are currently offered to patients as the only way to prevent relapse, Robert Whitaker's critical review of the evidence shows that these substances can exacerbate and lengthen conduct described as psychotic in the medium and long term. Their claimed relapse-preventive effects are based on poor science and a remarkable refusal to acknowledge a solid research base that argues for a very different use of these drugs. In his chapter Craig Newnes comes to the same conclusion with antidepressants: these substances have been shown by researchers to increase suicidality, and depression itself is listed as a possible consequence of taking these substances. The chapter also uses depression as an example of the invalidity and unreliability of psychiatric diagnosis.

Section Two is about professional and self-help strategies for discontinuation. Psychiatrists Swapnil Gupta and Naama Hofman report on deprescribing as a structured intervention to reduce prescribed psychotropic drug use and manage withdrawal symptoms. Bryan Shapiro focuses on the hyperbolic tapering of antidepressants; this approach of small, subtherapeutic doses of the antidepressant combined with a flexible attitude, patient education about withdrawal problems, and psychological support, whether through formal counselling or psychotherapy or peer support, should reduce the risk of withdrawal symptoms. The institutional support in crises during withdrawal from prescribed psychotropic drugs in

his catchment area, a model region, is presented by the psychiatrist Martin Zinkler. A service philosophy that is positive about discontinuing psychotropic drugs is a basic prerequisite. It ensures that psychotropic drug takers do not become dependent on the goodwill of individual psychiatric practitioners and are protected from unsettling contradictory statements about withdrawal problems. His colleagues Jann Schlimme and Michael Schwartz explain individual prescriptions during individual recovery; these make reduction easier and more successful. Pharmacists' strategies resulting from the special metabolism of psychotropic drugs during discontinuation are presented by molecular genetic researcher Peter Groot and psychiatrist Jim van Os: tapering strips tailored to the individual needs of the psychotropic drug takers. These make hyperbolic discontinuation possible with product units that the pharmaceutical industry does not want to provide. Hilde Schädle-Deininger and Christoph Müller explain the valuable contribution that nursing staff can make to alleviating withdrawal problems when discontinuing prescribed psychotropic drugs.

Because of the small number of effective strategies practised in the psychosocial field, approaches founded by former psychotropic drug takers or non-governmental support-organisations, in which professionals, users and survivors of psychiatry and relatives cooperate, are of particular importance. Anna Emmanouelidou discusses The Observatory for Human Rights in the Field of Mental Health in Greece. The Observatory created a supportive social network to accompany the discontinuation of prescribed psychotropic drugs and the search for a new way of life, thus contributing to a different understanding of emotional distress and well-being. From Canada, Céline Cyr reports how her self-help group offers psychotropic drug takers knowledge about the effects of these

substances, so that, with the combined knowledge of peers and self-help experiences, they can get closer to what they want in terms of psychotropic drugs and what they want out of life, thus regaining power over their lives. Since there are only very few self-help organisations that offer structured and competent help to cope with prescribed psychotropic drugs and their discontinuation, reliable and responsible online withdrawal support, as presented by Trudy Slaght and Leela Ehrhart, is of great importance. Here, those who are often isolated and misunderstood by those around them can find others who understand their problems and point the way to existing hidden resources. Exemplary individual strategies for coming off prescribed psychotropic drugs are presented at the end of this section. While Craig Newnes draws a comparison with the withdrawal from street drugs, alcohol and tobacco and reports on a woman dependent on antidepressants and her agreement with the psychologist to reduce and discontinue at her own pace, Susanne Cortez uses the example of the so-called atypical neuroleptic quetiapine to describe how she finally freed herself from this neuroleptic by a well thought-out, small-step procedure despite repeated initial failures at withdrawal.

Three contributions in the second section’s last part deal with policy-oriented approaches to discontinuation. Olga Runciman describes the International Institute for Psychotropic Drug Withdrawal, which promotes the dissemination of practical knowledge on risk-reducing discontinuation. She compares mainstream psychiatry to Fort Knox, the heavily secured gold depository in the USA, which needs to be cracked open in order to challenge its monopoly position and force it to recognise and embrace patient-centred knowledge about withdrawal problems and options. Marion Brown and Stevie Lewis approached the Scottish Parliament with a public petition to draw attention

to medically unexplained symptoms and functional neurological disorders in antidepressant withdrawal and to express their continuing concern about the lack of recognition and support for people who have problems with discontinuation. That withdrawal of prescribed psychotropic drugs also affects people in countries of the Global South is demonstrated by Tatiana Castillo-Parada and friends from the Mad Pride movement in Chile, which shows that discontinuing prescribed psychotropic drugs is possible and that there are alternatives to regain autonomy, emotional balance and quality of life without being dependent on harmful substances.

The contributions in the third section deal with liability issues arising from inadequate information about drug dependence and withdrawal risks. If the lack of information about these risks leads to a significant health impairment of a patient, this can justify a liability of the pharmaceutical company because of an instructional error, according to the jurists Marina Langfeldt and Jim Gottstein in their two contributions, whereby the latter emphasises the difficulty that currently still exists to enforce such claims in court.

What is to be done? Practical approaches to action for individual psychotropic drug takers are the topic of the fourth section. If one decides to discontinue prescribed psychotropic drugs, what has to be considered, regardless of whether one discontinues alone or with medical support? Volkmar Aderhold and co-authors answer this question in the first article. Next, Peter Breggin makes the case for making withdrawal from prescribed psychotropic drugs as safe as possible and recommends experienced clinical care, especially if someone has been taking combinations of psychotropic drugs for many months. Mary Ellen Copeland then explains how to use her Wellness Recovery Action Plan for prescribed psychotropic drug withdrawal to reflectively

manage possible withdrawal-related emotional and physical health problems.

The contributions in the fifth section deal with failures that can never be ruled out during discontinuation. First, Peter Lehmann recommends an advance directive tailored to discontinuation. Volkmar Aderhold concludes: if psychotropic drug takers are unable to stop taking prescribed drugs, especially neuroleptics, it is important that they and their doctors are informed about the possibility of minimum dosing and the necessity of monitoring their state of health.

All contributions show it is essential to support psychotropic drug takers if they want to stop taking their drugs or need to stop them for health reasons. Psychotropic drug takers, their relatives, their friends, their therapists and their doctors need information on how to stop these drugs carefully, responsibly and with risk-reducing measures. In addition, fundamental changes are needed in the psychosocial field, starting with a change in the training of medical doctors, in which the risks of dependence on prescribed psychotropic drugs are to be addressed as well as the possibilities of low-risk withdrawal, via the integration of the experiential knowledge of users and survivors of psychiatry, i.e., former patients. The development and provision of low-threshold forms of support during withdrawal, the financial support of independent organisations for psychotropic drug takers that offer help during withdrawal including supportive internet portals, the development of safe reduction techniques or their financing as they already exist, and the development of an industry-independent diagnostic system that includes dependence on prescribed psychotropic drugs are also needed. Finally, improved possibilities of recourse for injured parties as well as possibilities of sanctions for pharmaceutical companies and doctors who misinform

about dependence risks need to be expanded. Perhaps it is time to develop a humanistically oriented help system in which the prescription of psychotropic drugs would only be the exception.

Peter Lehmann & Craig Newnes

Introduction

Psychiatric Reforms and Coming off Prescribed Psychotropic Drugs in Brazil, a Global South Country *(Paulo Amarante)*

In Brazil, the asylum model defines the psychiatric system. Apart from the country-specific characteristics in Brazil, the situation regarding knowledge of risks and harms of prescribed psychotropic drugs and problems with their discontinuation is not significantly different from other countries in the Global South.

From the last decade of the 19th century until the 1950s, dozens of colonies for mad prisoners were created in the country; some were bigger than many cities. One, the Complexo Psiquiátrico do Juquery in Franco da Rocha in the metropolitan region of São Paulo, held almost 30,000 inmates (Farias & Sonim, 2014).

In 1978, the year in which the contemporary psychiatric reform process began in Brazil, 97% of total psychiatric funding was used for psychiatric asylum beds (Cerqueira, 1984). About 80,000 places were on floor beds, meaning 80,000 people had to sleep on floors. The average hospital stay exceeded years; for example, in the Hospício Nacional de Alienados *(National Asylum for the Insane)* in Rio de Janeiro, currently Hospício Pedro II, a census was carried out revealing an average stay of 26 years (Andrade, 1982).

Over the years, as a result of the politics of the first non-military government, things changed. Psychiatric reforms lead to a unified health system, which even today defines national health policy founded on the principles of free and universal access, decentralization, social participation and control. Health councils were created with equal participation from municipal, state and federal management bodies holding regular meetings to prepare and monitor health policy. Mental health service users/recipients and family members have become actors in the debates and elect representatives for participation in politics with statements, presentations, and comments on the topics discussed.

In 1987, the Brazilian psychiatric movement identified with Réseau Internacional, a network of critical professionals around the Italian reform psychiatrist Franco Basaglia in the 1960s and 1970s (Elkaïm, 1979), and gave rise to the motto *For a society without asylums*. Activists from other areas of human rights defence were incorporated, and the concept of the asylum as the social and cultural practice of segregation and discrimination was criticized (Venturini et al., 2020).

In the late 1980s and early 1990s, several initiatives appeared. The first non-asylum and non-outpatient spaces were created, such as the Psychosocial Care Centers and the Social Co-operation and the Co-operation Centers. Among others, the reform movement and social participation grew around a potent National Anti-Asylum Movement. Besides the opening of these new systems, called "substitutes for the asylum model", some asylums were closed. In 2001, the Brazilian Law 10.216 was approved and constituted an important instrument for new Brazilian psychiatric reform. The backbone of this process was the existence of a strong social movement composed of thousands of activists from all parts of society; (ex-) users

of psychiatry, human rights activists, professionals, family members, and politicians. Hundreds of asylums have been closed, many thousands of psychiatric beds have been abolished, countless community and territorial services and care centres have been opened. This psychiatric reform was powerful enough to influence a series of cultural initiatives, such as several feature films and theatre plays, marches and public cultural acts, arts exhibitions, diverse cultural events such as a Museum da Loucura *(Museum of Madness)*, a Festival of Loucura *(Festival of Madness)*, and political action from the Ministry of Culture for people in psychological distress such as Loucos pela Diversidade *(Mad in Diversity)* (Torre, 2018). Throughout this period, several music groups, theatre companies, carnival blocks and samba schools, radio stations and community TV were created; all were activities with people calling themselves mad people and (ex-) users or survivors of psychiatry.

However, the application of the principles set out in the laws has been very difficult, partly because of the historical predominance of the asylum model, with roots that penetrate culture and social tradition, and partly because of the strong resistance of the sectors interested in maintaining the system with its use of force and human rights violations. Such sectors are composed, in particular, by psychiatric associations that, very often, are led by psychiatric entrepreneurs themselves, i.e., by organisations that make psychiatric treatment a commercial business. And, not least, the resistance came from mainstream psychiatry’s attempts to maintain the medically centered hierarchy. With the exception of Brazil, it has been very difficult to close asylum institutions in other countries in Latin America, as well as to open humanistically orientated services and resist the medicalizing and pathologizing model of psychiatry, which is strongly influenced and financed by pharmaceutical firms.

Therefore, in 2017, as a result of an initiative of the Brazilian Mental Health Association, a network of human rights and mental health was organized in Latin America and the Caribbean. The network arose from the need to build a body of social support for implementing laws and the creation of new social and political practices in mental health. With the exchange of experiences among network participants, innovative and remarkable experiences have been made possible, especially aimed at the participation and protagonism of (ex-) users and survivors of psychiatry, such as self-help groups, artistic and cultural activities, initiatives to create jobs and earn money, and social participation. But despite all the social movement existing in Brazil, Argentina or Uruguay, the biopsychosocial paradigm of mental illness with its stereotype of public dangerousness, unpredictability and need for treatment, was not criticised.

For several decades, there have been movements in Brazil to criticise psychiatry and medicalisation. Although there have been many events to criticise the latter, such as the various congresses and seminars on the "rational use of medicines", positive results are hardly visible. It is important to highlight important initiatives, such as that of the Brazilian Society of Medicines Vigilance, the "Forum on medicalisation of education and society", and the "Support and Monitoring Centre for Learning". The "Despatologiza" *(Depathologize)* movement, born in the University of Campinas, is the protagonist of important initiatives, amongst which is the establishment of a protocol for the prescription of methylphenidate (trade names Concerta, Medikinet, Ritalin, etc.) – many thousands of pills are no longer consumed by children diagnosed with ADHD (Moysés & Collares, 2018).

Experiences of overcoming the use of prescribed psychotropic drugs (psychiatric drugs), and even more the

knowledge of how to deprescribe and/or withdraw from them without risk and how to help in the withdrawal process are poorly promoted or almost non-existent. As mentioned at the outset, psychiatric reforms in Brazil may differ from reforms in other countries of the Global South: The dominance of biologically oriented psychiatry exists here as well as there, and presumably this is also the case in middle- and high-income countries (Lehmann, 2021). Psychiatric drugs are administered, but no help is offered in discontinuing them.

The proposal known as Autonomous Medicines Management, for example, does not trigger questioning the use of prescribed psychotropic drugs. It can serve, in part, to adapt the users of psychiatric drugs to the controlled use of them, without problematizing the lack of information about their toxic effects, about the risk of physiological and secondary psychological dependence, about withdrawal symptoms, about alternatives, about the higher recovery rates in rural areas of developing countries with their reduced availability of "effective" synthetic psychiatric drugs compared with the rates in the so-called First World with its modern drugs, and about the higher mortality rate by an average of two to three decades of people with certain psychiatric diagnoses (and drug treatment) compared with the general society.

Finally, initiatives to support withdrawal from psychiatric medication are practically non-existent, restricted to medication self-management projects; these are mostly dedicated to managing the consumption of psychiatric drugs rather than ending it. There is no entity or organisation that does this systematically, such as the International Institute for Psychiatric Drug Withdrawal (IIPDW).