Dr Yolande Lucire Website: http://www.drlucire.com
PhD MBBS DPM FRANZCP (1971-2011) [redacted]
FORENSIC & MEDICO-LEGAL PSYCHIATRY Provider No. 0012 809B
AKATHISIA CLINIC
[redacted]

5/7/19

Dear Commissioners,

if I had had more time, I might have been able to make this shorter. I apologise for the typographical errors.

I have worked on this for a long time however recently I have had a 12 week bout of pneumonia. My husband has had a second stoke which rendered him blind and he demands my care leaving me with insufficient time to do justice to this appalling problem which does fit into your terms of reference concerning best practice and prevention of suicide.

William Osler the famous Canadian physician said

'Listen to your patient he is telling you the diagnosis'

I am able to come to Victoria at very short notice and answer any questions that the commission wants to ask me.

Yours sincerely,

Yolande Lucire

CURRICULUM VITAE updated April 2019
Dr Yolande Lucire
PhD MBBS (1964) DPM (1967) (FRANZCP 1971-2011)
Forensic & Medico-Legal Psychiatry
Website: www.drlucire.com

Most papers are available in full on the website.

Senior Research Associate: Department of Government and International Relations, University of Sydney. (no longer)
Conjoint Senior Lecturer in Rural Health, 2003-2005.

Qualifications

2011 Certificate of competence in safety pharmacogenomics Karolinska Institutet Stockholm, Sweden.
1996 PhD UNSW Public Health Medical Anthropology History of Psychiatry, Ethics and in History and Philosophy of Science
1970-2011 Member then Fellow, Royal Australian & New Zealand College of Psychiatrists
1967 Diploma of Psychological Medicine, London
1964 MB BS, University of Sydney

Work:

2008 to present: mainly research into medication induced causes of death, suicide and homicide and conditions leading to them and the costs of mental health

2009 - 2011 Medico-legal psychiatry related to workers' compensation claims and research into genetic links to adverse reactions to psychiatric drugs.

1972 - 2008 Private practice, originally child and family, psychotherapy then general, forensic and medico-legal psychiatry in Sydney; medico-legal work relating to psychiatric defences in criminal proceedings and workers' compensation/personal injury claims; research resulting in the papers listed below.

2001 - 2006 Conjoint Senior Lecturer, Psychiatry, Rural Medical School.

1997 - 2005 Consultant Psychiatrist, Nolan House, Albury.

1994 - 1995 Consultant Forensic Psychiatrist, London, Devonshire Place.

Locum Consultant Psychiatrist: East Ham Memorial Hospital.

Fellow: Wellcome Institute for the History of Medicine. (Completing PhD).

1983 -1994 then 1996 Senior Forensic Psychiatrist, Consultant to Department of Corrective Services NSW, and Long Bay Prison Hospital.

1972 - 1980 Consultant (VMO) South Sydney Hospital, (including Rehabilitation) Psychiatrist, Rozelle Hospital, Sydney.

1972 - Present Consultant Psychiatrist in private practice, Sydney.

1967 - 1972 General Practice.

1968 - 1970 Senior Registrar in Child Psychiatry, Royal Alexandria Hospital for Children.

1967 Registrar, Sutton & Belmont Hospital, Surrey, UK.

1965 SRMO, Netherne Hospital, Surrey, UK.

1964 RMO, Prince Henry Hospital.

Book: Constructing RSI: Belief and Desire, UNSW Press, 2003

https://www.lrb.co.uk/v26/n01/carl-elliott/scriveners-palsy

Recent invited speaker invitations

1) Pathology Update conference The Power of Personalised Pathology
Pathology, Update. 22-24 February, 2019 Melbourne Convention Centre South Wharf Melbourne. From Personalized Medicine to Personalized Justice: the promises of translational pharmacogenomics in the justice system

2) IATDMCT International Association of Therapeutic Drug Monitoring and Clinical Toxiclogy: Anti depressants leading to akathisia in poor metabolisers. Top Science Down Under/ 16-19 September 2018.

Other recent presentations

3) The Australian Academy of Forensic Sciences Plenary Session May 16, 2018. From Personalized Medicine to Personalized Justice: the Promises of Translational Pharmacogenomics in the Justice System
4) **HPARA (Health Practitioners of Australia Reform Association) CONFERENCE - 26 May 2018** How medication-induced catastrophes were covered up at the HCCC, Medical Board & NSW Health: A whistle blower's tale of reprisals.
5) RANZCP Forensic Psychiatry Conference Sep 06 - 08, 2018 Poster Respiratory Collapse, Genetic Pharmacology & Protecting the Public.

Publications in peer reviewed medical and forensic journals

6) Lucire Y Crotty C Eikelenboom S Critique of Ekhart et al. (in press)
7) 2017 Cole, S., Polasek, T. M., Perera, V., & Lucire, Y. Do drug interactions in CYP poor metabolizers increase the risk of serious adverse effects to zolpidem?. (Citation)
8) 2016 Polasek, T. M., Perera, V., & Lucire, Y. (2016). Serious adverse drug reactions to zolpidem: does impaired metabolic clearance and concurrent SSRI/SNRI use increase risk?. Journal of Pharmacy Practice and Research, 46(2), 139-142. http://onlinelibrary.wiley.com/doi/10.1002/jppr.1176/full
9) 2016 Ng, L., & Lucire, Y. (2016). Distilling ethics, compassion, science and the art of medicine. BMJ, 355, i6510. http://www.bmj.com/content/355/bmj.i6510
10) 2016 Lucire, Y. (2016). Pharmacological Iatrogenesis: Substance/Medication-Induced Disorders That Masquerade as Mental Illness. Epidemiology (sunnyvale), 6(217), 2161-1165. https://www.researchgate.net/publication/299355176_Pharmacological_Iatrogenesis_SubstanceMedication-Induced_Disorders_That_Masquerade_as_Mental_Illness (full text available)
11) 2016 Loonen, A. J., & Verkes, R. J. (2016). Comments on Lucire and Crotty, 2011. Pharmacogenomics and personalized medicine, 9, 85. 2016 Lucire, Y. (2016). Comments on Lucire and Crotty, 2011 Reply. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4993408/
12) 2016 Eikelenboom-Schieveld, S. J., Lucire, Y., & Fogleman, J. C. (2016). The relevance of cytochrome P450 polymorphism in forensic medicine and akathisia-related violence and suicide. Journal of forensic and legal medicine, 41, 65-71. http://www.jflmjournal.org/article/S1752-928X(16)30005-1/fulltext
13) 2011 Lucire, Y., & Crotty, C. (2011). Antidepressant-induced akathisia-related homicides associated with diminishing mutations in metabolizing genes of the CYP450 family. Pharmacogenomics and personalized medicine, 4, 65. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3513220/
14) 2010 Wong, S. H., Happy, C., Blinka, D., Gock, S., Jentzen, J. M., Donald Hon, J., ... & Neuman, M. G. From personalized medicine to personalized justice: the promises of translational pharmacogenomics in the justice system. Pharmacogenomics, 11(6), 731-737.
15) https://www.researchgate.net/profile/Kiang-Teck_Yeo/publication/226043685_From_Personalized_Medicine_to_Personalized_Justice_The_Promises_of_Translational_Pharmacogenomics_in_the_Justice_System/links/0c9605306544ba6ffa000000/From-Personalized-Medicine-to-Personalized-Justice-The-Promises-of-Translational-Pharmacogenomics-in-the-Justice-System.pdf

16) 2001 Sex and the practitioner: The Victim Presented at the Plenary Session of the Australian Academy of Forensic Sciences September 11, 2001. Australian Journal of Forensic Sciences. Vol. 34 no.1 18-22.
17) 2002 Lucire, Y. (2002). Sex and the practitioner: The victim. Australian Journal of Forensic Sciences, 34(1), 17-24. https://www.drlucire.com/dr-lucire-publications-submissions--media.html
18) 2001 The Bearing of Daubert on Sexual Abuse Allegations. Journal of the Australian Academy of Forensic Sciences. Vol 32, No. 245-59, 2001. https://www.drlucire.com/dr-lucire-publications-submissions--media.html
19) 1986 Neurosis in the Workplace. 1986 Medical Journal of Australia 145: 323-7. This paper has been given many citations both in medical and in social science journals. https://www.drlucire.com/dr-lucire-publications-submissions-- https://www.drlucire.com/dr-lucire-publications-submissions--media.html
20) 1975 Lucire, Y. (1975). Factors influencing conception in women seeking termination of pregnancy. A pilot study of 100 women. The Medical journal of Australia, 1(26), 824-827. https://www.drlucire.com/dr-lucire-publications-submissions--media.html

PhD 1996

1996 PhD, Ideology and aetiology: RSI an epidemic of craft palsy. This multidisciplinary humanities PhD was written in the Department of History and Philosophy of Science and was examined in public health, medical anthropology and history of medicine and reviewed by an ethicist.

> The reviews:
> Professor Arthur Kleinman
> Department of Anthropology
> Wm. James Hall 330 Harvard University
> CAMBRIDGE, MA 02138
> USA February 1997
> Re Ideology and Aetiology: RSI, an Epidemic of Craft Palsy
> This is a scholarly dissertation, written with great clarity and including an impressive review of several literatures: RSI, writers' block, somatization, etc. The last is about as well reviewed as I could have hoped. The central argument is advanced with considerable empirical support from the research literature. It is an argument for the role of cultural and social research in clinical and policy settings as much as for psychiatry's role in assessing an epidemic of functional complaints.

The idea of collective experience of functional symptoms receives a good deal of support in the dissertation. This is an important advance over the great emphasis routinely given the individual level of analysis. The author reviews this as well as linguistic, gender, and political aspects of expressing the problem. The issue at hand is the iatrogenic creation of moral pain and shared illness complaints owing to medical, union, and other social activities. This social genesis not only explains this case study but a number of other instances of collective sickness as well. It is nicely grounded in anthro studies.

The thesis builds very effectively from classical medical sociological accounts to the ideas of medical history, and clinical and social science assessment. The fact that the author is herself a protagonist in the Australian epidemic lends poignancy to the dissertation. The critical review and analysis impresses me as original, scholarly and compelling. I have no problem whatsoever with the methodology or findings. The

interpretation for my interests is perhaps too focused on political economic issues and cultural matters. In fact, what is most impressive about this account is the attempt to relate RSI to larger contextual social forces. It is surprising in this regard not to read much mention of the role of the 'state'.

I think this thesis would be accepted in most Departments of Anthropology and Social Medicine in the U.S., indeed it should be published as a monograph. I give it a high recommendation. The analysis is critical, balanced, and focused on the key questions. This thesis should be published.

21) Edward Shorter PhD
Faculty of Medicine
University of Toronto
CANADA

Re Ideology and Aetiology: RSI, an Epidemic of Craft Palsy
I found this thesis most impressive and I unconditionally recommend its acceptance.
This thesis takes a scholarly look at the epidemic of 'Repetition Strain Injury" (RSI) that affected Australia during the l980s, placing the epidemic in the context of writing on international patterns of epidemic hysteria and of Australian medical politics and labour relations. The author's conclusion, that RSI represented a combination of suggestibility on the part of sufferers, self-serving aggrandisement on the part of some members of the medical profession, and a Labour-relations strategy on the part of the unions strikes me as well born out by the facts. Lucire has reconstructed this story on the basis of primary sources, has set it within the framework of medical sociology, and has told it in a literate and lively manner. That the author herself had a partisan role in the events she describes does not detract from the scholarly value of the thesis: Given the research she had done, I think it would be difficult to come to any conclusion other than the one she reaches.
The dissertation represents that rather rare bird, a scholarly study that has the ability to make a considerable impact on public policy and discussion. A triumph of original scholarship and thought, it deserves to be published as a book. Lucire's work should have a considerable impact on the debate about such vexing conditions as RSI, both in Australia and abroad.

22) Dr Stephanie Short
School of Health Services Management
University of NSW
Sydney, AUSTRALIA

Re Ideology and Aetiology: RSI, an Epidemic of Craft Palsy
This is a fascinating iconoclastic thesis. The first chapter provides a very good overview and analysis of the relevant literature in the social studies of science, and of key developments and insights in medical sociology. It draws in particular on insights from labelling theory, and from the work of Parsons, Freidson and Navarro, with emphasis on the role of physicians as moral entrepreneurs. The thesis draws also on the work of the libertarian/anarchist, Ivan Illich.
In my view this thesis makes an original contribution to our academic understanding of the social construction of medical knowledge, through analysis of the case study of RSI. The case study reveals how certain trade union officials, Federal government agencies and a handful of doctors constructed, albeit unwittingly, the epidemic of repetitive strain injury in Australia in the

l980s. The insights about the political and social context within which the occupational health and safety movement developed are particularly fascinating and convincing.
The thesis reveals a more than respectable knowledge of the injury and somatization paradigms in occupational health and safety, and makes a convincing case for an alternative explanatory perspective which posits that RSI can be understood as a socially constructed epidemic, or as an example of cultural iatrogenesis. The implications of this thesis for ethical medical practice and for the funding and organisation of health care are immense. This has clearly been a very costly epidemic for many involved, both in human and financial terms. And professional and other empires have been built on it.
(I have put these in because the Medical Council appears to believe that I wrote a PhD in philosophy.)

Submissions and Conference Papers and Reports to which Dr. Lucire contributed:

23) 2017 RANZCP Forensic section Fremantle conference . The relevance of cytochrome P450 polymorphism in forensic medicine and akathisia-related violence and suicide. Journal of forensic and legal medicine, 41, 65-71.
24) 2009 Expert Report on 92 of Dr. Lucire's cases. REPORT OF THE PSYCHIATRIC DRUG SAFETY EXPERT ADVISORY PANEL This report confirmed causes of the suicide that I had been reporting to NSW Medical Board of NSW since 1997 which have been attributed to "standard psychiatric practice" and not investigated. https://www.tga.gov.au/sites/default/files/alerts-medicine-ssri-pdseap-091224.pdf
25) 2012 The Empathic Therapy Conference 2012, The Conference of the Center for the Study of Empathic Therapy, Education & Living, Syracuse NY, March 2012. Invited speaker, plenary session: Akathisia homicides. https://www.youtube.com/watch?v=IEoSs6Yo0DA
26) 2012 The Australia and New Zealand Association of Psychiatry, Psychology and Law, Conference, 'Evolving Paradigms in Forensic Practice,' Melbourne, November 2012. Paper: Failure of regulators. See enclosed
27) 2012 Pharmacogenomics and Psychiatry Conference, New York, March 2012. 2 Posters on Do street drugs cause schizophrenia and part of Lucire and Crotty
28) 2012 Human Genome Meeting 2012. Darling Harbour, Sydney Homicides under mental health care
29) 2012 Human Genome Meeting 2012. Do street drugs cause schizophrenia? Why do some people think they do.
30) 2010 Re-focussing Upstream: New Psychiatric Drugs, Genetic Polymorphisms and Public Health. Prepared For Submission Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals. (Garling Inquiry. This was ignored on the basis that "the health department does not agree with her.")
31) 2010 The Hidden Toll: Suicide in Australia Submission to Senate Suicide Inquiry 2010 on the Prevalence of Medication-Induced Suicide and its Relationship to Demand for Services and Public Health. SUBMISSION.
32) 2010 Editorial: From personalized medicine to personalized justice: the promises of translational pharmacogenomics in the justice system Wong SH, Happy C, Blinka D, Gock S, Jentzen JM, Donald Hon J, Coleman H, Jortani SA, Lucire Yolande, Morris-Kukoski CL, Neuman MG, Orsulak PJ, Sander T, Wagner MA, Wynn JR, Wu AH, Yeo KT. Pharmacogenomics. 2010, Jun;11(6):731-7.
33) 2009 Report of the Psychiatric Drug Safety Expert Advisory Panel, 24 December 2009. This investigation was conducted on 90 of Dr. Lucire's 90 reported cases of suicidal and homicidal akathisia in 2007.

34) 2009 Genetic Polymorphisms, Antidepressants, Akathisia Homicide and the Crisis in Mental Health: Prototype for a Project to Provide Adequate Defences. Poster at The Bureau of Crime Statistics and Research's 40th Anniversary Symposium, 18 – 19 February 2009.
35) 2009 CYP450 TESTING MAY BE ESSENTIAL IN PSYCHIATRY. Presented at ASCEPT conference 2009. During 2003-4 193 reports were made to ADRAC from one Health Area of persons who were akathisic and suicidal, homicidal, hallucinated and violent on new antidepressants and atypicals and required hospitalization. A clinically identical sample of 72 was tested for CYP450 genes and 66 had diminished CYP450 capacity (16 homozygous PMs, 16 compound heterozygous PMs, and 34 a huge increase in multiple mutations over non clinical populations). Psychiatric drugs have a narrow therapeutic window, and are ineffective below and both toxic and ineffective above that blood level. Diminished Metabolizer status has the same clinical consequences as overmedication and as co-prescribing of inhibitors and competing substrates. The side effects seen are those listed in Product Information (PI). Testing the other 191 seems to be a matter of urgency, so they do not again develop these conditions, which seem more dangerous when they occur for the second or third time, unheeded. Acknowledgement of thanks to Healthscope Molecular and Diversity Health Institute Research Laboratory for testing.
36) 2008 Submission To Commonwealth Minister of Health concerning the implementation of the Deloitte report commissioned by the Australian Centre for Health Research. Improving the Quality Use of Medicines in Australia; Realising the Potential of Pharmacogenomics, October 2008. http://www.tga.gov.au/alerts/medicines/pdseap-report2009.htm
37) 2016 submission to Senate inquiry The Senate Community Affairs References Committee Medical complaints process in Australia
38) https://www.google.com.au/search?source=hp&ei=bwWGWqOTK4Oc8QXKlZ2YCQ&q=Senate+Regulators+LUCIRE&oq=Senate+Regulators+LUCIRE&gs_l=psy-ab.3...10325.18813.0.19439.24.22.0.2.2.0.239.3482.0j14j4.18.0....0...1c.1.64.psy-ab..4.17.2937...0j0i131k1j0i10k1j0i22i30k1j33i21k1j33i160k1.0.pUfXy5wKh8g
39) Community Affairs References Committee
40) Complaints mechanism administered under the Health Practitioner Regulation National Law.
41) May 2006 Review of Inquiry Into Complaints Handling In NSW Health Organisation:
42) Forensic & Medico-Legal Psychiatry, Akathisia Clinic Dr Yolande Lucire Submissionhttps://www.scribd.com/document/2220637/Review-Of-Inquiry-Into-Complaints-Handling-In-NSW-Health https://www.parliament.nsw.gov.au/committees/DBAssets/InquirySubmission/Body/47187/sub%2011.pdf
43) A Senate Inquiry 2016 – 2017 submission
44) Submission 87 ...Complaints mechanism administered under the Health Practitioner Regulation National Law Co submitted to the Council of Australian Governments (COAG) Health Council
45) AN INDIVIDUAL NON-CONFIDENTIAL SUBMISSION BY Yolande Lucire
46) 2011 Submission Select Committee on Youth Suicides in the NorthernTerritory
47) https://parliament.nt.gov.au/__data/assets/pdf_file/0009/366408/Sub-No.-16,-Dr-Yolande-Lucire,-Part-1,-30-Sept-2011.pdf
48) 2007 Review to Improve Transparency of the Therapeutic Goods Administration (TGA https://www.tga.gov.au/sites/default/files/review-tga-transparency-1101-submission-yolande-lucire.pdf
49) 2008 Submission to Commission of Inquiry: Acute Care Services in NSW Public Hospitals on the prevalence and costs of adverse drug reactions to the health service: focus on psychiatric drugs and Vioxx.

50) 2006 Impacts of Medical Technology in Australia, Australian Government Productivity Commission. Mr. Gary Banks, Chair, Submission Impacts of Medical Technology in Australia, Australian Government Productivity Commission http://www.pc.gov.au/inquiries/completed/medical-technology/submissions/subpr047/subpr047.pdf. https://www.pc.gov.au/inquiries/completed/medical-technology/submissions/subpr047/subpr047.pdf
51) 2007 Lucire, Y. (2007). New Drugs New Problems. Australian & New Zealand Journal of Psychiatry, 41(1_suppl), A52-A52.
52) 2006 The Effects of Pharmaceutical Industry Fraud, and the Texas Medication Algorithm Project on Mental Health Costs And Demand, RANZCP Conference, Gold Coast, 2006.
53) 2005 The Ethics of the Solitary Empiricist: How Pharmas Changed Common Human Unhappiness into a Deficit Disease. Blackheath Philosophy Forum, May 9, 2005.
54) 2005 Pharma Fraud, Pharmacological Iatrogenesis and the Crisis In Mental Health. Precedent: (the Law Magazine) 2005.
55) 2005 New Drugs New Problems: PowerPoint, presented Section of Forensic Psychiatry, April 9, 2005.
56) 2005 Lucire, Y. (2005). New drugs, new problems. Australian Journal of Forensic Sciences, 37(1), 9-25.
57) 2005 Lucire, Y. (2005). Do SSRIs Induce Suicide? Australian and New Zealand Journal of Psychiatry, 39, A147.
58) 2005 Lucire, Y. (2005, December). Do SSRIS induce suicide: A Daubert hearing. In AUSTRALIAN AND NEW ZEALAND JOURNAL OF PSYCHIATRY (Vol. 39, pp. A147-A147). 9600 GARSINGTON RD, OXFORD OX4 2DQ, OXON, ENGLAND: BLACKWELL PUBLISHING.
59) 2005 Effects of Second Generation Antidepressants and Antipsychotics on Mental Health Services in Australia. Royal Australian and New Zealand College of Psychiatrists 40th Conference, Convention Centre, Sydney 22 to 27 May, 2005.
60) 2005 Akathisia and Crime: Product Liability Issues. Royal Australian and New Zealand College of Psychiatrists 40th Conference, Convention Centre, Sydney 22 to 27 May, 2005.
61) 2004 Submission to Complaints Handling Inquiry NSW Department of Health. http://www.scribd.com/doc/2220637/Review-Of-Inquiry-Into-Complaints-Handling-In-NSW-Health
62) 2004 SSRIs: Do they cause suicide? The Science: Daubert Admissible Evidence. Australian Academy of Forensic Sciences, May 19, 2004. Also presented at International conference of Medical Law, Sydney, 2004.
63) 2004 SSRIs and their effects on Mental Health Presentations: A plausible Hypothesis, (PowerPoint). Presented at RANZCP Forensic Section Conference October 2004, Fremantle.
64) 2004 Do Second Generation Antidepressants Cause Suicide? A Daubert Hearing. Health, Australian Journal of Forensic Sciences. May 19, 2004.
65) 2003 The Use of Textual Analysis in Differentiating True from Fabricated Sex Abuse Allegations. (PowerPoint). Presented at RANZCP Forensic Section Conference October 2003, Geelong.
66) 2003 SSRIs: Forensic Issues. Risk Benefit Analysis and Potential for Litigation In Australia. Duty To Warn? (PowerPoint presentation). Presented at RANZCP Forensic Section Conference, October 2003, Geelong.
67) 2003 Lucire, Y. (2003). Is Confabulation Legitimate Evidence?. Australian and New Zealand Journal of Psychiatry, 37, A24-A25
68) 2002 Submission To: Proceedings Before Standing Committee on Law and Justice Inquiry Into 2002 Child Sexual Assault Matters. At Sydney on Friday 10 May, 2002.

69) 2002 Submission to IPP Inquiry: Review of the Law of Negligence: http://www.google.com.au/search?q=cache:fLSVEzzxGHQJ:www.pc.gov.au/inquiry/workerscomp/subs/sub102.rtf+negligence+Lucire&hl=en&start=4&ie=UTF-8 (no longer accessible).
70) 2002 New Drugs New Problems Medico-political Expose of the Suicide Crisis in Mental Health, Australian Journal of Forensic Sciences.
71) 2002 Lucire, Y. (2002, December). Confabulation and other pathologies of belief. In AUSTRALIAN AND NEW ZEALAND JOURNAL OF PSYCHIATRY (Vol. 36, No. 6, pp. A27-A27). 54 UNIVERSITY ST, PO BOX 378, CARLTON, VICTORIA 3053, AUSTRALIA: BLACKWELL PUBLISHING ASIA.
72) 2002 Confabulation: Forensic Issues. ANZAPPL Conference July 2002, Darwin.
73) 2002 Comparison Codes Medical Practice Act and Common Law. Whither 200 years of due process? Australian Journal of Forensic Sciences. Vol 34, No.1, 22-24, 2002.
74) 2001 Towards A Taxonomy of Confabulation RANZCP Conference Brisbane June 2001.
75) 2001 The Social Construction of the War Neuroses: Are We Being Served? Commissioned paper for 11th Brigade Senior Medical Officers Conference, 14 July, 2001, Townsville Presented again, RANZCP Forensic Section Conference, 2001. Published in BMJ online. http://www.bmj.com/cgi/eletters/322/7278/95
76) 2001 Politicising Medicine and Medicalizing Industrial Relations (repeated) RANZCP Forensic Section Conference, 2001.
77) 2001 Lucire, Y. (2001). Constructing RSI: Belief and Desire.
78) 2001 Health Status and Predicament in Claimants for RSI 1986-1992. RANZCP Forensic Section Conference, 2001.
79) 2000 The Politicization of Medicine and the Medicalization of Industrial Relations. Presented at Garran and Baxter conference on Psychological Injury.
80) 2000 PhD. Ideology and Aetiology: RSI: an epidemic of craft palsy.
81) 2000 Lucire, Y. (2000). The Bearing of Daubert on Sexual Abuse Litigation. Australian Journal of Forensic Sciences, 32(2), 45-59.
82) 2000 How to do a Sex Abuse Evaluation. RANZCP Conference Forensic Section, June 2000, Port Douglas.
83) 2000 Constructing RSI: Belief and Desire. BMJ: British Medical Journal, 328(7435), 354.Book review
84) 2000 Comparative Analysis of Paradigmatic Assumptions of the True Believers and The Sceptics contributing to Moral Panic about Child Sexual Abuse. Published on website at www.lucire.com.au
85) 200 Submission to Productivity Commission on adverse responses to antidepressants and the increase in demand for mental health services. http://www.pc.gov.au/__data/assets/pdf_file/0003/17814/subpr047.pdf
86) 1996 The Narcissist in the Culture of Compensation. Presented 1992 RANZCP Conference, Brisbane.
87) 1996 The five-colour theorem: A model to elucidate the components of illness, disease and morbidity. Presented at Philosophy and Psychiatry Conference, 1996.
88) 1996 Square Pegs in Round Holes: A Comparison of Medical & Legal Concepts of "Causation" in Epidemic Neurosis, using the epidemic of RSI Proceedings of Conference of the Medico-legal Society of Victoria. Kotakinabalu, 1986.
89) 1993 Medea - Anatomy of a Multicide. Journal of the Australian Academy of Forensic Sciences. December 1993.
90) 1993 Lucire, Y. (1993). Medea: Perspectives on a Multicide. Australian Journal of Forensic Sciences, 25(2), 74-82.
91) 1991 The NSW Mental Health Review Tribunal, first seven years of operations. Presented RANZCP Forensic Section Conference November 15-20, 1991.

92) 1991 Life events and getting sick with "RSI." Presented RANZCP Forensic Section Conference November 15-20, 1991.
93) 1990 The Role of the Psychiatric Assessor in Personal Injury Claims. Presented at RANZCP Forensic Psychiatry Conference Leura, November 1990.
94) 1990 Darke, S., Hall, W., & LUCIRE, Y. (1990). THE INJECTING AND SEXUAL BEHAVIOUR OF INTRAVENOUS DRUG USERS. Medical journal of Australia, 153(7).
95) 1990 Chronic Fatigue Syndrome: What is a disease? Debate with the Prince of Wales Hospital, Presented in November 1990, at the Institute of Psychiatry in NSW, for Continuing Medical Education.
96) 1989 Analysis of the Function of the Expert, in "The Expert Witness Self- Examined" in book, The Expert Medical Witness, Federation Press 1989.
97) 1988 Social Iatrogenesis of Epidemic Neurosis. (RSI) Journal of Community Health Studies XX (2) 1988.
98) 1988 Lucire, Y. (1988). A reply to Dr Russell. Australian and New Zealand Journal of Public Health, 12(2), 140-143.
99) 1986 Workers' Compensation: A New Approach: Submission to writers of white paper on workers' compensation in NSW, 1986. (Unpublished).
100) 1986 Theory and Philosophy of Assessment: An analysis of the sources of variance in expert opinion evidence. Forensic Psychiatry Bulletin, 1986.
101) 1986 RSI, an Epidemic of Craft Palsy. A chapter commissioned by Dr. (now professor) Professor Ivor Jones, then Snr. lecturer in Psychiatry, Melbourne University, for text book, "Essentials of Australian Forensic Psychiatry," 1986. (This book was never published).
102) 1986 Resistance to paradigm shift, The Injury Theory versus the Psychosocial Model of Causation in Epidemic RSI. Read at RANZCP Annual Conference, May 1986. Analysis of sources of resistance to the psychosocial model.
103) 1986 Repetitive Strain Injury - An Epidemic of Craft Palsy. Proceedings of the Medico-Legal Society of NSW. Vol. 8, pages 134-146.
104) 1986 Lucire, Y. (1986). RSI: When emotions are converted. Safety in Australia, 9, 8-12.
105) 1986 Lucire, Y. (1986). Neurosis in the workplace. The Medical Journal of Australia, 145(7), 323-327.
106) 1986 Lucire, Y. (1986). Angry debate as psychiatrist claims RSI is in the mind. The National Times, 9.
107) 1986 Institutionalised & Rewarded Neurosis: RSI, the Australian Disease. Australian Institute of Management Journal, April 1986.
108) 1986 Differential Diagnosis of Conversion. Read at RANZCP Annual Conference, May 1986.
109) 1985 When emotions get converted. On the genesis of RSI as Conversion Disorder Safety Australia, Feb. 1986. Read at Medical Mythology conference, November 1985.
110) 1985 The Use of Proforma for Disability Evaluation. Unpublished but widely read. Presented RANZCP conference, Hobart, May 1985.
111) 1985 The First Forensic Interview, "RSI" - the Use of a Pre-Printed Proforma. Presented November 1985 and available in video from the Institute of Psychiatry, Rozelle Hospital. Also available in print.
112) 1985 Lucire, Y. (1985). What the community can do about epidemic conversion. In RSI: Medical Mythology seminar. Organized by Social Impacts Pty Ltd, Sydney (Vol. 21).
113) 1985 Lucire, Y. (1985). Neurosis in an occupational setting. RSI: Medical Mythology, Social Impacts.
114) 1983 Lucire, Y. (1983). 2 New Laws-the Administrative Appeals Tribunal And Freedom Of Information Act. Social Alternatives, 47.

115) 1982 The Medical Evidence in the First 50 Administrative Appeals Tribunal Decisions. Legal Service Bulletin, Dec. 1982. (Australian) Analysis of the difficulties of evaluation of Invalid Pension applicants.
116) 1982 The Adversary System or a Better Way? Read at the RANZCP Conference 1983. Prepared as a submission on the Invalid Pension problem for Senator Grimes in 1982.
117) 1982 Lucire, Y. (1982). Review of the First 50 AAT Decisions. Legal Service Bull., 7, 275.
118) 1981 Lucire, Y. (1981). I Fear the Greeks When They Bear Gifts. Legal Service Bull., 6, 34.
119) 1981 I Fear the Greeks. Legal Service Bulletin, Feb. 1981. A medico-political expose of Social Security Conspiracy (prepared originally for a conference of psychiatry and law but deemed sub-judice at the time). Submission to the Minister and Commission of Inquiry into Social Security Prosecutions. Associations of Forensic Psychiatry 1988-1993
120) Committee Member Australian New Zealand Association of Psychology, Psychiatry and the Law, NSW Branch. 2001-2005.
121) Council member, Australian Academy of Forensic Sciences, 2001- 2010
122) Fellow of the RANZCP, Member Forensic Section (Now resigned).
123) Member: International Centre for the Study of Psychiatry and Psychology (ICSPP).
124) Member: Healthy Skepticism (Countering false and misleading advertising by Pharma) http://www.healthyskepticism.org/global/about/us
125) Member: Australian Society for Clinical and Experimental Pharmacologists and Toxicologists. ASCEPT.

Speaking invitations

126) Invited Speaker Conference of the Medico-legal Society of Victoria. Kotakinabalu 1986. Square Pegs in Round Holes: A Comparison of Medical & Legal Concepts of "Causation" in Epidemic Neurosis, using the Epidemic of RSI as an example, Published in Proceedings.
127) Invited Speaker: Disease Mongering Conference, Newcastle, Australia, and April 2006. Constructing RSI: Iatrogenesis of an Epidemic.
128) Invited Speaker: Royal College of Psychiatrists Annual Conference, Glasgow, Scotland, 8th to 10th July 2006 Constructing RSI: Iatrogenesis of an Epidemic.
129) Invited Speaker: Conference, The Proliferation of Diseases that cannot be objectified. Fribourg, Switzerland, 14-15 September 2006. Constructing RSI: Iatrogenesis of an Epidemic.

Internet Communities membership

British Medical Journal (BMJ) alerts on Adverse Drug Reactions.
FDA alerts: warnings and advisories and changes to Product Information, weekly.
Biojest (Biojest is an invitation-only community dedicated to exposing pharmaceutical industry fraud. It comprises around 200 multidisciplinary professionals dedicated to sharing information and getting drug companies to tell the truth).
SSRI research, Antipsychotics research.
Pharmalot: http://www.pharmalot.com/news
Psych Rights: http://psychrights.org/index.htm
I receive about 60 informative emails each night as well as digests of new papers put together by Pharmaceutical Company interests.
I receive Google alerts on akathisia and pharmacogenetics.

I access Medline and Web of Science and communicate with others with similar interests. I have trained a Dutch doctor in USA in forensic pharmacogenetics and she is now writing a PhD.

Dr Yolande Lucire
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FORENSIC & MEDICO-LEGAL PSYCHIATRY
PERSONALIZED MEDICINE AND FORENSIC PHARMACOGENOMICS
AKATHISIA CLINIC
Provider No. 0012 809B
[redacted]
Website: http://www.drlucire.com
Email: [redacted]

I have read the Expert Witness Code of Conduct and agree to be bound by it, and I enclose my curriculum vitae. Relevant to this report are the following:

I have a Certificate in Safety Pharmacogenomics from the Karolinska Institutet Stockholm, Sweden, 2012.

I am the author of:

> Lucire, Y. (2005). **New drugs, new problems.** *Australian Journal of Forensic Sciences*, *37*(1), 9-25. http://psychrights.org/articles/newdrugsnewproblems.htm

I am a contributing author to:

> Editorial: From personalized medicine to personalized justice: The promises of translational pharmacogenomics in the justice system. Wong SH, Happy C, Blinka D, Gock S, Jentzen JM, Donald Honπ J, Coleman H, Jordan SA, Lucire Yolande, Morris-Kukoski CL, Neuman MG, Orsulak PJ, Sander T, Wagner MA, Wynn JR, Wu AH, Yeo KT. Pharmacogenomics. 2010, Jun; 11(6): 731-7. http://www.drlucire.com/uploads/4/0/2/1/40210161/from_personalized_medicine_to_personalized_justice.pdf

I am the principal author and researcher in:

> Lucire Yolande, Crotty C. Antidepressant-induced akathisia homicides associated with diminishing mutations in metabolizing genes of the CYP450 family. Pharmacogenomics and Personalized Medicine 2011:4 1–17. http://www.drlucire.com/uploads/4/0/2/1/40210161/antidepindhom_akcyp450_lucirecrot_2011.pdfw

I am the co-author of Do Street Drugs Cause Schizophrenia? Why Do Some People Think They Do?:

http://www.drlucire.com/do-street-drugs-cause-schizophrenia.html

I am a contributing author to:

> Eikelenboom-Schieveld, S. J., Lucire, Yolande., & Fogleman, J. C. (2016). The relevance of cytochrome P450 polymorphism in forensic medicine and akathisia-related violence and suicide. *Journal of forensic and legal medicine*, *41*, 65-71.

http://www.drlucire.com/uploads/4/0/2/1/40210161/relevanceofcyp450inforensics_eikellucrfogel_2016.pdf

I am a contributing author to:

Cole, S., Polasek, T. M., Perera, V., & Lucire, Y. Do drug interactions in CYP poor metabolisers increase the risk of serious adverse effects to zolpidem?. http://mm2015shpa.com/wp-content/uploads/2015/12/149-Cole-Samantha-Do-drug-interactions-in-CYP-poor-metabolisers-increase-the-risk-of-adverse-effects-to-zolpidem.pdf

I am the principal researcher and co-author of:

Polasek, T. M., Perera, V., & Lucire, Yolande. (2016). Serious adverse drug reactions to zolpidem: does impaired metabolic clearance and concurrent SSRI/SNRI use increase risk?. Journal of Pharmacy Practice and Research, 46(2), 139-142. http://onlinelibrary.wiley.com/doi/10.1002/jppr.1176/epdf

The following paper has been published gratis in a non-peer-reviewed journal. It needs to be judged by its reference base. I have been unable to get it taken down.

Lucire, Y. (2016). Pharmacological Iatrogenesis: Substance/Medication-Induced Disorders That Masquerade as Mental Illness. *Epidemiology (sunnyvale)*, *6*(217), 2161-1165. http://www.omicsonline.org/open-access/pharmacological-iatrogenesis-substancemedicationinduced-disordersthat-masquerade-as-mental-illness-2161-1165-1000217.pdf

I am the author of the response here: Comments on Lucire and Crotty, 2011:

https://www.dovepress.com/comments-on-lucire-and-crotty-2011-peer-reviewed-article-PGPM

Also relevant to my work at the following notifications: this

The United States Food and Drug Administration is withholding reports linking psychiatric drugs to homicides:

http://www.madinamerica.com/2016/05/the-fda-is-hiding-reports-linking-psych-drugs-to-homicides/

I am the author of the response to Dr Loonen

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4993408/

Yours sincerely,

Dr Yolande Lucire
Consultant Psychiatrist

Submission to the Royal Commission into Victoria's Mental Health System

Part I Summary

This submission addresses the terms of reference 1, 2.2, 2.4, 2.5.

It will address science based evidence published in peer reviewed journals high level Public Health Advisories that need to underpin practice, and invites the Royal Commission's attention on the sources of the problems with treatments administered in mental health services as practiced in Victoria and nationally. This submission provides detail and suggests remedies to improve services and outcomes and reduce costs.

Attention to evidence-based practice simultaneously addresses the prevention of suicide.

Attention prevents the creation of iatrogenic neurotoxic illness, of epidemic and apparently intractable substance/medication induced disorders.

Summary

The underlying problem with mental health outcomes [redacted].

Akathisia is a dangerous side effect of virtually all medication used in psychiatry, and it has a direct relationship to substance induced psychotic symptoms, suicide aggression and homicide and many forms of toxic behaviours. [1]

Publications about Medication induced suicide and homicide in peer reviewed journals go back to the 1950s, and were known to me from my 1960s undergraduate textbook.

Professor Sachdev's book, *Akathisia and Restless Legs* (Cambridge University press 1995) describes acute, chronic and subacute akathisia withdrawal and post withdrawal akathisia all of which are common on many psychiatric drugs. Professor Sachdev also suggests how such problems might be avoided: by informed and ethical practice.

I submit that his protocol would be an appropriate standard of care to endorse.[2] This protocol is only courteous common sense in prescribing any medication or treatment as every treatment has an attendant risk.

[redacted] refuse to inform themselves and do not accept the body of literature about akathisia and its relationship to medication-induced suicide, homicide, and violence. They seem to find it irrelevant that Australian prescriber information is one-third the size of that given to doctors in the United States, and they do not see how that redacted information contributes to negative mental health outcomes.

The standard for psychiatric practice is set by RANZCP and its problematic clinical practice guidelines (CPGs - see below)

These CPGs set the standard for the National Mental Health Commission in a circularity, as its leader, Professor Ian Hickie, is the lead signatory of these same guidelines). The Medical Board/Council of New South Wales, the NSW Health Care Complaints Commission, New South Wales Health, and at least one ombudsman have told me that the “College is the expert.”

My personal experience of Medical Board of Victoria both by proxy and personal is that it (along with NSW and AHPRA) also to declines to countenance complaints of suicidality and violence attributed to prescribing of medication.

A Google Scholar search of the terms “medication-induced suicide homicide” finds about 18,400 results. My co-authored paper, 'Antidepressant-induced akathisia-related homicides associated with diminishing mutations in metabolizing genes of the CYP450 family', Y. Lucire, C. Crotty, Pharmacogenomics and Personalized Medicine, 2011, leads this literature:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3513220/

Using the RANZCP and its ghost drafted clinical practice guidelines as “expert” defeats the sole purpose of National Medical Practice Acts. The only role of these Regulators and their state divisions is to protect the public. The cannot protect the public if the College and its ghost drafted CPGs are cited as “the expert.”

The RANZCP, Regulators of Medical Practice, state Boards and NSW Medical Council, AHPRA and policy makers such as the National Mental Health Commission have all been captured by the pharmaceutical industry through influential comprador psychiatrists dubbed “Key Opinion Leaders.”

By promoting RANZCP Guidelines as “the expert’ they protect members of the College and current practices. They do not protect the public.

Knowledge and understanding of the catastrophic consequences that mental health medications have on some people is not mentioned in clinical practice guidelines. Whether this was intentional of not is a matter for a court of law.

The legislation of all the regulators demands the use of an expert. With my publication record on medication-induced suicide, and my PhD, I am accepted as such an expert.

If one adds 'Lucire' to an Internet search of 'medication-induced suicide and homicide', my publications and the authors who reference them can also be found:

About 299 results
https://scholar.google.com.au/scholar?hl=en&as_sdt=0%2C5&q=medication+induced+suicide+homicide+lucire&oq=medication+induced+suicide+homicide+lucire

Supreme Courts in the United States and Australia, and the Therapeutic Goods Administration all accept my expertise.

The regulators - advised by the RANZCP - regard my concerns about antidepressant suicide (which are not shared by the HCCC, the College or its members nor by [redacted]) as “not yet psychiatric orthodoxy”, even as the outcomes for those receiving "standard psychiatric practice" have been fatal and/or catastrophic producing neuroleptic induced deficit syndromes or in DSM-IV, medication induced

dementia. Outcomes continue to worsen, as treaters and regulators ignore the literature on the causes of these outcomes.

'Akathisia suicide' on Google Scholar:

https://scholar.google.com.au/scholar?hl=en&as_sdt=0%2C5&q=Akathisia+suicide&btnG=

'Akathisia' on Google (about 24,600 results):

https://scholar.google.com.au/scholar?hl=en&as_sdt=0%2C5&q=Akathisia+&btnG=

This submission addresses the epidemiological consequences of not teaching prescribers and patients what they need to know about the pharmaceutical industry, about doing basic research on the Internet, about the drugs they prescribe, about suicide and violence, about epidemiology and the importance of accurate diagnosis

Published data available in the public arena revealed increased morbidity, (that being doctor-patient contacts) or demand for care and costs, increased youth and adult suicides and homicides within taxpayer-funded Mental Health Services in New South Wales and increased disability pensions and requirement for costly and frequently counterproductive medical treatments.

The origins of the dominant mental health care paradigm of the antidepressant era were identified in multiple forms: fraudulent promotion of drugs, biased education by drug companies, captured regulators, institutional ideologies, ghost-drafted clinical practice guidelines, poor quality product information and ineffective drug approval procedures that ensured neither safety nor efficacy.

Misreported clinical trial data for new antidepressants and atypical antipsychotics revealed undisclosed suicides, deaths and drop-outs in clinical trials demonstrating lack of safety and efficacy.

There have been increases in costs, demand, morbidity, suicide, homicide, deaths and disability under mental health care consistent with known adverse effects of medication.

Having examined and diagnosed some 700 cases of adverse drug reactions causing hospital admissions, suicides, violence I can confirm by providing 600 or more de identified reports, that the epidemic comprised of adverse drug reactions (ADRs) to medications. 95% were persons were misdiagnosed with “mental illness” only after medication. About 5% had mental illnesses before they were medicated. Both groups had adverse the same range of ADRs.

Information about safety and efficacy has been manipulated in favour of the pseudo-scientific ideology of the pharmaceutical industry.

Guidelines and drug reps recommend a “pill for every ill” and a “rescue medication” for each side effect.

Regulators and governments remain in denial although this public health problem is in plain sight and in the public arena.

Misinformation has resulted in prescribing practices that produced an epidemic of akathisia-related suicide and homicide as well as substance/medication-induced conditions mimicking the mental illnesses that the drugs were supposed to cure or prevent.

Information about safety and efficacy has been manipulated in favour of the pseudo-scientific ideology of the pharmaceutical industry.

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[1] Neuroleptic-induced Acute Akathisia and substance/medication-induced disorders

Neuroleptic induced Acute Akathisia is a fluctuating can't-sit-down restlessness associated with suicide and homicide since 1964 and with aggression, suicide attempts, toxic hallucinosis and behavioural dyscontrol.

DSM-IV since 1994 states that Serotonin Reuptake Induced akathisia has the same associated features suicide attempts, aggression, toxic psychotic complications, (or de novo psychosis in person who had nor been psychotic before being treated) and behavioral dyscontrol.

DSM-5 has introduced Medication-induced acute and tardive akathisia but does not accommodate chronic, withdrawal, post withdrawal and delayed post withdrawal akathisia and other delayed post withdrawal (flashbacks for LSD are the best known of those) states that are regularly mistaken for new of continuing mental illnesses. Otherwise, DSM-IV offered many substance-induced disorders and the ICD-10 provides F10 - F19, Mental and behavioural disorders due to psychoactive substance use.

As the United States is faced with the same iatrogenic epidemic, DSM-5 provides diagnostic categories of substance/medication-induced disorders: acute and tardive akathisia, substance/medication-induced -anxiety disorder, -delirium, -bipolar and related disorder, -depressive disorder, -neurocognitive disorder, -obsessive-compulsive and related disorders, -psychotic disorder, -sexual dysfunction disorder, -induced sleep disorder and substance-induced addictive disorders. All are consistent with reported effects of medications.

[2]

Part II Definitions

What are we talking about when we say "mental illness"? What does "depression' mean? Why do the clinical practice guidelines to schizophrenia invent a definition not consistent with ICD 10 or DSM-IV or -5?

This definition of mental illness provided in the terms of reference:

> **Mental illness** means the experience of symptoms which impact thinking, perceptions, emotions, behaviour and relationships to others, or a combination of these.

The terms of reference state "Each year one in five people in Victoria experience some form of mental illness."

When I was a medical student in 1963, it was textbook psychiatry that two in five women and fewer men could expect to experience a mental illness in their lifetime

Mental illness is not usefully defined in the terms of reference.

The Royal Commission's definition conflates mental illness with adverse drug reactions, substance misuse, reactive depression, and common human unhappiness. It also encompasses grief, mourning, anxiety (including post-traumatic stress disorder), all of which can be severe and painful. It also accommodates adverse effects of alcohol, party drugs and addictions as well as personality disorders.

The new definition of mental illness has enhanced that figure so that mental illness has become an epidemic.

It is improbable that the incidence or prevalence of mental illnesses has increased. Schizophrenia affects 1% of the community, mostly intermittently, across cultures and decades. Bipolar affects 0.5% across cultures and decades.

Each form of distress warrants a different mode of intervention.

Few are likely to respond to medication (other than temporary sedation) and at least 40% of users will suffer adversity of various levels of severity if prescribed antidepressant or anti psychotic medication. See Part 4 about pharmacogenetics.

Iatrogenic disorders are more numerous in the Diagnostic System DSM-5 than the mental illnesses and more prevalent in the community. Please see PowerPoint, 'Academy 6' for a full list of also the chart below.

Drug company-funded professors don't teach that to their students that outcome for treatment of bipolar is much worse than it was 100 years ago.[1]

People so diagnosed have more episodes. Instead of 0.5% of the population being so diagnosed, I understand that 10% of children are diagnosed with bipolar disorder in the United States. I don't know what the figure is here, but the rates of diagnosis are increasing.

The Diagnostic and Statistical Manual of the American Psychiatric Association, is a resolutely atheoretical and descriptive nosology known as DSM. It groups conditions by their symptoms. If applied to medical conditions one would see up diabetes mellitus (caused by pancreatic failure) and diabetes insipidus (cause by a brain

tumour) in the same category as they share the symptoms of thirst and excessive urine production.

Persons with mood changes are grouped together. Bipolar I (formerly manic-depressive psychosis) is diagnostically limited in both phases (manic and depressive) by a “not caused by substance or medication” exclusion.[2]

Bipolar II has no exclusions. It accommodates a medication-induced manic shift, adverse effects of medication, worsening depression and suicidality, serotonergic akathisia as well as natural exuberance, cyclothymia and excitability, all within the embrace of American psychiatry’s socially constructed disorders.

Calling a condition with similar symptoms but a different cause by the name of the more serious condition causes a patient to believe he has a mental illness and to accept long-term treatment.

Language short-circuits reasoning. People who get a diagnosis of bipolar II because they do not meet the criteria for bipolar I (which has a substance/medication exclusion), get the same drugs and stay ill and have a greater suicide rate than bipolar patients. The word “bipolar” associates in the minds of most doctors with Lithium so people with bipolar II get lithium. Lithium further interferes with cytochrome P450 metabolism and impairs the metabolism of drugs. Rapid cycling in manic depression only started to become a problem after we started treating people with antidepressants.

This is a systemic error in Australian psychiatry (and probably in American as well), and it is another source of the public health disaster that mental health has become.

The use of the term *hypomania* should not be used in the product information, because it mis-educates doctors and causes confusion.

DSM-5 lists Substance/medication-induced bipolar and related disorders.

If one is to identify “best practice” then every patient needs to be individually diagnosed on first contact or admission and over several sessions according to Australia’s official diagnostic system, the International Classification of Diseases (ICD-10). For those who are familiar only with the American system, the translation is available in the textbooks.

All demand accurate diagnosis as the successful management of each of these difficulties is a very different approach to successfully treating mental illness.

Accurate diagnosis is relevant to funding decisions. A full diagnostic interview usually takes several sessions.

Solution: Create a proforma a downloadable questionnaire for hospitals and private practitioners to use hospital and ensure every patient gets a proper diagnosis.

Such basic education can empower even enrolled nurses to fill in relevant information over time while interacting with patients, as there is rarely time to take a full history on first contact. E-records are entirely unsuitable for this purpose.

1. Identify the presenting problem and concern. Currently, in epidemic numbers, it is failure to recover due to adverse effects of medication so involuntary and weird ego-dystonic suicidality without a death wish is very common

2. Record their childhood and family history, and social, surgical, and medical history. Assess their physical health and current stressors.
3. Conduct a mental state examination, which is not to be confused with the Mini–Mental State Examination (MMS), which is a brief Neuro-psychological screening test for dementia.
4. Take a history of their mental health problems, treatments, responses admissions, and emotional disturbances, and their causes.
5. Examine patients for the side effects of the medication that they are taking, or have been taking. Use Prescriber Information from the website of the US FDA, as Australian Product Information is inadequate. A pharmacist can also assist
6. Interview relatives in front of the patient and have the patient answer questions in front of family if she wishes. This does not breach their confidentiality. The patient can always refuse to answer
7. If necessary, take a swab and test for metabolizing genes. Informed consent is on the application form. Testing for drug metabolising genes, which costs one sixth of a day in a hospital ward, $100 by cheek swab).[3]
8. Diagnose according to the DSM but better on ICD-10, which codes medication, induced disorders listing every medication and coding the kind of reaction to it. Never ignore the substance/general medical condition exclusion diagnostic exclusion clause:

   The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

9. Get pharmacy and Medicare dispensing records the patient is unsure of what she is taking.
10. Check out drug-drug interactions on Drugs.com or Google.
11. Educate patients about their condition, understanding that the word “doctor” means “teacher.”

If medication is required, get the patient's informed consent by downloading Consumer Information from the website of the Therapeutic Goods Administration, in many languages and have them read warnings about sucidality if necessary with assistance. If you get consent, advise the patient to report side effects immediately. Monitor closely

Warning Information

* Health care providers should carefully monitor patients receiving antidepressants for possible worsening of depression or suicidality, especially at the beginning of therapy or when the dose either increases or decreases. Although FDA has not concluded that these drugs cause worsening depression or suicidality, health care providers should be aware that worsening of symptoms could be due to the underlying disease or might be a result of drug therapy.

* Heath care providers should carefully evaluate patients in whom depression persistently worsens, or emergent suicidality is severe, abrupt in onset, or was not part of the presenting symptoms, to determine what intervention, including discontinuing or modifying the current drug therapy, is indicated.

* Anxiety, agitation, panic attacks, insomnia, irritability, hostility, impulsivity, akathisia (severe restlessness), hypomania, and mania have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric. Although FDA has not concluded that these symptoms are a precursor to either worsening of depression or the emergence of suicidal impulses, there is concern that patients who experience one or more of these symptoms may be at increased risk for worsening depression or suicidality. Therefore, therapy should be evaluated, and medications may need to be discontinued, when symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

* If a decision is made to discontinue treatment, certain of these medications should be tapered rather than stopped abruptly (see labeling for individual drug products for details).

* Because antidepressants are believed to have the potential for inducing manic episodes in patients with bipolar disorder, there is a concern about using antidepressants alone in this population. Therefore, patients should be adequately screened to determine if they are at risk for bipolar disorder before initiating antidepressant treatment so that they can be appropriately monitored during treatment. Such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and depression.

It is in the interests of psychiatrists and of the pharmaceutical industry to enlarge a category of mental illness - to define more people as mentally ill – as this increases demand for mental health care and increases funding for the management of this newly diagnosed "mental illness" which, in four cases out of five, is nothing of the sort.

It is within my knowledge that mental health is always very keen to take over Drug and Alcohol services patients and their funding when they should have a supervised withdrawal in a specialised or psychiatric ward. 30% of the research sample cited in 'Akathisia Homicides' comprised persons who were first given antipsychotics, which are permitted on the PBS only for schizophrenia for a toxic psychosis caused by a previous mediation and misdiagnosed.

As the people who become psychotic on amphetamines and cannabis are already likely to have defective metabolising genes, they should not be given more medication that demands the same metabolic pathway, as that is the path to chronic invalidity. See PowerPoint "Do street drugs cause schizophrenia and why do some people think they do?"

The International Classification of Diseases devotes space to adverse drug reactions. A copy should be on every ward or accessible by electronic means. Only then will funding authorities know what conditions mental health professionals are dealing with.

As costs and demand for mental health care have quintupled since 1990, it is reasonable to expect that out of every five patients you see, four of them are suffering from iatrogenic disorders, adverse effects of medication rather than mental illnesses. And most are being treated with drugs that they cannot metabolise.

It is in the interests of the pharmaceutical industry, which coincide with those of [redacted], that the incidence and prevalence of mental illness be as large as possible. This diagnostic lumping operation benefits psychiatrists, tends to sideline drug and alcohol services, and by any estimate has increased demand, costs, and suicides, violence homicidal behaviour (drug company term "hostility" in mental health wards and services.

This is essential to understand, because the correct treatment for mental illness is catastrophic for the treatment of substance/medication-induced disorders. This chart demonstrates these essential differences:

Mental states due to toxicity	THE FUNCTIONAL PSYCHOSES
Akathisia, restlessness, obsessive preoccupation with death, dying and suicide. Inexplicable impulse to kill people one most loves, violence, behavioural dyscontrol, confusion/ambulant delirium, manic shift. Confusion misidentification Weird violent dreams, insomnia, Sick, vomiting, racing heart, loss of coordination, cognitive impairment and memory problems. Confabulations, shifting false reports, misinterpretation, serotonin toxicity or neuroleptic malignant syndrome.	Clear mind, absent confusion. Absent physical / neurological disease. Absent substance/medication use. Specific voice hallucinations, rare if ever visual, 3rd party or conversation. Fixed delusions, correctly defined. Mania or depression. Absent causation.
Prominent: confusion, lack of coordination memory/cognition impaired.	Absent: confusion, lack of coordination, otherwise clear thinking.*"*
Toxin or medication in use or recently used.	All "functional psychoses" carry the exclusion, *"not caused by substance or medication*
Classification by DSM IV TR and DSM-5	
Neurotoxic conditions as classified by the DSM. DSM IV TR 333.99 Neuroleptic and SSRI- Induced Akathisia DSM-5 333.99 medication induced acute akathisia DSM-5 333.72 Tardive Akathisia Then between DSM IV TR 292.0 and 292.9 with sub classifications Substance-induced delirium Substance-induced persisting	**Mental illnesses as classified by DSM** DSM IV TR 295 Schizophrenia DSM IV TR 295.40 Schizophreniform Disorder DSM IV TR297.1 Delusional Disorder DSM IV TR 298.8 Brief Psychotic Disorder DSM IV TR 296 Manic Episode DSM IV TR 296 Major Depressive

dementia Substance-induced persisting amnestic disorder Substance-induced psychotic disorder Substance-induced mood disorder Substance-induced anxiety disorder Hallucinogen persisting perceptual disorder Substance-induced sexual dysfunction Substance-induced sleep disorder DSM IV TR 995.2 Adverse Effects of Medication NOS DSM-5 substance induced Bipolar disorder	Episode
Classified by ICD	
ICD-10 F10 - F19 as mental and behavioural disorders due to psychoactive substance use. Psychoactive medications used in psychiatry and elsewhere are coded here as “other”. They have the same consequences for people who are unable, for reasons of genetics or dosing, to metabolise the medication. 281.9 -84 Substance induced depressive disorders ICD-10 code 781.0 Akathisia. (Coded together with medication-induced parkinsonism)	ICD 10 F20.9 schizophrenia ICD 10 F 20.81 Schizophreniform disorder ICD 10 F25.0 bipolar type ICD 10 F25.1 depressive type ICD 10 F22 Delusional Disorder ICD 10 F23 Brief psychotic Disorder ICD 10 F32 0-9 Depressive disorder ICD 10 F296.01-66 Bipolar 1 Disorder ICD 10

Unrecognized side effects fill hospitals and prisons with non-recovering patients who have sub-lethal conditions, recurrent suicidality, episodic violence and pseudo-dementia.

“Psychiatric disorders” are now the leading cause of disability pensions in Australia.

Antidepressants may be valuable drugs for the people who have biological depression and can metabolise them normally, provided that they are used correctly, but for the majority of the population, who can't metabolise one or more medications,

they may have catastrophic adverse drug reactions, including intense, protracted withdrawal syndromes leading to non-recovery.

Once a person has been diagnosed with mental illness they cannot get a visa to visit the United States. They cannot get life insurance. There are a lot of jobs they can't get. They are thoroughly stigmatised.

However, if they are correctly diagnosed with an adverse drug reaction, and are slowly and safely withdrawn from the offending drug/s, they do not attract such a stigma, and the road to recovery becomes open to them.

[redacted]

[1] Healy, D. (2006). The latest mania: selling bipolar disorder. *PLoS medicine*, *3*(4), e185.

[2] Criteria for Manic Episode DSM IV TR etc

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
1. inflated self-esteem or grandiosity
2. decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
3. more talkative than usual or pressure to keep talking
4. flight of ideas or subjective experience that thoughts are racing
5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
6. increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C. The symptoms do not meet criteria for a Mixed Episode (see Criteria for Mixed Episode).
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).
Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.
Episode Features
A Manic Episode is defined by a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood. This period of abnormal mood must last at least 1 week (or less if hospitalization is required) (Criterion A).

[3] NSW Government Response to the recommendations of the Inquiry into theManagement of Health Care Delivery in NSW Recommendation 24
The Committee recommends that NSW Health provide funding for clinical pharmacologists in each Local Health District to provide education about recent advances in drug therapy and adverse drug reactions, to better target pharmaceutical treatments for mental illness. https://www.parliament.nsw.gov.au/tp/files/76015/Government%20Response%20-%20Recommendations%20for%20Management%20of%20Health%20Care%20Delivery%20in%20NSW.pdf
Recommendation 25
The Committee recommends that NSW Health actively pursues and funds the increased use of pharmacogenomics testing as a means of improving treatment for patients with a mental illness.

Part 111 Background and details and some solutions

Background and details and some solutions

In 1974, Ivan Illich published Medical Nemesis showing how doctors were responsible for the epidemics of modern medicine, and the creation of much of the ill health that they treated.[1]

Illich popularized the term, iatrogenesis, composed of the Greek words for “healer” (iatros) and for “origins” (genesis). Iatrogenesis was clinical, when the pain, sickness and death resulted from the provision of medical care. It was social, when the organization of health care generated dependency and ill health, and it was structural when doctors, with their delusions of efficacy, undermined the natural confidence of ordinary people caring for each other. In this view, “iatrogenic disease” comprised only that illness “which would not have come about unless sound and professionally recommended treatment had been applied.”

That is to say, iatrogenic illness was a consequence of what apparently passed for “sound and professionally recommended treatment”.

Within this definition, a patient could sue his therapist if the latter, in the course of his treatment, had not applied a recommended treatment and thus risked making him sick.

In his critique of Illich, Vicente Navarro held that responsibility for iatrogenesis did not lie with the medical profession at all but with powerful corporate classes

These were big business like the pharmaceutical industry; governments and insurance companies all of which determined who should be treated and by whom health care was to be delivered and what form it would take.

Evidence of an epidemic of suicide and homicide under Mental Health Care (Manifestations of the side effect “akathisia”)

Statistical data was collected by various agencies, for different purposes, using dissimilar means and according to disparate criteria. The data evidenced an epidemic of “psychiatric” disability, of suicidality and violence associated with mental health services and, inevitably, medication.

By 2003 Professor Beverley Raphael had published research on the huge increases suicide under mental health care in the decade after the introduction of Prozac in 1990 Her report was summarized in the now defunct Bulletin. C citing Victorian cases so it is relevant to this Royal Commission. [2]

Dr. Raphael did not join the dots when I gave her the causes in a letter that summarized the essential knowledge about SSRI suicide to that date. This letter is footnoted and should be read in full. She was Director of Mental Health and retired soon after.[3]

Professor Raphael is not longer alive or she might have to answer why her response was "I will ask the College."

Youth Suicide

As measured by the Australian Bureau of Statistics, suicide in young people began to rise in the mid-1970s in lockstep with a trend to prescribe amphetamines and methylphenidate for the American Psychiatric Association's social construction of inattention in youth and later adults identified by a checklist "diagnosis," Attention Deficit Hyperactivity Disorder (ADHD). Causation was irrelevant as it is in the DSM

The side effects of methylphenidate and amphetamines include sudden death, akathisia toxic psychosis, depressed mood, aggressive behaviour, visual hallucinations, insomnia, suicidal ideation and psychotic behaviour.[4]

Youth suicide continued to rise as antidepressants (not "approved" for children even by the low standard of the US FDA: two positive trials and they can and do conduct thousands) came to be prescribed for what earlier generations of psychiatrists led by Anna Freud termed "adolescent turmoil" and atypical antipsychotics (not "approved" for children) were prescribed for an hypothetical "pre-psychosis syndrome.[5]

Pre-psychosis syndrome was Professor McGorry's invention.

https://www.google.com.au/search?source=hp&ei=tzEdXbbCM8b79QOFra_QCA&q=McGorry+lunatic&oq=McGorry+lunatic&gs_l=psy-ab.12...1641.12844..14673...0.0..1.221.3919.0j16j5.....0....1..gws-wiz.....0..0j0i131j0i10j0i13j0i13i10j0i13i10i30j0i13i5i30j0i8i13i30j0i8i13i10i30j33i160j33i21.hYjKm0zT5Lc

The Royal Commission has been put on notice by a meeting outside Victoria's parliament protesting against Professor McGorry and Dr Cockram's involvement as advisors to the Royal Commission. Professor McGorry's work needs to be evaluated by international experts who can sign the expert code of conduct.

Suicide rate adolescents

In the state of New South Wales, suicide in the 15-24 year age group also peaked in 1997 at 20.3/100,000.[6]

Suicide rates

In the 1920s, suicide accounted for approximately 1% of all deaths. The rate during the Great Depresion hovered around 9/100,000. In 1996-1998, when the Government's programs to address depression and prevent suicide were well under way, suicide accounted for 2% of all deaths Suicide rates in Australia rose and peaked in 1963 (17.5 per 100,000). The rise was attributed to the availability of benzodiazepine sedatives and suicides fell after they were

restricted. Tricyclic antidepressants contributed as they also induced suicide and they had escaped from offices of specialists who used them carefully for biological depression or melancholia into family doctors" offices where they come to be prescribed for situational depression (where they were known to be ineffective) and they were not monitored.[7]

The year 1984 post-dated by a decade the increasong use of psycho stimulant drugs for Attention Deficit Hyperactivity Disorder (ADHD), and the national suicide rate was 11.3/100,000.

The suicide rate in NSW was 12.7 in 1990, to 14.6 in 1997 and 14.3/100,000 in 1998.

This rise coincided initially with ADHD drugs (with similar side effect profiles to SSRIs including suicidality and aggression) then with increased prescribing of "new generation" antidepressants to which atypical antipsychotics were being added in line with recommendations in Clinical Practice Guidelines and RANZCP guidelines for the treatment of children. These guidelines contradicted US FDA public health advisories adn drug company caveats in Product information which states "safety and efficacy have nopt been demonstated demonstrated in adolescents". This lack of safety and efficacy does not stop them from being approved see Darrow below.

Adult Male Suicide

The all-ages standardized rates of male suicide registered in 1997 and 1998 were the highest since 1963 and, before that, 1931.[8]

After 1998, the suicide rate began it to rise again particularly in males reaching a rate of 20.3/1000 in 2001 and it fell back, with rates after 2006 still subject to revision.

Female suicide

Female suicide rates stayed much the same.

Hanging

Hanging, usually 10% of suicides peaked at 50% of suicides in 1998.[9] Hanging is the most common method of suicide in those suffering from akathisia.[10]

Antidepressants (that carried a high suicide risk and often induced toxic hallucinosis) seemed to be followed by atypical antipsychotics, which had shown double the risk in clinical trials. In the clinical trial presented to the US FDA for he licensing of olanzapine risperidon. These prescribing practices set up a quagmire of drug-drug interactions as well being synergistic for neurotoxic effects including suicide.[11]

Suicide is under-reported

While the government, through its spokespersons, Key Opinion Leaders, was congratulating itself for reducing the suicide rate from its 1997 peak, suicide was being underreported by 30%.

According to the NSW Clinical Excellence Commission, in the 18 months to June 2008, at least 175 more people died from suicide within seven days of contact with the health system. Submissions to state and federal health ministers and regulators about causation were simply ignored.[12]

At the same time, street drugs, amphetamines and opioids were being used in the community and they contributed to this increase.

https://www.google.com.au/search?source=hp&ei=ULQeXcWqNIey9QOmj4S4DQ&q=drug+induced+dementia&oq=Drug-induced++dementia.+&gs_l=psy-ab.1.0.0i22i30l10.2630.2630..10358...0.0..0.176.176.0j1.....0....2j1..gws-wiz.....0.6CjfAJugaZ0

Suicide by patients being treated by NSW mental health

In the 10 years, 1993 to 2002, counted within 28 days of contact, 1290 persons treated in NSW public mental health care committed suicide: Average 129 a year.

In 2002 NSW Health changed the mode of counting but the numbers got worse.[13,14]

In the 6 years, 2003 to 2008, counted within 7 days of contact a further 937 persons treated in NSW public mental health care committed suicide: Average 156 a year.

2227 persons committed suicide between 1993 and 2008, in 16 years under NSW care mental health care where these drugs were being prescribed or changed.

Homicide by patients being treated by NSW mental health

In the 10 years, 1993 to 2002, counted within 28 days of contact:

36 patients being treated in the New South Wales Mental Health public sector committed homicide, 3.6 a year.

NSW changed the mode of counting but numbers got worse.

Homicide under NSW Mental health Care

In the 6 years, 2003 to 2008, counted within 7 days of contact, 43 patients being treated in the New South Wales Mental Health public sector committed homicide. 7 a year

79 patients committed homicide in 16 years, an average of 5 a year, killing friends, family members, nurses and health care workers.

Australia from these numbers

Multiply the New South Wales figures by 4 to estimate what was happening in Australian Public Sector ten years ago in 2011. It has only go worse.

Everyone has stopped counting suicides and homicides

Australia from these numbers

Multiply the New South Wales figures by 4 to estimate what was happening in Australian Public Sector ten years ago in 2011.

Many more committed suicide and homicide on drugs prescribed by NSW Health outside of these restricted parameters (Personal knowledge).

Between 1993 and 2001, suicide numbers under mental health care trebled, increasing from 9% to 21% of all suicides in New South Wales. Increased suicide numbers in NSW were exactly accounted for by the suicides committed by patients under Mental Health care.15

Hospitalizations for suicide attempts

Hospitalizations for suicide attempts in NSW increased threefold from 55/100,000 of population in 1989-90, to 155/100,000 of population in 2004-05.

These accounted for 9,000 hospitalizations a year and some hospitals did not count them at all.[16]

Aggression Absconding and violence committed under NSW mental health care

Mental health patients, treated voluntarily were not known for absconding or for violence, but the population of mental health patient after 1990 became aggressive and restless after taking medication. Newly built wards needed to be locked and security guards were provided.[17]

In 2013, police in New South Wales received 38,000 mental health-related call-outs.

\As nearly everyone admitted to mental health care is or has been medicated with drugs that have akathisia, suicidality, and in the USA, “suicide attempt” listed among their side effects, they were implicated in these deaths. [18]

Intra-family homicides are reported almost daily in the press. They are attributed to mental illness but examination shows that mental illness was very rarely in evidence before medication.

However, a man who suffered from paranoid schizophrenia killed his friend. He was not medicated, as he had been unable to tolerate any drug. The notion of using personalized medicine and a personalized dose after testing for metabolizing genes is still being ridiculed (Personal experience).

More persons known to the author committed homicide beyond the limitation period of seven days, as they had remained homicidal they were still taking medication prescribed by NSW Health, and more still while committed suicide and homicide while being treated entirely in the private sector.

ABS 4329.0.00.006 - Mortality of People Using Mental Health Services and Prescription Medications, Analysis of 2011 data

At the instigation of the National Mental Health Commission, the Australian Bureau of Statistics in September 2017 published that:

In 2012, 14.8% of the population had accessed mental health services and had been dispensed one or more of the five groups of mental health drugs on the Pharmaceutical Benefits Scheme.

Antidepressants, antipsychotics, benzodiazepine sedatives like Valium, non-benzodiazepine sedatives like Zolpidem, and psychostimulants for ADHD, all of which increase mortality in using populations.

In my sample of 700 suffering from adverse drug reactions mental heath drugs (a misnomer I apologize) drugs were usually prescribed in polypharmacy mixes.

This 14.8 % accounted for 49.6% of the deaths (n=153,451) in age range 15-75 and 52% of the suicides (n= 2,295) in the age range 15-75.

That is, 75,000 deaths and 1145 suicides were associated with five groups of drugs. Each of these groups is associated with increased death rates.

Veteran suicide

The number of Australian veterans committing suicide reached 3 times the number than died in Afghanistan.[19,20]

The absolute number of suicides in Australia increased by 732 between 2012 and 2016, which is well in excess of the population increase.

Costs

Demand for mental health care (and costs) doubled in decade from 1990 and quadrupled since new generation drugs. Mental Health advocates demand more resources, and more doctors to prescribe more drugs. Because that is how they have been taught.

The number of people presenting for psychiatric treatment in emergency departments doubled in the first decade after the introduction of fluoxetine.[21] The cost of providing "mental health services" and medicines in the Commonwealth (all states and territories) continued to increase, from AU 550 million in 1992 to AU$1.4 billion in 2005.[22].

According to Gruen Lateral Economics 2013:

> The cost of mental illness to Australia's wellbeing has hit $200 billion a year - equivalent to about 12 per cent of the economy's annual output.[23]

Who is getting antidepressants and mental health drugs

Lucire and Crotty (2011)

Lucire and Crotty (2011) found in their study, that nearly 70% of their gene-tested subjects had been fully functional workers or students being treated for compensable injuries and/or stressors.[24] 40% had no conditions before they took illicit substances, 3% had taken herbs that had adverse reactions and many more had taken some of the 167 medicines that have psychiatric side effects, mostly tetracyclines or antihistamines. 3% had anorexia nervosa, (iron deficiency) 3% were being treated for the effects of sexual abuse, 2% for brain injuries, 1 for organophosphate poisoning and 1 for epilepsy.

The expected array of human problems was disclosed; alcohol overuse, personality disorders, bereavements. The pre-medication conditions of 6 could not be reliably assessed and only four had mental illnesses diagnosed before medication. This adds up to over 100% as the categories overlapped, and many subjects had more than one problem.

Criminal behaviour, behavioural dyscontrol and forensic facilities

Prisons and prison hospitals were overwhelmed with akathisia violence, which many psychiatrists were unable to recognize.

Statistics for suicides and homicides committed inside Australian prisons were not readily available.

In the last decade, one patient committed suicide and two patients committed homicide in the Long Bay Forensic Hospital and one committed homicide in the Victorian forensic hospital and these were reported in the press. A submission on causes made no impact.[25] Please read this footnote.

The bed requirements for the forensic patient population (called criminally insane in USA) in New South Wales nearly trebled between 1992 and 2003.[26] Most psychiatrists in these institutions (and in the public sector) do not differentiate between medication-induced violence and the relatively rare pattern of delusional violence associated with mental illness (Personal experience).

Supreme Court decisions in Australia

Supreme courts demand expert code of conduct and determine causation by using scientific method. An opinion had to be referenced to the scientific literature and expert is adperson who has superior knowledge or she is not permitted to give evidence. Supreme Courts have acknowledged causation in the cases of Regina v Hawkins [2001] NSWSC 420.

https://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/nsw/NSWSC/2001/420.html?context=1;query=Hawkins;mask_path=au/cases/nsw/NSWSC

Regina v Paul Anthony Roberts (SCNSW 2004, unreported), [27] The Supreme court accepted my evidence in R v B (SCWA 64 of 2004) who killed loved ones or tried to kill children in a state of medication-induced akathisia. The appropriate defence in such cases (provided no alcohol or illicit substance was taken) is involuntary intoxication.[28] A plea of Not Guilty by Reason of Mental Illness (NGRI) or even diminished responsibility on account of hypothetical mental illness sentences them to more of the drugs that made them violent in the first place.

Supreme Courts in USA

Medication induced suicide Case law

https://scholar.google.com.au/scholar?hl=en&as_sdt=2006&q=medication+induced+suicide&oq=

Medication induced Homicide Case law

Deaths and disability caused by psychiatric drugs

Suicide is not the only cause of death from psychiatric drugs.

A carefully controlled cohort study of depressed people over 65 years of age found that SSRIs led to falls.

For every 28 elderly people treated for 1 year with an SSRI, there was one additional death.[29]

The risk of bleeding is trebled and strokes are common.[30]

Diabetes and metabolic syndrome are problematic, but suicide is the major cause of death in those treated for serious mental illness with medication.

Deteriorating outcomes in mental illness, deaths, violence, and suicide rates have been documented by epidemiologists and have increased up to 20-fold since 1924.[31,32,33,34,35,36]

Some people taking psychiatric drugs develop akathisia and some people who develop akathisia kill themselves or others.

Yet the drugs can be effective in persons suffering serious depression, provided their doses are adjusted according to their ability to metabolize them normally and there is informed monitoring.

Workers Compensation and Disability Support

In New South Wales, “psychological injury” stress claims from bullying increased from 473 in 1991-2 to 3,202 in 2004-5.

WorkCover and personal injury claimants comprised 38% of Lucire and Crotty’s sample tested for metabolizing genes. Many progressed to the Australian Disability Support Pension adding to the 258,640 persons or 31.3% of disability pensioners receiving benefits for “poorly defined psychological conditions”

which had overtaken musculoskeletal disability, formerly the major cause of disability for work. [37]

Whitaker had described this same progression from taking medication to long-term disability support in the United States.[38]

New generation drugs

In 1990, fluoxetine, the first of a dozen "new generation" antidepressants was introduced in Australia. By 1997, five more antidepressants (SSRIs and SSRIs) and three atypical antipsychotics had been added to the Pharmaceutical Benefits Scheme. With it came a massive promotion campaign exaggerating its benefits and not warning of well-established harms for which damages were regularly being paid in USA.

By 2000, [redacted]. More settlements followed. By 1998, five new antidepressants and three atypical antipsychotics (of which virtually none are approved for children) were made available on the Pharmaceutical Benefits Scheme.

These new drugs were falsely promoted as safe and effective when they were ineffective and dangerous. The makers of the drugs in question had paid billions of dollars in fines having been charged under the False Claims Act in USA.[39,40]

Early critiques of new drugs

In 2002, the suicideologist Ronald Maris summarized information already published that showed the new antidepressants induced suicide at four times the rate of older TCAs, which themselves were known to induce suicide in some cases.[41] Akathisia and suicide were recognized effects of the Tricyclic Antidepressants in the 1960s.[42]

In 2003, Healy and Whitaker reviewed many epidemiological studies and the clinical trials that had been presented to the US FDA for the licensing of antidepressants.[43] [44]

They reported on follow-up studies, and studies in the community and on information from morgues all of which disclosed that the population that was taking antidepressants, or had just stopped taking them, committed or attempted suicide at a rate that ranged between twice and infinitely more times more often than the same population taking placebos or not using medication at all. Clinical trial subjects had been selected because they had no prior suicide history and suffered from "minor mental disorders," stress-related conditions described by Healy (who had court-ordered access to the drug company archives) as "the Valium-using population of the 1970s."

The Drug Safety Research Unit studies of selective serotonin reuptake inhibitors (SSRIs) and mirtazapine in primary care practice in the United Kingdom had found 110 suicides in 50,150 users of SSRIs.

The range among fluoxetine, sertraline, paroxetine and fluvoxamine was 182-269/100,000, average: 219/100,000.[45] About one in 500 persons taking antidepressants seems to have died by suicide while treated in primary care in Great Britain.

Healy and Whitaker's conclusion was modest:

The data reviewed made it difficult to sustain a null hypothesis that SSRIs did not cause problems in some individuals.[46]

By 2003 and many times since, the proposition that "SSRIs induce suicide" passed the scientific standard of proof in scores of epidemiological studies and in American courtrooms. It was underpinned by over 120 peer-reviewed publications and was matter of textbook psychiatry. The

The trials presented for US FDA approval had been selected out nearly 400 antidepressant trials whose raw data was later reviewed in detail by the Cochrane Collaboration and others.[47,48,49,50,51]

The undisclosed trials had failed to show either safety or efficacy, and had revealed substantial numbers of suicides and related behaviours, both on active substance and in withdrawal.

United States Food and Drug Administration

On March 22 2004, the US FDA issued a Public Health Advisory: "Worsening Depression and Suicidality in Patients, Adults and Children Being Treated with Antidepressant Medication."

It advised parents and caregivers to monitor patients daily for anxiety, agitation, panic attacks, insomnia, irritability, hostility (code for homicidal ideation), impulsivity, akathisia (severe restlessness), hypomania, and mania all of which had been reported in adult and child patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and non-psychiatric. An adverse drug reaction is in the body while the condition being treated is in the mind. Adverse drug reactions affect the body and the brain and have effects on the mind.

Bipolar

This advisory contained ill informed misinformation in that it conflated manic depression, a mental illness, with a medication-induced manic shift, which is an adverse drug reaction, caused by an overly high dose or diminished Cytochrome P450 metabolism.[52]

Diminished metabolism prolongs half-life and may push the drug in question out of the therapeutic level into a toxic and ineffective level. Bipolar II in the Diagnostic and Statistical Manual of Mental and Behavioural Disorders (DSM) of the American Psychiatric Association (APE) accommodates a medication-induced manic shift, adverse effects of medication, worsening depression and suicidality, serotonergic akathisia as well as natural exuberance, cyclothymia and excitability within the embrace of American psychiatry's socially constructed disorders. Calling a condition with similar symptoms but a different cause (and therefore remedy) by the name of the more serious condition induces a person to believe that she has a mental illness and to accept Lithium, mood stabilizers and other long-term treatment. This increases numbers under mental health care taking remedies that had not effective as the cause, medication toxicity, is not addressed but may be exacerbated.

Changes in practice after drug companies captured regulators, policy and education

Reports made to regulators and ignored

In 2005, the author reported to Adverse Drug Reactions Advisory Committee (ADRAC) of the Therapeutic Goods Administration (TGA) that in 2003-4, 192

persons in two years had been admitted to a rural admission ward, some many times, because they had become suicidal and homicidal only after taking antidepressants. [5354] These reports included a homicide, eight suicides, and scores of violent episodes and several attempted homicides. She reported (or supported) 42 similar cases to the Medical Board of NSW, the regulator of medical practice charged only with protecting the public. All of them, including the treatment whose outcome had been fatal both before and after being reported, were deemed to be instances of "standard psychiatric practice", which the authorities have not yet defined. The ward's bed numbers increased from 14 to 22 between 2000 and 2004 and continued to increase.

A thousand new secure mental health beds were built in New South Wales alone to accommodate this new epidemic.

For example: one previously open rural ward increased capacity from 12 open beds in 1998 to fifty secure beds in 2014. The population of 150,000 needed more than four times as many beds as had been required in 1992.[5556] A random sample of over thirty persons from that region who were seen for medico-legal purposes was comprised only of patients suffering from adverse effects of medication on polypharmacy. Any health benefits to patients of these cost increases were hard to find. In USA, Preda et al. had reported already in 2000 that 10% of admissions to a psychiatric ward were for antidepressant-induced mania and psychosis.[57]

Reports to Health Departments

In 2007, the author provided to the Secretary of the Commonwealth Department of Health, 90 redacted medico-legal reports concerning fully functional working persons who had been bullied and had become incapacitated for work, suicidal and homicidal only after taking antidepressants for work stress. These reports informed the Report of the Psychiatric Drug Safety Expert Advisory Panel (2009) which accepted and explained causation by medication. Its recommendations to bring product information at least the standards of labels on the website of the US FDA were ignored.[58] Quite the reverse occurred. Product Information in Australia was further abbreviated and posted on the website of the Therapeutic Goods Administration. The author reported over 100 cases to state and federal and state health ministers who also ignored them, taking advice from key opinion leaders or the regulators that had been captured.

Lucire and Crotty (2011) reported on a further similarly affected 125 persons who had been tested for metabolizing genes. Piatkov looked at 40 of them examined at NSW Health. [59]

86 had been tested in a laboratory that looked at 25 genes, and all but three had genetic problems slowing metabolism. The misdiagnosis of the DSM-5 categories of substance/medication-induced disorders resulted in mental illness diagnoses being made and the patients getting additional prescribing cascades with polypharmacy.[60] These persons became long term clients of mental health services, contributed to suicide and attempted suicide statistics, increased demand on beds and increased numbers on disability support pensions. They also required many medical services for unrecognized cardiac, gastrointestinal, bleeding, endocrine, immune system and skin problems as listed in each drug's Product Information.

Most of those who had stopped taking antidepressants made a full but slow recovery from akathisia; some possibly one in five developed chronic, and some developed delayed post withdrawal akathisia weeks and months after stopping their medicines. Withdrawal akathisia went on for years and was the hardest to manage and reverse.

Many remained physically disabled and felt weak and remained on disability support. Suicidal and homicidal ideation both sometimes persisted for months after withdrawal. When a subject understood its cause and see that it was decreasing in intensity, it was less dangerous and easier to tolerate. Sometimes suicidality developed for the first time when a dose was missed and when the subject tried to stop taking the drugs.

Piatkov et al. reported on 40 of Lucire's suicidal akathisia patients, comparing them with a drug clinic and the local population, Akathisia patients had significantly more diminishing cytochrome P450 metabolism mutations and more multiple mutations than did drug clinic patients and many times more that the medical population.[61]

RANZCP and Role of Key Opinion Leaders

The pharmaceutical industry, when it wants to market a drug, particularly for purposes for which it has never been approved, called "off label" turns to "key opinion leaders" or "KOLs" to disseminate the clinical trial information of that they provide for them. Key Opinion Leaders – so designated by the pharmaceutical industry – advise the regulators, create policy and sign guidelines.

Psychiatrists who volunteer for this role of information bearers emerge in every country.

In Australia, the government and institutions have put their power behind KOLs who publish guidelines on which family doctors and psychiatrists base their prescribing. They are well remunerated by the pharmaceutical industry. Some have received multi million dollar grants to do small clinical trials and give lectures and produce guidelines to diagnose and treat with drugs when were not approved, for example, for children. These grants are mostly, but not always, listed on their curricula vitae.[62]

Professor Ian Hickie: Problematic Clinical Practice Guidelines

Professor Ian Hickie, a Key Opinion Leader repeatedly tells his audiences that SSRIs decreased suicide, sometimes misrepresenting his association study that showed that suicide rates actually increased in younger people after antidepressants were introduced.[63]

He is the signatory of clinical practice guidelines of apocryphal origin. They bear a close resemblance to the graphics and protocols that emerged from the Texas Medication Algorithm Project (TMAP) the consortium that produced them for many countries.[64] When they were criticised by Professor Parker, Professpor Hickie defended his guidelines saying they were the same as guidelines elsewhere. Of course they were. They had a common source: the fraudulent consortium known as the Texas Medication Algorithm Project and ghost writers in Canada. I will send by email or USB stick details of their fraudulence

The Summary of guideline for the treatment of depression Pete M. Ellis, Ian B. Hickie and Don A. R. Smith for the RANZCP Clinical Practice Guideline Team for Depression

The first guideline to the treatment of depression opens with "Depression is common, serious and treatable. It affects 1 in 25 people in any 1 month." The guideline recommended nefazadone - which had already been withdrawn because of liver injuries - or high dose venlafaxine "augmented," in case of inadequate response, with atypical antipsychotics and Lithium. [redacted][65]

The next guideline referenced 118 papers in the text and 247 references trail after the paper. The 247 papers in the reference base do not relate to the text of the guideline and its publication in a peer-reviewed journal does it no credit.[66]

Professor Hickie still calls the suicide reports in the literature "anecdotal" preferring to refer to some clinical trials in which no suicides occurred.

He pressured the Australian Broadcasting Corporation (ABC) not to inform the of this tragic public health problem, to not air Scientist Dr. Maryanne Demasi's excellent programs about the causes of child suicide.

In the popular Australian Broadcasting Corporation's televised Q&A program, Sarah Collins asked him:

> From studies that look at the effectiveness of drugs on mental health patients, it is obvious that these medications are not effective and are being overused. How do you respond to research put forward from professionals such as Gøtzsche and Whitaker that highlights in the end it's only the drug companies who are benefiting, not us the patients? Why are we not taking this on board and funding more psychology and psychiatric treatments or detoxification clinics?

Professor Hickie responded, avoiding the elephant in the room:

> I think it's sad that we have visitors from other countries, the United States, UK, come here and bring a media line that is not very helpful.[67]

Professor Patrick McGorry

Professor McGorry's guideline in the Early Psychosis Prevention and Intervention Program (EPPIC) still recommends the use of many antidepressants and antipsychotic medications that have never been approved for children for a hypothetical pre-psychosis syndrome, or for "psychosis" lasting over 24 hours.[68]

In 2005, the US FDA mandated a Black Box warning about doubling of sucidality by antidepressants in persons fewer than 18 and it extended the warning to person to the age of 25 in 2007. The Therapeutic Goods Administration (TGA) did not permit any Black Box warning to be placed in Australian Product Information for Australian doctors and patients. Their makers do not recommend antidepressants for young people, but Professor McGorry does.

For example, Eli Lilly does not recommend olanzapine for persons under 18 years of age but Professor McGorry does. The Key Opinion Leaders still deny, in the face of the warnings on each drug's label that psychiatric medications, and some others, can induce suicide and violence.

Whitaker had examined popular beliefs, “the story we told ourselves” about the efficacy of psychiatric drugs and showed and how they did not accord with published literature. Gøtzsche and his team of Cochrane researchers had unearthed primary data in the hundreds of clinical trials whose contents had not been disclosed. They found that that the sponsors had exaggerated efficacy of drugs used in psychiatry and had failed to report dropouts, suicides and violence. These fraudulent trials underpin the Clinical Practice Guidelines on which Australia’s mental health programs are based.[69]

Summary Australian and New Zealand clinical practice guideline for the treatment of schizophrenia (2003) signed by Patrick McGorry, Eoin Killackey, Kathryn Elkins, Martin Lambert and Tim Lambert for the RANZCP Clinical PracticeGuideline Team for the Treatment of Schizophrenia defines schiaophrenia this way

What is schizophrenia?

Schizophrenia is a psychotic disorder that is defined in terms of a variable confluence of positive and negative symptoms without the sustained presence of major mood disturbance. Cognitive impairment and disability are common additional concomitants. The boundaries and validity of the concept, especially int he onset phase, remain problematic. Schizophrenia\overlaps with other psychotic disorders phenotypically and in terms of underlying risk factors.

This contradicts Australian official diagnostic system the ICD 10 and the DSM-5 which define schizophrenia in a way that differentiates it from a bunch of psychotic disorders that are substance induced, transient and warrant different intervention.

Diagnosis odSchizophrenia

The DSM 5 outlines the following criterion to make a diagnosis of schizophrenia:

Two or more of the following for at least a one-month (or longer) period of time, and at least one of them must be 1, 2, or 3:

Delusions

Hallucinations

Disorganized speech

Grossly disorganized or catatonic behavior

Negative symptoms, such as diminished emotional expression

Impairment in one of the major areas of functioning for a significant period of time since the onset of the disturbance: Work, interpersonal relations, or self-care.

Some signs of the disorder must last for a continuous period of at least 6 months. This six-month period must include at least one month of symptoms (or less if treated) that meet criterion A (active phase symptoms) and may include periods of residual symptoms. During residual periods, only negative symptoms may be present.

Schizoaffective disorder and bipolar or depressive disorder with psychotic features have been ruled out:

No major depressive or manic episodes occurred concurrently with active phase symptoms

If mood episodes (depressive or manic) have occurred during active phase symptoms, they have been present for a minority of the total duration of the active and residual phases of the illness.

The disturbance is not caused by the effects of a substance or another medical condition

If there is a history of autism spectrum disorder or a communication disorder (childhood onset), the diagnosis of schizophrenia is only made if prominent delusions or hallucinations, along with other symptoms, are present for at least one month

It is a moot point to know if this is new wauy of describing schjizophrenoa is deliberate fraud or based or caused by ignorance. The guidelines defineition would put very large populations on expensive. dangerous and suicidogenic medications such as Zyprexa and Risperdal.

The Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists still advocates for the use of antidepressants for children even though not one of their makers, or the FDA or the TGA had ever approved them.

Drug makers are prohibited from promoting their wares for “off label” or not “approved” use.

However, they are permitted to arrange for Key Opinion Leaders, or professional associations, and for patient support groups and guideline writers to promote “off label” uses for them.

Clinical guidance on the use of antidepressant medication in children and adolescents” appeared in a family medicine magazine. It contradicted the US FDA and the body of literature that underpinned its warnings.

Nine influential child psychiatrists signed this guideline, which claimed that antidepressants were important drugs for children, even though they had not been “approved” because they had not surpassed any substance in two clinical trials on any criterion in that age group.[70]

For example: Study 239 and Treatment for Adolescents With Depression Study In the widely reported Study 329, 11 children developed suicidal ideation on paroxetine and only one on placebo. Paroxetine had been marketed on the basis that it was safe and effective for children. [71] The primary data in this trial was re-analysed by Jureidini et al. There had been eleven suicidal events on active substance and only one on placebo.[72] There are six such studies on the website of the US FDA.

Contrary to information published from the Treatment for Adolescents With Depression Study (TADS), there had been a significant increase of suicidal events in the adolescents on antidepressant medication (11%) in comparison to the group on placebo (2.7%) There were four times more suicidal events with fluoxetine than with placebo during the randomized controlled trial, and this difference was statistically significant.[73, 74]

The role of the Royal Australian and New Zealand College of Psychiatrists

When the FDA published its 2004 advisory, the first for adults but fifth for children, the American Psychiatric Association immediately issued warnings

about suicide induction by antidepressants.[75] A spokesman for The Royal Australian and New Zealand College of Psychiatrists (RANZCP) refused saying: "the evidence isn not conclusive".[76] The RANZCP remains unconvinced, and supports its own clinical practice guidelines, which do not warn of catastrophic adverse effects and are not even consistent with each drug's product information.

The role of the Therapeutic Goods Administration

The TGA always claimed that its "the risk-benefit approach assures consumers that the products they take are safe for their intended use …"

However, after 1994 and the signing of a Free Trade Agreement with the United States, TGA adopted the standards of the US FDA for approving drugs, and did not tell anyone that the independent assessments were no longer being done and the formerly trusted risk-benefit approach no longer applied.

The process of approving drugs at US FDA "legalized fraud"

US FDA requires drug that sponsors to present only two clinical trials (they can and do conduct any number) in which the drug has improved on placebo on any surrogate criterion that the sponsor had chosen to use. Darrow had investigated the process of drug approval at the United States Food and Drug Administration and had concluded that the public should not rely on the fact of FDA approval as an indication that medicines, including new and very highly priced ones, possess efficacy that is meaningfully greater than no efficacy at all.[77] The FDA is legally obliged to "approve" new drugs "even though there may be preponderant evidence to the contrary based upon equally reliable studies."

For example: American Product Information for Zyprexa (olanzapine) differs from Australian in the MIMS Annual 2005 and on the website of the TGA. See PPT Failure of regulators

Australian Product information informs only of five "psychiatric" side effects, including akathisia and hallucinations while doctors in USA are warned of over 60, including coma, suicide, death, dementia, hallucinations, schizophrenic reaction and withdrawal reaction. Olanzapine had surpassed placebo in two trials in which 50% of starters dropped out leaving around two thousand of whom twenty died, 12 by suicide, on olanzapine, while there was a single death in the placebo arm. [78] Deaths and dropouts do not appear in its product information or in the literature that these drugs have generated.

In premarketing trials involving more than 3100 patients and/or normal subjects, accidental or intentional acute over dosage of olanzapine was identified in 67 patients. That is an overdose rate of 2,161/100.000, and this produces a heavy toll on the public purse for olanzapine-induced suicide admissions.

Olanzapine and quetiapine are marketed as antipsychotics and both cause serotonin syndrome so are SSRIs as well.

Quetiapine is marketed as an antidepressant, an anti-manic, an antipsychotic and a sleeping pill. If this marketing were true, psychiatrists would need no other medicines. Quetiapine carries the mandated text and black box warning about suicide.

The TGA should but does not warn that some of the drugs of concern, marketed as antidepressants and atypical antipsychotics, are toxic for over

75% of Melanesians from one island and East Asians the majority of whom lack metabolizing genes for some antidepressants.

They are also toxic for people under 25 in whom cytochrome P450 enzymes are immature. Adults who have diminished metabolism genes may become catastrophically toxic, suicidal and violent even on low doses.

But without doubt, the major problem that needs to be addressed by relevant authorities is the manner in which drugs are prescribed, for conditions for which they have not been approved, which they cannot change, in huge doses and with interacting polypharmacy.

FDA findings about atypical antipsychotics

Journalist Robert Whitaker, via the Freedom of Information Act gained access to FDA data on the drug trials for the atypicals risperidone, quetiapine and olanzapine. Whitaker found that one in every 145 patients who entered the trials died, and yet those deaths were never mentioned in the scientific literature. The trials were structured to favour the atypicals and most of the study reports were discounted by the FDA as being biased. One in every thirty-five patients in risperidone trials experienced a serious adverse event, defined by the FDA as a life threatening event or one that required hospitalization. Twenty-two% of patients in olanzapine trials suffered serious adverse events. The atypicals did not demonstrate superior effectiveness or safety over typical antipsychotics and FDA prohibited their sponsors from making this claim.[79]

The role of the Commonwealth Department of Health in Australia

The Commonwealth Department of Health has disregarded information that would be embarrassing.

It hosts a website, Mindframe, to inform about what it considers to be “appropriate” reporting of suicide and mental illness and this does not include reporting medication.[80]

A compliant press, whose proprietors derive income from drug company advertising, reports the events as the consequence of mental illness. Homicides, no matter how improbable, are attributed to mental illness but, on examination, mental illness was not in evidence before medication.

Role of regulators of medical practice

Legislators, regulators of medicines, psychiatrists, my colleagues, coroners, Medical Boards, State and Commonwealth Mental Health Commissions, the Clinical Excellence Commission, medical insurers and editors of drug company-dependent journals have all been informed in detail.

All join common cause to ignore the pharmacological causes of this public health disaster, to reject epidemiology and science.

The regulator of medical practice, the NSW Health Care Complaints Commission whose only role is to protect the public has repeatedly prosecuted the author in a manner consisted t with SLAPP writs.[81]

One reprimand was the outcome of a complaint made by a Registration Board about an expert report. It was for a client in front of this same board, which had the power to strike off the medical practitioner, and it did so. It either ignored of did not read the expert report but made a complaint about it. The report contained well-referenced detail about the fraudulent promotion of olanzapine and risperidone as revealed in False Claims Act litigation in USA. The opinion

was that the client had no mental illness but suffered from listed adverse effects of medications, which a pharmacogenetic profile proved the person could not metabolize.

The author received a letter, which stated:

> Please be reminded that it is inappropriate to provide your opinion on the validity of anti-psychotic medication in medico-legal assessments, and you should consider avoiding making similar opinions in future medico-legal reports."

Discussion

This dominant view of how psychiatry should be practiced has been imposed thus by the pharmaceutical industry and its agents. Various tribunals that have psychiatrists as members enforce this view, and they have ordered professionals who came before them, suicidal and psychotic only after taking antidepressants, to continue taking them.

These tribunals routinely reject causation by medication and pharmacogenetic evidence.

Their members have no comprehension of Cytochrome P450-based interactions described in product information and refuse to countenance the existence of drug company fraud.

They have no idea that metabolism for drugs varies a thousand-fold between individuals, as when prescribing, they follow algorithms as recommended by the Texas Medication Algorithm Project (TMAP).[82]

Algorithms are average doses suggested by the drug industry, inappropriate in the age of information and personalized medicine. Mental Health Review Tribunals staffed by the same doctors as are causing the problem put patients in a position where the treating doctor can force them to take the drugs that are making them suicidal or have them injected, and they prescribe them in large and incompatible doses in ignorance of consequences.

Mental Health Review Tribunals give Australian psychiatrists more power that they have in any Western country.

Such a tribunal enforced a combination of fluoxetine and risperidone by injection in one patient, although it is prohibited in both drugs' product information. This caused homicidal ideation to go on for nine months and a homicide to occur after a similar akathisia-inducer was prescribed in the face of a written caveat not to prescribe a drug metabolized by cytochrome P450 again. The Supreme Court of Appeal knew and recognised the problem but he regulators and RANZCP refuse to countenance it

These deadly practices are recognised by Supreme Courts in criminal matters.

Negligence cases are settled quietly and damages are paid. It is in the realms of the unthinkable that good people can stand by and see this public health catastrophe and do nothing. Vioxx, which doubled cardiovascular events in a population using it, was withdrawn from circulation.

It is a legitimate question to ask why taxpayers are still subsidizing the irresponsible use of antidepressants and atypical antipsychotics which increased deaths and suicides and their precursor states by two to six-fold over placebo in the best clinical trials that their makers could produce.

And also to ask why drugs that multiplied suicidality eleven-fold in the case of paroxetine for children, or four-fold for sertraline are still being recommended by EPPIC Guidelines and used. That no suicides occurred in a trial of antidepressants suggests only that clinical trial subjects were warned of the risk, and that those persons who became suicidal were withdrawn. Suicides should not occur in practice if patient are warned and watched.

Warning does not happen in the community, as prescribers have not been advised how poorly these drugs were tolerated and how many subjects had been withdrawn and could not complete trials.

A Medical Board has determined that medications and doses that had caused people to commit suicide and homicides were “standard psychiatric treatment” even when the consequence had been fatal.

Akathisia cases were not investigated or given any attention. All notifications by patients and doctors were ignored or discontinued. A Coroner, sitting on five cases of antidepressant-akathisia-related suicides brought before him refused to hear this evidence.

Yet the harm done is in plain sight.

Peter Gøtzsche of the Nordic Cochrane Center has reported on organized denial on three continents.[83] Key Opinion Leaders guide are part of a denial industry, such as developed over the holocaust, tobacco, asbestos and climate change.

Introducing his book about reasons that our brains cannot accommodate climate change, George Marshall tells of the Polish resistance fighter Jan Karski gave eyewitness testimony to the Supreme Court judge, Felix Frankfurter in 1942.[84] Supported by the Polish ambassador, he reported the clearing of the Warsaw Ghetto and the systematic murder of Polish Jews in the Belzac Concentration Camp. Listening to him, Frankfurter, himself a Jew, and one of the outstanding legal minds of his generation replied, “I must be frank. I am unable to believe him.” He added, “I did not say this young man is lying. I said I am unable to believe him. There is a difference.”

This raises the issue of our ability to separate what we know from what we believe, to put aside the things that seem too painful or embarrassing to accept. How is it possible when presented with overwhelming evidence, even the evidence of our own eyes, that we can deliberately ignore something – while being entirely aware that this is what we are doing? The magnitude and enormity of the lethal nature of Pharma-driven “biological” psychiatry is too painful to tolerate but it cannot go on forever.

A public inquiry with the status of a Royal Commission is needed in Australia to count how many people have committed uncharacteristic violence or homicide, committed, attempted or thought about suicide, have been misdiagnosed and have needed hospitalization, had lives and reputations destroyed and how many have become clients of mental health services only after psychiatric drugs were prescribed for common human unhappiness. Such an inquiry would return its multimillion-dollar cost multi-fold. The taxpayer currently funds a “privatized profits, socialized costs” model of health care delivery.

Legislation to facilitate legal action by patients and survivors needs to be enacted as well as a False Claims Act similar to that in the United States to identify fraudulent representations by pharmaceutical industry and fraud in the

community. It needs to simplify litigation and enable persons injured by medicines that have been fraudulently promoted and gain pro rata payments from multiple drug companies where more than one drug had been used. A petition needs to go all around the world asking for the signatures of those who have lost loved ones or have had their lives and reputations destroyed.

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[1] Illich, I. (1974). Medical nemesis: The expropriation of health. Elkrimbouziane.

[2] Greenland H. The Bulletin October 3, 2003. Care to comment? Letters to The Bulletin should be no longer than 200 words and sent to: bulletinletters@acp.com.au or Letters Editor, The Bulletin, GPO Box 3957, Sydney, NSW 1028.

Reform of the mental health system in Australia in the 1980s and 1990s hit all the hot buttons. “Human rights”. “Community care”. “End of the “stigma”. “Self-reliance”, “More normal lives”. There were to be no more men in white coats to whisk away the family embarrassment in the middle of the night.

No more lingering, living deaths behind high walls.

No more padded cells.

No more people strapped to benches and convulsed with electricity.

You could throw away the straitjackets; the nightmare of mental illness was over.

Ken Kesey”s Nurse Ratched was out of a job.

People with mental illness were to walk free.

They walked all right, many of them to premature deaths.

During that short march to the promised psychiatric paradise, the annual number of fatalities has doubled.

In the larger states, it may have quadrupled.

About 400 mentally ill patients throughout Australia – most of them aged in their 20s and 30s – will commit suicide this year because the places that once treated them have been closed or diminished.

They are being turned away and sent to their deaths.

Duty to Care, a landmark West Australian study that recorded this growing toll, introduced the concept of “excess deaths”.

Some of these excess deaths are of other people.

Brutally put, increasing numbers of those turned away are going home to kill.

Murders by mentally disordered persons (to use the jargon of criminologists) – although much rarer than suicides – are running at three a month, having nearly doubled from 20 victims in 2000-”01 to 36 in 2001-”02.

If there is any good news – and a cynic may have predicted this – it is that the rising homicide toll, rather than the suicides, appears to have prompted a belated change of heart by authorities – in NSW, at least.

Following an investigation into a cluster of mental health homicides in the state, undertaken by a man who can only be described as NSW Health’s confidential agent, an unheralded, secret inquiry has been set up.

The absence of fanfare is true to form.

For almost a decade there has been an official cover-up (see story on page 28) of the death toll in NSW and a remarkable media reticence about criticising an experiment that has had such a high cost in human terms.

One head-office apparatchik, whose job is to secretly add up the death figures, admits: “If it had been SARS [deaths], there would have been an outcry.

” To be fair, a journalist with The Sydney Morning Herald who tried in 2001 to use freedom-of-information laws to force NSW Health to release the death toll figures was refused on the grounds that “it would unreasonably divert the department’s resources to attempt to process your application”.

One of the new mental health system’s critics (you might have labelled him alarmist if you did not know the numbers) cites Freud’s contention that two forces lie at the root of human existence – the life force and the death force, or Eros and Thanet’s, to use the ancient Greek concepts – and argues that the second has been let loose.

When you talk to the loved ones of the victims, they have a tendency to blame the doctors – and the coroners” findings often echo this.

How could health professionals have let these sick people out when the families and friends knew these patients would try to kill themselves or others? Unavoidable, all-too-human error does play its part and Dr Bill Barclay, probably Australia’s most experienced forensic psychiatrist, argues convincingly that not all these deaths are preventable.

“Even the best psychiatrists make mistakes in risk assessment,” he says.

“And we all know that even if we hold people for treatment, we may only be delaying their suicide.

” But that delay can and does offer a window of opportunity for successful treatment, as Barclay concedes.

Trouble is, as we shall see, the state of the system and its underlying philosophy does not encourage such delays – in fact, they discourage it.

Even with improvements in the clinical practice of hospital psychiatrists – whom family members without exception cry out for – the death toll will persist if the built-in bias of discharging unrecovered and dangerously ill people is not ended.

Authorities have replies for all these arguments.

Their main one – the reefer madness defence, if you like – is that the new libertarian system has been overwhelmed by a wave of drug-induced or drug-exacerbated madness.

Professor Beverley Raphael, director of the NSW Centre for Mental Health, said in June that the numbers of people requiring psychiatric treatment fronting at hospital emergency departments had doubled in the past decade.

She put it down to drugs.

Barclay also says that drug addiction has added a new dimension to mental health care.

“When I left the system in the late 1980s, this problem did not exist,” he says.

Yet it remains true that many of the deaths are not related to drug addiction.

While the silence of governments, the obfuscation of health authorities and media deafness have largely kept this new category of deaths out of the public arena, coroners have heard the screams.

Take one case off the top of a pile of findings from coroners in NSW and Victoria.

Significantly, it does not involve illicit drugs.

B[redacted] was 19, a tall, good-looking man who worked part-time in a supermarket and was scoring top marks in his TAFE course.

Like his mates, he skated and had studs in all the wrong places.

The only clouds on his parents" horizons were that he had lately become introverted, brooding and played rap music so loud that it disturbed the neighbours.

Then in the early hours of the second Monday in December 2002, Ben took the family car and tried to drive over a cliff.

When that failed, he drove headlong into the side of a house.

Still alive, and charged with all the energy a psychotic episode produces, he fled into nearby bushland.

B[redacted] family and mates joined police in the manhunt that followed.

It wasn't until some hours later that he was finally captured – his mates had caught him earlier but he had managed to break free.

Half-dressed, bloodied and wild-eyed, he was admitted to [redacted] the psychiatric unit at [redacted] hospital on the [redacted].

Less than 48 hours later, he was discharged – by a doctor with "only" four months" experience in the job, according to the coroner, although a more senior doctor assented to this discharge.

B[redacted] was lucky to stay that long: his mother and B[redacted] were told on his second night he would have to give up his bed and be sent home if a more pressing case presented.

His father brought him home the next day.

B[redacted] waited until the family was asleep that evening then walked out of the house to a nearby railway bridge and threw himself in front of a train.

Police took fingerprints from his bedroom to match the remains.

B[redacted] mother and father recounted these details from their [redacted] project home at [redacted], a typical subdivision circling regional centres in the state.

C[redacted]'s father G[redacted] paces and hovers at the far end of the living room, breaking his silence only after his wife C[redacted] has told the story of their son's final days.

"Why didn't they tell us that the medication takes at least two weeks to start working?" he asks from the far corner.

"They told us nothing," C[redacted] adds, "Just sent B[redacted] home as though he had a Band-Aid on him.

Even when my daughter had the cast taken off her broken arm, they said don't go yet until you have talked to the doctor.

We didn't even get that.

" The day B[redacted] came home, G[redacted] arranged with his employer to take four weeks" leave to care for his son.

But that first night B[redacted] took his life.

Still broken with grief, G[redacted] tries to understand what happened.

C[redacted] is in no doubt about what should have happened.

"They should have kept him two or three weeks until they were sure he was all right.

I know he would have come well.

" But such treatment is rarely available or possible today.

In the 1980s, the doctrine of "least-restrictive care environment" was written into mental health acts in all states and the wholesale closure of psychiatric hospitals followed.

Some of the lost beds were transferred to general hospitals as new psychiatric annexes were established; these are invariably crowded and unwelcoming.

Community care was the new panacea, yet it was a promised land never reached.

As a pathologist who gave evidence to the NSW Upper House select committee on mental health last year put it: "Community care too often means no care.

" Yet the instincts of B[redacted] [redacted]'s mother about the hospital care her son should have had are correct.

The anti-depressants prescribed for B[redacted] not only take time to take effect, in some cases, they don't work at all; in others, they can worsen a patient's condition before they kick in.

Barclay says they can take two to four weeks to work.

The uncertainty of medication is one reason why the critics of de-institutionalisation advocate a return to longer stays and closer observation.

The Duty to Care study in WA noted that, in acute cases, the average length of stay has been reduced from five days to three.

Coroner [redacted] made these points in his finding on C[redacted]'s death: "Staff were over-anxious to discharge B[redacted] due to the perennial shortage of beds at [redacted] and this is one of the many cases which highlight government neglect in the area of mental health facilities.

" Like C[redacted], half of mental health suicides happen within 48 hours of discharge.

Yet it has been known for at least a decade that the suicide rate in the immediate period after discharge is 100 times the rate for the general population; for patients with depression, it is up to 500 times.

A 1995 research paper, published by NSW Health itself, listed among the reasons for this "the fact that the patient may not be fully recovered".

Stories of sending vulnerable, unrecovered patients back into the world are legion.

Just last month a neighbour told me this story, which checked out.

A country NSW woman (call her Jan) with a long record of mental illness had recently attempted suicide.

She went to hospital where she tried to kill herself again but was nevertheless discharged two days later and put on a bus alone to go home to a vacant house. (Her sister had been at the hospital half an hour before the discharge but was told it would not happen until the next day.)

The next morning, unable to rise Jan, her sister rang a community mental health worker soon after 9 am to ask for an urgent visit, only to be told not to worry because Jan had been instructed to ring for an appointment.

Jan's sister then drove the two hours from Sydney to find Jan dead from an overdose.

On Jan's answer machine was a message from the health worker, left at 9.40 am, reminding Jan to ring about her appointment.

Understandably, Jan's sister is not just grief-stricken but angry.

If it can be put this way, B[redacted] and Jan were lucky to be even admitted to a hospital psychiatric ward.

Take the case of Bob Robinson (not his real name because his family was divided over the use of it).

This 29-year-old, suffering from schizophrenia, attempted suicide by jumping from the first-floor balcony of his family home in the [redacted]

Taken to hospital by his mother "Joan", Bob convinced "the community assessment team" that he was OK.

Despite his mother's misgivings ("Look, they treated me like an idiot," she recalls in her strong, educated voice), he was sent home.

That night she suspected he had overdosed – she found emptied medication packets in the bathroom – and rang the hospital again, only to be told to monitor his condition and ring again in the morning.

Later, desperately worried, she tried her brother (a doctor in Brisbane) but he was at a dinner party and she didn't want to bother him.

It was a long watchful night: about 2 am, and then a few hours later, she checked.

When she finally woke at 7.

30 am after a night of fitful sleep, Bob was scarcely breathing and died on the way to hospital.

Only now is Robinson's mother coming to terms with the death of her youngest son.

"I was off my head for 18 months, crying all the time.

" She still has not forgiven the hospital and confesses she has not been able to decide on a headstone for the grave.

"I just haven't had the strength.

" Like C[redacted], Joan Robinson says her son should have been kept in hospital.

"You know it is not certain that he even suicided.

He told me he just wanted to get rid of the voices.

" This "overanxious to discharge" habit was at the centre of recent media furore over a man who sued NSW Health and won $300,000 in damages.

Under the influence of alcohol and marijuana, K[redacted] had a major psychotic episode (he tried to throttle a three-year-old and had to be subdued with a cricket bat) but was released from hospital care the next day despite the objections of his brother.

He went back to the brother's house and later that day murdered the brother's fiancée.

Taxed with this over anxiety to release, a hospital psychiatrist echoed official policy: "I cannot go and jump on everyone and put everyone in the wards because yesterday he was suicidal … or murderous."

But staff is aware that they are discharging people who are still possibly suicidal or murderous.

Their union, the Salaried Medical Officers Federation, told last year's NSW Upper House inquiry into mental health services: "It is often the case that patients are discharged from hospital in a state of health which 10 years ago would have resulted in their admission to hospital." The National Association of Practising Psychiatrists made the same point: "Early discharge of patients in the acute phase of psychotic illness is now routine." It is easy to see why.

The doctrine of least-restrictive care has led to fewer and fewer beds, and the consequent overcrowding, understaffing and overwork prompt staff to discharge too soon.

How this combination can work is illustrated in the case of J[redacted]'s 28-year-old daughter K[redacted].

She was discharged from a [redacted] hospital psychiatric unit and hanged herself a month later (there was no follow-up supervision by community mental health staff).

J[redacted] admits that her daughter wanted to get out.

"When my daughter saw the people roaming around in that psychiatric ward, it scared the crapola out of her.

All types were jammed in there together.

It was like putting a child recovering from having her tonsils out in with a lot of old people dying of throat cancer.

" She adds that the doctor who rebuffed her pleas to hold her daughter longer "had black circles under her eyes; she had probably just worked a 36-hour shift".

Proper hospital care – if it were available – is the safe alternative.

As the WA study Duty to Care (documenting the fate of every mental health patient in the state between 1980 and 1998) pointed out: "The suicide rate was lowest during inpatient care and was comparable to the suicide rate of the general population.

" A Victorian study of mental health suicides between 1989 and 1994 found only 13 inpatient suicides in the total of 619.

The factors that lead to preventable patient suicides are also behind the homicides, according to Bill Barclay.

He should know, for he is NSW Health's confidential private investigator.

Probably the foremost authority on the public mental health system, Barclay was chief psychiatrist in the NSW health system from 1966 to 1977, then embarked on a late career as an expert witness in cases of murder by mentally disordered people.

"I helped develop the defence of substantial impairment," he says.

When a cluster of nine homicides by recently discharged psychiatric patients occurred in NSW in 2001, the NSW Centre for Mental Health sent for Barclay.

He cannot divulge details of his report – he suggests I try an FOI approach – but in the recent Attia the coroner subpoenaed murder-suicide case in NSW part of his secret report.

Violent and suicidal, Hossam Attia tried to kill himself by driving his car into a wall.

After being admitted to hospital, he was assessed by two psychiatrists as being at high risk of doing harm to himself and his family, and was recommended for hospital treatment.

Two days later, another two psychiatrists (without consultation with Hassam's wife or their colleagues) gave him a prescription for anti-depressants and let him loose.

He went home and shot his wife, then himself.

Their three children were in the house at the time.

Asked later by the coroner why they discharged him, the doctors replied: "Risks of suicide and harm to others were considered high.

However, community management was considered the least restrictive option.

" The Hippocratic oath whatever the macro defects of the system, the parents and wives of victims, even the coroners, often blame the staff.

"I still can't bring myself to forgive the hospital and the triage nurse and the crisis assessment team that sent Bob home," Joan Robinson says.

Coroner [redacted] was trenchant about the psychiatrists at [redacted] who discharged B[redacted] describing their evidence as "talking in circles".

He found: "Medical justice does not appear to have been done.

NSW deputy chief coroner Jacqueline Milledge came to the same conclusion in the Attia case.

[redacted] is still critical of staff at [redacted] in Sydney.

When [redacted] accompanied her 27-year-old son M[redacted] (who had a history of depression, drug overdoses and suicide attempts) to [redacted] Hospital after police found him sitting in his sealed car with a hose connected to the exhaust, the first psychiatrist she saw refused to admit him.

"He said that M[redacted] told him he was just experimenting with car exhaust fumes – and he believed him. If I hadn"t burst into tears and refused to leave, they would not have admitted M[redacted]."

" Later that night, she rang the staff to say her son had phoned home from the ward to say goodbye and she begged for a close watch on him.

But it wasn't close enough; he committed suicide early the next morning.

O[redacted] is one of those parents who continue to campaign for mental health reform.

G[redacted] in Victoria has been at it for 10 years.

After repeated suicide attempts, his son J[redacted] was discharged three times in eight days before he eventually succeeded in killing himself.

B[redacted] sees the problem as the failure of staff to observe the high-sounding treatment protocols on mental illness and suicide that every state has in fact adopted.

Last year, the Victorian auditor-general found that these protocols were more frequently breached than honoured.

J[redacted] puts it simply: staff at the hospital and community mental health workers "failed my daughter".

Even New Zealand-born author and forensic nurse [redacted], who advocates a return to the old stand-alone psychiatric hospitals, surprises me when I advance the alibi that staff discharge because of the pressure on beds.

"No, the staff should treat them properly no matter what the conditions," Neame says.

"If people need treatment, nurses and registrars should just keep them there, even if it means beds in the corridors or mattresses on the floor." But it is K[redacted], the quietly spoken widow of G[redacted] who absconded from the [redacted] unit at Sydney"s [redacted] Hospital and jumped from [redacted] Bridge, who makes the point about staff culpability most persuasively.

She recounts her own struggle to have G[redacted] admitted: he woke her at 3am one morning to give her a suicide note but, even though he was suffering from psychosis as well as deep depression ("the television was telling him to kill himself"), it took her until 7pm that night to get him admitted.

A crisis team came in the morning but declined to act.

When the hospital did agree to admit him after hours of waiting, she was not consulted during his assessment.

She is convinced staff were too lax in their supervision, allowing him to abscond and go to his death.

The only extenuating circumstance she will allow them – and C[redacted] has mentioned this, too – is the bedlam and circus antics that can reign in hospital psychiatric wards.

"All kinds of cases are bunched together in the unit, including the chronic cases, the regulars who roam around disrupting and claiming a lot of attention," she says.

This memory softens but does not alter her judgment: the more-beds position won"t wash.

"Every service could do with more funding.

That"s just avoiding the problem," she says.

"The assessment procedures are what is crucial and staff have to remember they have a duty to care.

Hospitals are there to save lives – and I”m afraid that, as far as people with life-threatening psychiatric conditions are concerned, they are not.

” Alibis and defenders There are, on the other hand, defenders of the system.

Their argument is essentially that the suicide and homicide death toll is the unfortunate price we pay for freedom and the happiness of the greater number.

Victoria’s deputy chief psychiatrist Ruth Vine, for example, sees the suicide toll as “the downside” of an approach that is basically heading in the right direction.

Vine sees the call for more beds and longer stays as “simplistic”.

She believes the prime emphasis should be on active support in the community after discharge.

Whether that would have saved people such as [redacted] or [redacted] is a moot point; families do have to sleep and cannot run shifts like a hospital can.

Nor are they in a position to deal with florid (angry and violent) psychosis.

Although Vine acknowledges the number of beds is under pressure in Victoria, she also points out that a relatively low% age of discharged patients actually commit suicide or murder, and that picking the future dead (and killers for that matter) among thousands of cases each year is well nigh impossible.

But the mental health authorities in NSW are not in a position to rely on the upbeat Vine position. The death toll is too high.

They acknowledge that gadflies such as Sydney psychiatrist Jean Lennane (see story on page 26), and the small band of psychiatrists and parents who have been campaigning for reform, have a point.

Without fanfare, NSW Health (the Centre for Mental Health is its policy and advisory unit) has set up the Sentinel Events Review Committee. Its brief is to come up with recommendations to cut the death toll among patients of the mental health system. The secrecy surrounding this committee makes Lennane wary. Nearly half the committee’s members are either employed or funded by NSW Health and the committee meets at NSW Health’s head office. Members have been literally sworn to secrecy; each has had to sign a confidentiality agreement and are warned that they face a fine of $10,000 or six months in jail if they break it.

This is enough to deter members of the committee from speaking on the record.

Its chairman, Professor Peter Baume, did not respond to messages from The Bulletin on his answering machine.

The NSW death-toll committee is what is known as “a standing committee” – like the committees that exist for child deaths and anaesthesia deaths in most states.

This is the first for mental health in Australia and has long been advocated by people such as L[redacted].

“Death, after all, is the ultimate failure of a system of treatment,” she says.

The committee, set up in August last year, was recommended by the Barclay report on the bunch of 2001 homicides.

It is expected to issue its first report in February next year.

Among its 15 members is a carer representative, J[redacted]

Her presence is crucial because one of the most common threads in the tragedies of mental health deaths is that family members" opinions were not heeded.

Invariably they object to the rush to discharge or warn about what could happen, and almost invariably they are ignored, with deadly consequences.

Reefer madness The de-institutionalises blame drugs fortheir problems.

They argue that drug addiction either makes those already mentally ill worse, or it arouses an illness that would otherwise lie dormant.

Mentally ill people are now in a position to take recreational drugs like anyone else.

And they do. Massively.

Most people with serious mental illness use – unadulterated or in cocktails – alcohol, marijuana, amphetamines and heroin.

It"s not as though they are in constant party mode; it is more like "self-medication", a search for consolation, escape and mood improvement.

Observers can and do argue over this phenomenon – some blaming the drugs (especially marijuana) for causing or exacerbating illness.

Others, more controversially, see selfmedication as a means of increasing the level of serotonin in the brain in much the same way as modern anti-depressant and anti-psychotic drugs do.

(Low levels of serotonin are associated with acute mental illness; therefore, upping the level is viewed as a way of alleviating symptoms and increasing periods of normality and pleasure.) However, people in hospital emergency or psychiatric wards see only one side of the story: a wave of drug abusers and disturbed people coming through their doors. And after they have gone back out the doors, it"s the coroners" turn to see the same people with dual-diagnosis problems, or by that stage, "co-morbidity factors".

It"s not just a question of increased numbers. There are also the problems of diagnosis. When a mentally disturbed person turns up at a hospital under the influence of drugs such as alcohol and marijuana, the psychiatrist or nurse has to decide if their condition is drug-induced or if there is an underlying mental illness that has been exacerbated by drugs. While the layperson may think it doesn"t matter much – the person is still surely a suitable case for treatment – the "reforms" of the 1980s separated mental health and drug-addiction services. The first is only interested in cases of underlying sickness and the second in drug-induced problems. As it is often unclear what the correct diagnosis is, those in need can be shunted back and forth until they fall between two stools – sometimes to their death.

M[redacted] is a classic example of dual diagnosis: in and out of hospital psychiatric units, but as a heavy marijuana user he did try a month before his suicide to be admitted to a detox program.

He rang the program every day for four weeks to no avail.

There were never any spare beds.

Soon after, he began his final downward spiral.

The situation is no different or better elsewhere. Three years ago, Victorian deputy state coroner Iain West, delivering his findings on a clutch of drug and mental illness-related suicides on suburban railway lines in Melbourne, recommended that “consideration be given to establishing a specialist dual-diagnosis withdrawal unit and long-term rehabilitation unit, which has the capacity to accept involuntary admissions. Such a clinic would need to be staffed by clinicians educated and experienced in both mental health and substance abuse management.” This was not the first of such recommendations but they have not been acted upon.

“We now have four dual-diagnosis teams,” Ruth Vine says, “but no beds.” Whatever way you look at the death toll, the recurring problem is that there are just not enough hospital places. Even if the brave new world of mental health has been ambushed by history – by a pandemic of reefer madness – the de-institutionalisation push has clearly gone too far. Active, collaborative, longer-stay treatment in wellresourced hospital settings needs to be back on the agenda.

At the end of her interview, Raphael appeals for a positive story.

“Mental health needs all the friends it can get,” she says.

It certainly does.

But people with mental illness need them more.

The crisis they face was captured last year in an exchange between Dr Brian Pezzuti, chair of the NSW select committee into mental health, and a government pathologist giving (unauthorised) evidence about the problem of too-rapid discharge.

Pezzuti was looking for confirmation that the witness saw the problem in terms of too few beds, and he got it – in spades.

Chair: “There is too much pressure on hospital beds, is there not?” Dr Ella Sugo: “Yes, but I guess there is going to be pressure in the graveyard if it continues.

” Read more by clicking below: * How the figures were covered up * The official story * Source: National Mental Health Report 2002 ** Source: Victorian Attorney-General”s Report 2002 Care to comment? Letters to The Bulletin should be no longer than 200 words and sent to: [redacted]

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Letters may be edited for length and clarity.

For Sydney psychiatrist Jean Lennane, the long silence on the mounting mental health death toll is explained by an unholy united front.

“People with a mental illness have been caught in a deadly pincer movement from the right and the left,” she says when talking about the closure of psychiatric hospitals in the past 15 years and the doctrine of least-restrictive care.

“The right believes in curbing public spending regardless of the human cost, and the left believes in promoting freedom even if it kills you.

” There is no doubt that least-restrictive care is also least-expensive care.

Ruth Vine, the deputy chief psychiatrist in Victoria, says the cost of an acute bed in a hospital is $380 a day, compared with $200 a day for a bed in a 24-hour staffed community residential unit.

Between World War II and 1980, the numbers in psychiatric hospitals fell from 400 per 100,000 to fewer than 100.

Nevertheless, the 1980s reformers further accelerated the cuts, halving beds nationwide.

As for the fatal effects of this revolution, the mental health authorities have been secretly collecting the figures, counting the bodies.

Each year, hospitals and area health services tot up the death toll.

They have special forms.

In NSW, they are called “Mental health client death report forms”, and in Victoria, “Notifications of reportable deaths including suicides in the public mental health service”.

These macabre pieces of paper, dry collections of statistics steeped in pain and tragedy, have been flowing into capital city head offices for more than a decade.

Requests for these figures were rebuffed in NSW and Victoria: the collected figures were “unreliable”, “unavailable” and yet to be checked against coronial records.

There are other reasons for the official silence, which Gavin Stewart, evaluations manager at the NSW Centre for Mental Health, spells out: media reporting of suicides leads to a copycat surge in suicides.

“A stack of studies confirm this,” he says.

Lennane, chief gadfly from NAPP, counters: “This may be true of celebrity suicides but the official suppression of these figures for a decade has led to hundreds of preventable suicides.

The real danger is in the censorship of the death toll.

That”s what kills.

” Only in Western Australia have the death toll figures been published.

A University of WA research team found annual deaths from suicide among mental health patients doubled from 1980 to 1998.

The climb was sharpest in the early 1980s at the beginning of the bed closures and accelerated again in the late 1990s when there was another round of bed reductions.

In NSW, there appears to have been an even more dramatic increase in suicides of the mentally ill.

A research paper covering 1993-1995 gave an average five or six deaths a month from suicide by mental health patients.

Five years later, the toll for 1999 and 2000 was 14 to 15 a month, according to a leaked draft confidential memo from NSW Health.

Lennane produces 1989 figures that show 2 to 3 deaths a month.

While there is an official argument that the pre-1995 figures underestimated the death toll, the point made in 1997 by New Zealand nurse Peter Neame (and echoed by the WA study) appears to be inescapable: “You cannot close places of safety for the mentally ill – psychiatric hospitals – without a subsequent rise in the suicide rate.

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Beverley Raphael, the friendly, squeaky-voiced professor who heads up the Centre for Mental Health in NSW Health, is defensive at first.

She begins by justifying the refusal to release death toll figures – they are “not reliable”, have yet to be “processed”, “finally collated”, “fully analysed”, and matched with coronial figures.

They will be made publicly available next year, she promises.

Informed the delay could appear astonishing given the seriousness of the situation, Raphael admits: “It certainly sounds like it should have happened earlier .

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it was certainly on the agenda.

” She is equally ill at ease when asked for figures about her claims of increasing numbers of mental health staff.

Her centre does not have workforce data but this is “another data-collection initiative we are putting in place”.

About midway through the interview, Raphael reveals she shares concerns about the death toll and claims credit for the Sentinel Events Review Committee.

“It was my push that has put this absolutely independent committee into place.

It has been my clear belief since I arrived in this position [in 1996] that we need more beds.

” The NSW government has listened to her, she says, delivering funds for 300 more beds in recent years.

Raphael is certainly aware of the bed shortage.

As she told the NSW select committee into mental health, when giving evidence on August 12 last year: “As occurred in the middle of last night, I am rung to find a bed when one is needed.

” Raphael reports some progress, claiming the mental health suicide toll is falling.

Victoria”s deputy chief psychiatrist Ruth Vine makes virtually the same claim for her state.

But the critics claim otherwise.

When Four Corners put the Raphael claim to former National Association of Practising Psychiatrists president Rachel Falk last year, Falk dismissed it as “patently nonsense.

Why would they be decreasing when the system is demonstrably getting worse and worse?” It is of course easier and quicker to demolish a system than to rebuild it.

Beds are being promised, and even built, but there is no staff.

Dr Alex Campbell, acting head of the Central Coast Area Health Service in NSW, told the [redacted] inquest in June (see main story) that, while there were plans to treble the number of beds to 75, the department could not even staff the existing 25 beds.

Falk says: “The working conditions are so poor – the staff dissatisfaction, burnout, incapacity to actually do what they want to do with patients, help them, treat them adequately – people don”t want to go into the system.

” – HALL GREENLAND Care to comment? Letters to The Bulletin should be no longer than 200 words and sent to: bulletinletters@acp.

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Reform of the mental health system in Australia in the 1980s and 1990s hit all the hot buttons.

“Human rights”.

“Community care”.

“End of the stigma”.

“Self-reliance”.

“More normal lives”.

There were to be no more men in white coats to whisk away the family embarrassment in the middle of the night.

No more lingering, living deaths behind high walls.

No more padded cells.

No more people strapped to benches and convulsed with electricity.

You could throw away the straitjackets; the nightmare of mental illness was over.

Ken Kesey"s Nurse Ratched was out of a job.

People with mental illness were to walk free.

They walked all right, many of them to premature deaths.

During that short march to the promised psychiatric paradise, the annual number of fatalities has doubled.

In the larger states, it may have quadrupled.

About 400 mentally ill patients throughout Australia – most of them aged in their 20s and 30s – will commit suicide this year because the places that once treated them have been closed or diminished.

They are being turned away and sent to their deaths.

Duty to Care, a landmark West Australian study that recorded this growing toll, introduced the concept of "excess deaths".

Some of these excess deaths are of other people.

Brutally put, increasing numbers of those turned away are going home to kill.

Murders by mentally disordered persons (to use the jargon of criminologists) – although much rarer than suicides – are running at three a month, having nearly doubled from 20 victims in 2000-"01 to 36 in 2001-"02.

If there is any good news – and a cynic may have predicted this – it is that the rising homicide toll, rather than the suicides, appears to have prompted a belated change of heart by authorities – in NSW, at least.

Following an investigation into a cluster of mental health homicides in the state, undertaken by a man who can only be described as NSW Health"s confidential agent, an unheralded, secret inquiry has been set up.

The absence of fanfare is true to form.

For almost a decade there has been an official cover-up (see story on page 28) of the death toll in NSW and a remarkable media reticence about criticising an experiment that has had such a high cost in human terms.

One head-office apparatchik, whose job is to secretly add up the death figures, admits: "If it had been SARS [deaths], there would have been an outcry.

" To be fair, a journalist with The Sydney Morning Herald who tried in 2001 to use freedom-of-information laws to force NSW Health to release the death toll figures was refused on the grounds that "it would unreasonably divert the department"s resources to attempt to process your application".

One of the new mental health system"s critics (you might have labelled him alarmist if you did not know the numbers) cites Freud"s contention that two forces lie at the root of human existence – the life force and the death force, or Eros and Thanatos, to use the ancient Greek concepts – and argues that the second has been let loose.

When you talk to the loved ones of the victims, they have a tendency to blame the doctors – and the coroners" findings often echo this.

How could health professionals have let these sick people out when the families and friends knew these patients would try to kill themselves or others? Unavoidable, all-too-human error does play its part and Dr Bill Barclay, probably Australia"s most experienced forensic psychiatrist, argues convincingly that not all these deaths are preventable.

"Even the best psychiatrists make mistakes in risk assessment," he says.

"And we all know that even if we hold people for treatment, we may only be delaying their suicide.

" But that delay can and does offer a window of opportunity for successful treatment, as Barclay concedes.

Trouble is, as we shall see, the state of the system and its underlying philosophy do not encourage such delays – in fact, they discourage it.

Even with improvements in the clinical practice of hospital psychiatrists – which family members without exception cry out for – the death toll will persist if the built-in bias of discharging unrecovered and dangerously ill people is not ended.

Authorities have replies for all these arguments.

Their main one – the reefer madness defence, if you like – is that the new libertarian system has been overwhelmed by a wave of drug-induced or drug-exacerbated madness.

Professor Beverley Raphael, director of the NSW Centre for Mental Health, said in June that the numbers of people requiring psychiatric treatment fronting at hospital emergency departments had doubled in the past decade.

She put it down to drugs.

Barclay also says that drug addiction has added a new dimension to mental health care.

"When I left the system in the late 1980s, this problem did not exist," he says.

Yet it remains true that many of the deaths are not related to drug addiction.

While the silence of governments, the obfuscation of health authorities and media deafness have largely kept this new category of deaths out of the public arena, coroners have heard the screams.

Take one case off the top of a pile of findings from coroners in NSW and Victoria.

Significantly, it does not involve illicit drugs.

[redacted] was 19, a tall, good-looking man who worked part-time in a supermarket and was scoring top marks in his TAFE course.

Like his mates, he skated and had studs in all the wrong places.

The only clouds on his parents" horizons were that he had lately become introverted, brooding and played rap music so loud that it disturbed the neighbours.

Then in the early hours of the second Monday in December 2002, Ben took the family car and tried to drive over a cliff.

When that failed, he drove headlong into the side of a house.

Still alive, and charged with all the energy a psychotic episode produces, he fled into nearby bushland.

B[redacted]”s family and mates joined police in the manhunt that followed.

It wasn”t until some hours later that he was finally captured – his mates had caught him earlier but he had managed to break free.

Half-dressed, bloodied and wild-eyed, he was admitted to [redacted], the psychiatric unit at [redacted] hospital on the [redacted].

Less than 48 hours later, he was discharged – by a doctor with “only” four months” experience in the job, according to the coroner, although a more senior doctor assented to this discharge.

B[redacted] was lucky to stay that long: his mother and B[redacted] were told on his second night he would have to give up his bed and be sent home if a more pressing case presented.

His father brought him home the next day.

B[redacted] waited until the family was asleep that evening, then walked out of the house to a nearby railway bridge and threw himself in front of a train.

Police took fingerprints from his bedroom to match the remains.

B[redacted]”s mother and father recounted these details from their [redacted] project home at [redacted], a typical subdivision circling regional centres in the state.

C[redacted]”s father G[redacted] paces and hovers at the far end of the living room, breaking his silence only after his wife C[redacted] has told the story of their son”s final days.

“Why didn”t they tell us that the medication takes at least two weeks to start working?” he asks from the far corner.

“They told us nothing,” C[redacted] adds, “Just sent B[redacted] home as though he had a Band-Aid on him.

Even when my daughter had the cast taken off her broken arm, they said don”t go yet until you have talked to the doctor.

We didn”t even get that.

” The day B[redacted] came home, G[redacted] arranged with his employer to take four weeks” leave to care for his son.

But that first night B[redacted] took his life.

Still broken with grief, G[redacted] tries to understand what happened.

C[redacted] is in no doubt about what should have happened.

“They should have kept him two or three weeks until they were sure he was all right.

I know he would have come good.

” But such treatment is rarely available or possible today.

In the 1980s, the doctrine of “least-restrictive care environment” was written into mental health acts in all states and the wholesale closure of psychiatric hospitals followed.

Some of the lost beds were transferred to general hospitals as new psychiatric annexes were established; these are invariably crowded and unwelcoming.

Community care was the new panacea, yet it was a promised land never reached.

As a pathologist who gave evidence to the NSW Upper House select committee on mental health last year put it: “Community care too often means no care.

” Yet the instincts of B[redacted]”s mother about the hospital care her son should have had are correct.

The anti-depressants prescribed for B[redacted] not only take time to take effect, in some cases, they don”t work at all; in others, they can worsen a patient”s condition before they kick in.

Barclay says they can take two to four weeks to work.

The uncertainty of medication is one reason why the critics of de-institutionalisation advocate a return to longer stays and closer observation.

The Duty to Care study in WA noted that, in acute cases, the average length of stay has been reduced from five days to three.

Coroner Michael Morahan made these points in his finding on [redacted]”s death: “Staff were over-anxious to discharge B[redacted] due to the perennial shortage of beds at [redacted] and this is one of the many cases which highlight government neglect in the area of mental health facilities.

” Like [redacted], half of mental health suicides happen within 48 hours of discharge.

Yet it has been known for at least a decade that the suicide rate in the immediate period after discharge is 100 times the rate for the general population; for patients with depression, it is up to 500 times.

A 1995 research paper, published by NSW Health itself, listed among the reasons for this “the fact that the patient may not be fully recovered”.

Stories of sending vulnerable, unrecovered patients back into the world are legion.

Just last month a neighbour told me this story, which checked out.

A country NSW woman (call her Jan) with a long record of mental illness had recently attempted suicide.

She went to hospital where she tried to kill herself again but was nevertheless discharged two days later and put on a bus alone to go home to a vacant house.

(Her sister had been at the hospital half an hour before the discharge but was told it would not happen until the next day.

) The next morning, unable to raise Jan, her sister rang a community mental health worker soon after 9am to ask for an urgent visit, only to be told not to worry because Jan had been instructed to ring for an appointment.

Jan”s sister then drove the two hours from Sydney to find Jan dead from an overdose.

On Jan”s answer machine was a message from the health worker, left at 9.

40am, reminding Jan to ring about her appointment.

Understandably, Jan”s sister is not just grief-stricken but angry.

If it can be put this way, B[redacted] and Jan were lucky to be even admitted to a hospital psychiatric ward.

Take the case of Bob Robinson (not his real name because his family was divided over the use of it).

This 29-year-old, suffering from schizophrenia, attempted suicide by jumping from the first-floor balcony of his family home in the [redacted]

Taken to hospital by his mother “Joan”, Bob convinced “the community assessment team” that he was OK.

Despite his mother”s misgivings (“Look, they treated me like an idiot,” she recalls in her strong, educated voice), he was sent home.

That night she suspected he had overdosed – she found emptied medication packets in the bathroom – and rang the hospital again, only to be told to monitor his condition and ring again in the morning.

Later, desperately worried, she tried her brother (a doctor in Brisbane) but he was at a dinner party and she didn”t want to bother him.

It was a long watchful night: about 2am, and then a few hours later, she checked.

When she finally woke at 7.

30am after a night of fitful sleep, Bob was scarcely breathing and died on the way to hospital.

Only now is Robinson”smother coming to terms with the death of her youngest son.

“I was off my head for 18 months, crying all the time.

” She still has not forgiven the hospital and confesses she has not been able to decide on a headstone for the grave.

“I just haven”t had the strength.

” Like [redacted], Joan Robinson says her son should have been kept in hospital.

“You know it is not certain that he even suicided.

He told me he just wanted to get rid of the voices.

” This “overanxious to discharge” habit was at the centre of recent media furore over a man who sued NSW Health and won $300,000 in damages.

Under the influence of alcohol and marijuana, K[redacted] had a major psychotic episode (he tried to throttle a three-year-old and had to be subdued with a cricket bat) but was released from hospital care the next day despite the objections of his brother.

He went back to the brother”s house and later that day murdered the brother”s fiancee.

Taxed with this overanxiety to release, a hospital psychiatrist echoed official policy: “I cannot go and jump on everyone and put everyone in the wards because yesterday he was suicidal .

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or murderous.

” But staff are aware that they are discharging people who are still possibly suicidal or murderous.

Their union, the Salaried Medical Officers Federation, told last year”s NSW Upper House inquiry into mental health services: “It is often the case that patients are discharged from hospital in a state of health which 10 years ago would have resulted in their admission to hospital.

” The National Association of Practising Psychiatrists made the same point: “Early discharge of patients in the acute phase of psychotic illness is now routine.

” It is easy to see why.

The doctrine of least-restrictive care has led to fewer and fewer beds, and the consequent overcrowding, understaffing and overwork prompt staff to discharge too soon.

How this combination can work is illustrated in the case of J[redacted]s 28-year-old daughter K[redacted].

She was discharged from a [redacted] Melbourne hospital psychiatric unit and hanged herself a month later (there was no follow-up supervision by community mental health staff).

J[redacted] admits that her daughter wanted to get out.

“When my daughter saw the people roaming around in that psychiatric ward, it scared the crapola out of her.

All types were jammed in there together.

It was like putting a child recovering from having her tonsils out in with a lot of old people dying of throat cancer.

” She adds that the doctor who rebuffed her pleas to hold her daughter longer “had black circles under her eyes; she had probably just worked a 36-hour shift”.

Proper hospital care – if it were available – is the safe alternative.

As the WA study Duty to Care (documenting the fate of every mental health patient in the state between 1980 and 1998) pointed out: “The suicide rate was lowest during inpatient care and was comparable to the suicide rate of the general population.

” A Victorian study of mental health suicides between 1989 and 1994 found only 13 inpatient suicides in the total of 619.

The factors that lead to preventable patient suicides are also behind the homicides, according to Bill Barclay.

He should know, for he is NSW Health”s confidential private investigator.

Probably the foremost authority on the public mental health system, Barclay was chief psychiatrist in the NSW health system from 1966 to 1977, then embarked on a late career as an expert witness in cases of murder by mentally disordered people.

“I helped develop the defence of substantial impairment,” he says.

When a cluster of nine homicides by recently discharged psychiatric patients occurred in NSW in 2001, the NSW Centre for Mental Health sent for Barclay.

He cannot divulge details of his report – he suggests I try an FOI approach – but in the recent Attia murder-suicide case in NSW part of his secret report was subpoenaed by the coroner.

Violent and suicidal, Hossam Attia tried to kill himself by driving his car into a wall.

After being admitted to hospital, he was assessed by two psychiatrists as being at high risk of doing harm to himself and his family, and was recommended for hospital treatment.

Two days later, another two psychiatrists (without consultation with Hossam"s wife or their colleagues) gave him a prescription for anti-depressants and let him loose.

He went home and shot his wife, then himself.

Their three children were in the house at the time.

Asked later by the coroner why they discharged him, the doctors replied: "Risks of suicide and harm to others were considered high.

However, community management was considered the least restrictive option.

" The HIPpocratic oath Whatever the macro defects of the system, the parents and wives of victims, even the coroners, often blame the staff.

"I still can"t bring myself to forgive the hospital and the triage nurse and the crisis assessment team that sent Bob home," Joan Robinson says.

Coroner Michael Morahan was trenchant about the psychiatrists at [redacted] who discharged B[redacted], describing their evidence as "talking in circles".

He found: "Medical justice does not appear to have been done.

" NSW deputy chief coroner Jacqueline Milledge came to the same conclusion in the Attia case.

D[redacted] is still critical of staff at [redacted] Hospital in Sydney.

When [redacted] accompanied her 27-year-old son M[redacted] (who had a history of depression, drug overdoses and suicide attempts) to [redacted]Hospital after police found him sitting in his sealed car with a hose connected to the exhaust, the first psychiatrist she saw refused to admit him.

"He said that M[redacted] told him he was just experimenting with car exhaust fumes – and he believed him.

If I hadn"t burst into tears and refused to leave, they would not have admitted Matthew.

" Later that night, she rang the staff to say her son had phoned home from the ward to say goodbye and she begged for a close watch on him.

But it wasn"t close enough; he committed suicide early the next morning.

[redacted] is one of those parents who continue to campaign for mental health reform.

G[redacted] in Victoria has been at it for 10 years.

After repeated suicide attempts, his son J[redacted] was discharged three times in eight days before he eventually succeeded in killing himself.

[redacted] sees the problem as the failure of staff to observe the highsounding treatment protocols on mental illness and suicide that every state has in fact adopted.

Last year, the Victorian auditor-general found that these protocols were more frequently breached than honoured.

[redacted] puts it simply: staff at the hospital and community mental health workers “failed my daughter”.

Even New Zealand-born author and forensic nurse [redacted] [redacted], who advocates a return to the old stand-alone psychiatric hospitals, surprises me when I advance the alibi that staff discharge because of the pressure on beds.

“No, the staff should treat them properly no matter what the conditions,” [redacted] says.

“If people need treatment, nurses and registrars should just keep them there, even if it means beds in the corridors or mattresses on the floor.

” But it is [redacted], the quietly spoken widow of [redacted], who absconded from the [redacted] unit at Sydney”s [redacted] Hospital and jumped from [redacted] Bridge, who makes the point about staff culpability most persuasively.

She recounts her own struggle to have [redacted] admitted: he woke her at 3am one morning to give her a suicide note but, even though he was suffering from psychosis as well as deep depression (“the television was telling him to kill himself”), it took her until 7pm that night to get him admitted.

A crisis team came in the morning but declined to act.

When the hospital did agree to admit him after hours of waiting, she was not consulted during his assessment.

She is convinced staff were too lax in their supervision, allowing him to abscond and go to his death.

The only extenuating circumstance she will allow them – and [redacted] has mentioned this, too – is the bedlam and circus antics that can reign in hospital psychiatric wards.

“All kinds of cases are bunched together in the unit, including the chronic cases, the regulars who roam around disrupting and claiming a lot of attention,” she says.

This memory softens but does not alter her judgment: the more-beds position won”t wash.

“Every service could do with more funding.

That”s just avoiding the problem,” she says.

“The assessment procedures are what is crucial and staff have to remember they have a duty to care.

Hospitals are there to save lives – and I”m afraid that, as far as people with life-threatening psychiatric conditions are concerned, they are not.

” Alibis and defenders There are, on the other hand, defenders of the system.

Their argument is essentially that the suicide and homicide death toll is the unfortunate price we pay for freedom and the happiness of the greater number.

Victoria"s deputy chief psychiatrist Ruth Vine, for example, sees the suicide toll as "the downside" of an approach that is basically heading in the right direction.

Vine sees the call for more beds and longer stays as "simplistic".

She believes the prime emphasis should be on active support in the community after discharge.

Whether that would have saved people such as [redacted] or Bob Robinson is a moot point; families do have to sleep and cannot run shifts like a hospital can.

Nor are they in a position to deal with florid (angry and violent) psychosis.

Although Vine acknowledges the number of beds is under pressure in Victoria, she also points out that a relatively low%age of discharged patients actually commit suicide or murder, and that picking the future dead (and killers for that matter) among thousands of cases each year is well nigh impossible.

But the mental health authorities in NSW are not in a position to rely on the upbeat Vine position.

The death toll is too high.

They acknowledge that gadflies such as Sydney psychiatrist Jean Lennane (see story on page 26), and the small band of psychiatrists and parents who have been campaigning for reform, have a point.

Without fanfare, NSW Health (the Centre for Mental Health is its policy and advisory unit) has set up the Sentinel Events Review Committee.

Its brief is to come up with recommendations to cut the death toll among patients of the mental health system.

The secrecy surrounding this committee makes Lennane wary.

Nearly half the committee"s members are either employed or funded by NSW Health and the committee meets at NSW Health"s head office.

Members have been literally sworn to secrecy; each has had to sign a confidentiality agreement and are warned that they face a fine of $10,000 or six months in jail if they break it.

This is enough to deter members of the committee from speaking on the record.

Its chairman, Professor Peter Baume, did not respond to messages from The Bulletin on his answering machine.

The NSW death-toll committee is what is known as "a standing committee" – like the committees that exist for child deaths and anaesthesia deaths in most states.

This is the first for mental health in Australia and has long been advocated by people such as Lennane.

"Death, after all, is the ultimate failure of a system of treatment," she says.

The committee, set up in August last year, was recommended by the Barclay report on the bunch of 2001 homicides.

It is expected to issue its first report in February next year.

Among its 15 members is a carer representative, [redacted].

Her presence is crucial because one of the most common threads in the tragedies of mental health deaths is that family members" opinions were not heeded.

Invariably they object to the rush to discharge or warn about what could happen, and almost invariably they are ignored, with deadly consequences.

Reefer madness The de-institutionalisers blame drugs for their problems.

They argue that drug addiction either makes those already mentally ill worse, or it arouses an illness that would otherwise lie dormant.

Mentally ill people are now in a position to take recreational drugs like anyone else.

And they do.

Massively.

Most people with serious mental illness use – unadulterated or in cocktails – alcohol, marijuana, amphetamines and heroin.

It"s not as though they are in constant party mode; it is more like "self-medication", a search for consolation, escape and mood improvement.

Observers can and do argue over this phenomenon – some blaming the drugs (especially marijuana) for causing or exacerbating illness.

Others, more controversially, see selfmedication as a means of increasing the level of serotonin in the brain in much the same way as modern anti-depressant and anti-psychotic drugs do.

(Low levels of serotonin are associated with acute mental illness; therefore, upping the level is viewed as a way of alleviating symptoms and increasing periods of normality and pleasure.

) However, people in hospital emergency or psychiatric wards see only one side of the story: a wave of drug abusers and disturbed people coming through their doors.

And after they have gone back out the doors, it"s the coroners" turn to see the same people with dual-diagnosis problems, or by that stage, "co-morbidity factors".

It"s not just a question of increased numbers.

There are also the problems of diagnosis.

When a mentally disturbed person turns up at a hospital under the influence of drugs such as alcohol and marijuana, the psychiatrist or nurse has to decide if their condition is drug-induced or if there is an underlying mental illness that has been exacerbated by drugs.

While the layperson may think it doesn"t matter much – the person is still surely a suitable case for treatment – the "reforms" of the 1980s separated mental health and drug-addiction services.

The first is only interested in cases of underlying sickness and the second in drug-induced problems.

As it is often unclear what the correct diagnosis is, those in need can be shunted back and forth until they fall between two stools – sometimes to their death.

[redacted] is a classic example of dual diagnosis: in and out of hospital psychiatric units, but as a heavy marijuana user he did try a month before his suicide to be admitted to a detox program.

He rang the program every day for four weeks to no avail.

There were never any spare beds.

Soon after, he began his final downward spiral.

The situation is no different or better elsewhere.

Three years ago, Victorian deputy state coroner Iain West, delivering his findings on a clutch of drug and mental illness-related suicides on suburban railway lines in Melbourne, recommended that “consideration be given to establishing a specialist dual-diagnosis withdrawal unit and long-term rehabilitation unit, which has the capacity to accept involuntary admissions.

Such a clinic would need to be staffed by clinicians educated and experienced in both mental health and substance abuse management.

” This was not the first of such recommendations but they have not been acted upon.

“We now have four dual-diagnosis teams,” Ruth Vine says, “but no beds.

” Whatever way you look at the death toll, the recurring problem is that there are just not enough hospital places.

Even if the brave new world of mental health has been ambushed by history – by a pandemic of reefer madness – the de-institutionalisation push has clearly gone too far.

Active, collaborative, longer-stay treatment in wellresourced hospital settings needs to be back on the agenda.

At the end of her interview, Raphael appeals for a positive story.

“Mental health needs all the friends it can get,” she says.

It certainly does.

But people with mental illness need them more.

The crisis they face was captured last year in an exchange between Dr Brian Pezzuti, chair of the NSW select committee into mental health, and a government pathologist giving (unauthorised) evidence about the problem of too-rapid discharge.

Pezzuti was looking for confirmation that the witness saw the problem in terms of too few beds, and he got it – in spades.

Chair: “There is too much pressure on hospital beds, is there not?” Dr Ella Sugo: “Yes, but I guess there is going to be pressure in the graveyard if it continues.

” Read more by clicking below: * How the figures were covered up * The official story * Source: National Mental Health Report 2002 ** Source: Victorian Attorney-General”s Report 2002 Care to comment? Letters to The Bulletin should be no longer than 200 words and sent to: bulletinletters@acp.

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au or Letters Editor, The Bulletin, GPO Box 3957, Sydney, NSW 1028.

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For Sydney psychiatrist Jean Lennane, the long silence on the mounting mental health death toll is explained by an unholy united front.

“People with a mental illness have been caught in a deadly pincer movement from the right and the left,” she says when talking about the closure of psychiatric hospitals in the past 15 years and the doctrine of least-restrictive care.

“The right believes in curbing public spending regardless of the human cost, and the left believes in promoting freedom even if it kills you.

” There is no doubt that least-restrictive care is also least-expensive care.

Ruth Vine, the deputy chief psychiatrist in Victoria, says the cost of an acute bed in a hospital is $380 a day, compared with $200 a day for a bed in a 24-hour staffed community residential unit.

Between World War II and 1980, the numbers in psychiatric hospitals fell from 400 per 100,000 to fewer than 100.

Nevertheless, the 1980s reformers further accelerated the cuts, halving beds nationwide.

As for the fatal effects of this revolution, the mental health authorities have been secretly collecting the figures, counting the bodies.

Each year, hospitals and area health services tot up the death toll.

They have special forms.

In NSW, they are called “Mental health client death report forms”, and in Victoria, “Notifications of reportable deaths including suicides in the public mental health service”.

These macabre pieces of paper, dry collections of statistics steeped in pain and tragedy, have been flowing into capital city head offices for more than a decade.

Requests for these figures were rebuffed in NSW and Victoria: the collected figures were “unreliable”, “unavailable” and yet to be checked against coronial records.

There are other reasons for the official silence, which Gavin Stewart, evaluations manager at the NSW Centre for Mental Health, spells out: media reporting of suicides leads to a copycat surge in suicides.

“A stack of studies confirm this,” he says.

Lennane, chief gadfly from NAPP, counters: “This may be true of celebrity suicides but the official suppression of these figures for a decade has led to hundreds of preventable suicides.

The real danger is in the censorship of the death toll.

That”s what kills.

” Only in Western Australia have the death toll figures been published.

A University of WA research team found annual deaths from suicide among mental health patients doubled from 1980 to 1998.

The climb was sharpest in the early 1980s at the beginning of the bed closures and accelerated again in the late 1990s when there was another round of bed reductions.

In NSW, there appears to have been an even more dramatic increase in suicides of the mentally ill.

A research paper covering 1993-1995 gave an average five or six deaths a month from suicide by mental health patients.

Five years later, the toll for 1999 and 2000 was 14 to 15 a month, according to a leaked draft confidential memo from NSW Health.

Lennane produces 1989 figures that show 2 to 3 deaths a month.

While there is an official argument that the pre-1995 figures underestimated the death toll, the point made in 1997 by New Zealand nurse Peter Neame (and echoed by the WA study) appears to be inescapable: “You cannot close places of safety for the mentally ill – psychiatric hospitals – without a subsequent rise in the suicide rate.

” Care to comment? Letters to The Bulletin should be no longer than 200 words and sent to: bulletinletters@acp.

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Beverley Raphael, the friendly, squeaky-voiced professor who heads up the Centre for Mental Health in NSW Health, is defensive at first.

She begins by justifying the refusal to release death toll figures – they are “not reliable”, have yet to be “processed”, “finally collated”, “fully analysed”, and matched with coronial figures.

They will be made publicly available next year, she promises.

Informed the delay could appear astonishing given the seriousness of the situation, Raphael admits: “It certainly sounds like it should have happened earlier .

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it was certainly on the agenda.

” She is equally ill at ease when asked for figures about her claims of increasing numbers of mental health staff.

Her centre does not have workforce data but this is “another data-collection initiative we are putting in place”.

About midway through the interview, Raphael reveals she shares concerns about the death toll and claims credit for the Sentinel Events Review Committee.

“It was my push that has put this absolutely independent committee into place.

It has been my clear belief since I arrived in this position [in 1996] that we need more beds.

" The NSW government has listened to her, she says, delivering funds for 300 more beds in recent years.

Raphael is certainly aware of the bed shortage.

As she told the NSW select committee into mental health, when giving evidence on August 12 last year: "As occurred in the middle of last night, I am rung to find a bed when one is needed.

" Raphael reports some progress, claiming the mental health suicide toll is falling.

Victoria"s deputy chief psychiatrist Ruth Vine makes virtually the same claim for her state.

But the critics claim otherwise.

When Four Corners put the Raphael claim to former National Association of Practising Psychiatrists president Rachel Falk last year, Falk dismissed it as "patently nonsense.

Why would they be decreasing when the system is demonstrably getting worse and worse?" It is of course easier and quicker to demolish a system than to rebuild it.

Beds are being promised, and even built, but there is no staff.

Dr Alex Campbell, acting head of the Central Coast Area Health Service in NSW, told the Ben Chapman inquest in June (see main story) that, while there were plans to treble the number of beds to 75, the department could not even staff the existing 25 beds.

Falk says: "The working conditions are so poor – the staff dissatisfaction, burnout, incapacity to actually do what they want to do with patients, help them, treat them adequately – people don"t want to go into the system.

" – HALL GREENLAND Care to comment? Letters to The Bulletin should be no longer than 200 words and sent to: bulletinletters@acp.

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[3] Dr Yolande Lucire PhD MBBS DPM FRANZCP

FORENSIC & MEDICO-LEGAL PSYCHIATRY

Conjoint Senior Lecturer, School of Rural Health

[redacted]

[redacted]

Dear Beverley,

I am writing to invite your attention to an issue that is shaping up as a public health catastrophe in psychiatry and for the profession: the induction of suicidality by all SSRIs. The problem of induced psychiatric disturbance is now known to affect at least 10% of research subjects, including those in healthy volunteer studies. The induction of suicide, the tip of an iceberg of parasuicide, is clearly visible the drug companies" own research which was presented to the FDA in the United States in the late eighties and earlier.

I note in a recent Bulletin article "Dying Shame" by Hall Greenland, dated October 1, 2003, that "a landmark" Western Australian Study that recorded this growing toll, (of suicides in mental health clients) introduced the concept of "excess deaths."

In the same article I read that Professor Beverley Raphael, Director of the NSW Centre for Mental Health said, in June, that the numbers of people requiring psychiatric treatment fronting at hospital emergency departments had doubled in the past decade. Professor Raphael put it down to drugs. The author goes on to say "Yet it remains true that many of the deaths are not due to drug addiction!" Later again

... half of mental health suicides happen within 48 hours of discharge. Yet it has been known for at least a decade that the suicide rate in the immediate period after discharge is 100 times the rate for the general population; for patients with depression, it is up to 500 times. A 1995 research paper, published by NSW Health itself, listed among the reasons for this "the fact that the patient may not be fully recovered."

I also note

The antidepressants prescribed for B[redacted] not only take time to take effect, in some cases, they don"t work at all; in others, they can worsen a patient"s condition before they kick in.

I suspect that medication with SSRIs was commenced in hospital and not yet followed up. Like these suicides, the SSRIs have also been around for about a decade. It may be possible to relate the poorly supervised use of SSRIs to the increasing rate of deaths by suicide in recently discharged mental health patients.

There are increasing numbers of persons being diagnosed with "depression" and then not being cured, as a psychiatrist of my vintage and experience had learnt to expect they should be if there were an effective remedy available. One estimate is that the diagnosis of depression as estimated from the treated population has increased by 1,000%

This increase in psychiatric disturbance, suicide and para-suicide in recently discharged patients is parallelled by the reports of akathisia with suicidal and homicidal ideation being a class effect of all SSRIs with the first month being a danger period as well as withdrawal and increase in dose.

Until I was introduced to David Healy"s recent work, which he has now published in a book, Let Them Eat Prozac, I had been diagnosing what I called "SSRI reactions" for eight or nine years but I did not know that was the same entity as akathisia. I was not familiar with the extensive literature about akathisia under that name, nor how common

or how dangerous the poorly recognised condition was nor its relationship to measurably increased rates of both suicide and parasuicide

Some of my colleagues were not aware of this and others are reluctant to do the research required to come to a well-informed view on this. .

Akathisia, specifically induced by SSRIs has been included in the latest DSM and separated from akathisia induced by other drugs.

An appropriate and safe response needs to be planned to what has turned into a public health disaster. Please forgive me if you are already aware of if you are already planning a response.

This information raises medico legal issues for Australian doctors which differ from those that exist for British or American clinicians. Bearing in mind the case of Rogers and Whittaker and the duty to warn of potentially catastrophic side effects, I believe that we need to develop policies on how this problem should be handled clinically and what kind of warnings should be given by doctors when they prescribe these drugs.

SSRIs are far from unproblematic. They are killing between 180 and 219 people for every 100,000 patients treated, mostly for minor mental disorders, at a rate that is on the average 2.5 times and up to 10 times the rate of untreated control subjects or other familiar suicide statistics.

Since mid October, on a rural psychiatric ward I have picked up more than a dozen cases of intense and bizarre suicidal ideation and parasuicide in patients on SSRIs on a rural psychiatric ward. Where I was able to stop the drug, suicidal thoughts remitted on withdrawal, in one case taking about a month to do so. In some cases, the suicidal ideation was not easily differentiated on clinical grounds from pre-existing problems, and this created a difficulty. The science supports the proposition that the SSRI is implicated.[1] The scientific underpinning of this knowledge has passed six Daubert Hearings in the Federal courts of the United States.

The dozen cases that I have seen in the past ten weeks involved six separate suicide attempts. All were as different as can be from cases of suicidal depression. Depression was not a prominent feature but agitation characterised all of them and almost manic behaviours with racing thoughts characterised quite a few. The sudden appearance of behaviour characteristics of borderline personality disorder was also seen and this particular personality change has been reported elsewhere as well.

They were typical cases of akathisia which has arisen early in treatment or on dose increase. My MOPS group identified two more in a month. The suicide attempts were characterised by a bizarre quality of “feeling numb, feeling nothing, nothing mattered” which is said to be typical of the emotional blunting consequent on the anxiolytic effect of these drugs. In all cases, the notion of suicide was foreign, ego-dystonic to these patients and it was rejected as “not myself”.

This phenomenon was first identified as something entirely new by Teicher and others in 1990[2], but not much was done by drug regulation authorities which are now belatedly moving in the direction of giving warnings. An internet search of SSRI suicide is an illuminating experience and our patients and their relatives will soon be doing it

I initially thought that the rural centre ward may have taken in a cluster, or that the prevalence of this problem might have been due to the penetration of drug company representatives in the area, but a Yale study suggests that this problem accounts for 8%

of admission to a psychiatric ward, and probably more are to be found in emergency rooms.[3]

I am attaching papers which have been sent to me by David Healy, some of my own research and one brief one on PowerPoint of my own. This was well received at the RANZCP forensic conference in Geelong in November 2003

Dr Healy emailed me to say that if he had the annual data on the actual usage of each of the SSRIs in Australia, for Prozac from circa 1989 or when it came on the market (I believe it was more like 1992) and Aropax and Zoloft from circa 1991/2 when they came on the market, then he could produce a reliable estimate for you of just how many people are likely to have killed themselves in Australia as a result of these drugs over that period. [4]

Dr Healy could also give you good estimates as to how many people are on these drugs long-term i.e. for more than a year. These calculations are made using a model which has been validated by the MHRA in Britain where the Department of Health had the data and handed them over

Dr Healy also invites your attention to the other big issue, the effects of these medications on children one and that he may be able to get an analysis together of the data from the trials for children. these drugs are already subject to warnings for use in children, but the effects are occurring in adults as well

Dr Healy"s email is [redacted].

In closing I would like to draw the following analogy, using the same numbers. I have chosen these figures as they are a fair average of the meta-analyses of suicide induction by SSSRIs with .02% successfully killing themselves and 2% attempting suicide, and 20% having unacceptable disturbances. We are seeing the multiplication of adverse side effects when the remedy is applied to large populations.

Penicillin was a wonder drug, and there is no doubt that it saves lives when given selectively to persons with bacterial infections. It is still a good drug for specific problems. Let us say that .02% of people have a fatal reaction to penicillin (2 per 100,000) and 2% have an adverse reaction which prolongs their illnesses, whatever they are. Penicillin cures 99% of selected patients, but it is now being given to a thousand times more patients, not those with bacterial infections those with high temperatures. and it is still killing .2% of those to whom it is given and nearly 2% are made worse. There is a point at which the type 2 errors, making people sick outnumber the people cured by penicillin.

This seems to have happened with the SSRI. The number of people that they kill is outnumbering by a factor of 2.5 on the average the possible number that would have died untreated. SSRIs are not being given for hospital depressions (where some are not effective) but for minor mental disturbances in the community, then the untreated suicide rate in this population is known and known and it is a lot less than the treated rate.

While there is no doubt that some people"s mood improves on SSRIs, (even that of some suicidal people) and it is unlikely that the drugs will be withdrawn in the near future (although information from the Internet suggests this is a possibility) we must collectively accept that there are some people who are made suicidal and violent and psychotic on SSRIs, and healthy volunteer studies suggest that this number is large, about 20% of the population. We collectively learn how to identify those people so we do not make them sick, are suicidal or otherwise violent as we have learnt to identify

allergy to penicillin. Rechallenge experiments can and have been done. If we do not do this, the courts will make us do it and punish us. [5]

Dr Yolande Lucire

Consultant Psychiatrist

January 2, 2004 Distribution:

Please feel free to distribute this information as you see fit.

Professor Beverley Raphael

Director of NSW Mental Health Mental Health Services

[redacted]

Dr. Ruth Vine Acting Director of Mental Health [redacted]

Dr Jonathan Philips Director of Mental Health Mental Health Services and Program Department of Human Services [redacted] Street Address Postal Address Department of Health [redacted]

[1] The 1993 United States Supreme Court decision in Daubert v. Merrell Dow Pharmaceuticals changed the criteria by which the views of experts are to be admitted as scientific testimony in court

The unanimous ruling states that the criterion of the scientific status of a proposition is that is can be tested, particularly by way of a logical process called "falsification". That [6] is, it must be possible to specify a set of circumstances, the occurrence of which, would demonstrate that the proposition is false. In effect, Daubert replaces the Frye and Bolam tests of "expert opinion", being that which is "generally accepted" by a significant number of authorities in the field, with Karl Popper"s notion of science as "knowledge" which has withstood rigorous testing. This sometimes entails a preliminary assessment, a Daubert Hearing, to decide if the reasoning or methodology underlying the testimony is scientifically valid. The Daubert judgement has been incorporated into the Federal Rules of Evidence at Rule 803, in the Unites States. Scientific method includes putting up a proposition couched in the negative, a null hypothesis, and testing it to see if it can be knocked down.

[2] Teicher MH. Glod CA. Cole JO. Antidepressant drugs and the emergence of suicidal tendencies. [Review] [163 refs] [Journal Article. Review. Review, Academic] Drug Safety. 8(3):186-212, 1993 Mar. UI: 8452661

[3] Preda A, MacLean RW, Mazure CM, Bowers MB (2001). Antidepressant associated mania and psychosis resulting in psychiatric admission. J Clinical Psychiatry 62, 30-33. Please note that the original Kahn studies did not count in suicides on cessation of the SSRIs, a danger period. Kahn coded them as placebo suicides. These studies have been re-analysed to take that into account

[4] Ritalin® hydrochloride methylphenidate hydrochloride tablets USP Prescriber information
http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/010187s66s67,018029s37s38,021284s6s8lbl.pdf

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[13] 1613/www.health.nsw.gov.au/pubs/2009/pdf/2nd_report.pdf

Sentinel Events Committee report 2003) *NSW Parliament Question asked on 13 May 2010 (session 54-1) and published in Questions & - 1613/www.health.nsw.gov.au/pubs/2009/pdf/2nd_report.pdf

[13] **NSW Parliament Question asked on 13 May 2010** 10221 - SUICIDE WARNING

[15] NSW Mental Health Sentinel Events Review Committee Tracking Tragedy A systemic look at homicide and non-fatal serious injury by mental health patients, and suicide death of mental health inpatients Fourth Report of the Committee. March 2008. http://pandora.nla.gov.au/pan/40156/20100301-1613/www.health.nsw.gov.au/pubs/2009/pdf/4th_report.pdf (Accessed December 4 2014)

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PSYCHIATRIC DRUGS Mr Daryl Maguire to the Deputy Premier, and Minister for Health.

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[25] **PARLIAMENTARY COMMITTEES ACT 2003**

INQUIRY INTO VIOLENCE AND SECURITY ARRANGEMENTS IN VICTORIAN HOSPITALS

"If at first, the idea is not absurd, then there is no hope for it" Albert Einstein

"The world is not dangerous because of those who do harm but because of those who look at it without doing anything" Albert Einstein

This submission does not address security, it addresses violence. The root causes of violence by persons treated with drugs used in psychiatry. This submission may not fit into the Terms of Reference.

The Terms of Reference do not address the root causes of violence in persons treated with psychiatric and non-psychiatric drugs that have akathisia, suicidal and homicidal ideation, suicidal and homicidal acts, aggression worsening of clinical conditions among their listed side effects.

I have practiced in open wards since 1964. It is only in the last 20 years that security guards have been needed. Psychiatric patients have become more violent, more suicidal and more homicidal with the addition of narrow metabolic therapeutic window drugs (antidepressants and antipsychotics) that that carry high rates of akathisia in clinical trials and more in the community in Australia where these drugs are prescribed by general practitioners where they are not asked relevant questions.

Psychiatric patients started to become dangerous to the extent that security guards and locked doors were needed on busy wards from about 1990 in Australia.

I do not blame doctors, as they are being mis-eduacated by a louder voice than mine, Big Pharma"s.

1990 was the year that Prozac (fluoxetine), the first of the SSRIs, was introduced. The suicide rate in 1997, the year that Risperdal (risperidone) and Zyprexa (olanzapine) were introduced and often given on top of by then five new antidepressants produced the highest suicide rate since 1964.

964 was just after tricyclic antidepressants escaped from the offices of into doctors surgeries to be used by general practitioners who did not know, as 1960 textbooks told us, that these drugs had suicide among their listed side effects. In the 1960s, 1970s psychiatrist who knew they induced suicide and aggression (to self and others) in some people. It was in our undergraduate textbook.

Following is a statement from a textbook of psychiatry published over 40 years ago that is referring to observations in patients during initial treatment with tricyclic antidepressants [**Clinical Psychiatry, by Mayer-Gross, Slater, and Roth, 1960, p. 231**]:

"With beginning convalescence (following initiation of treatment with tricyclic antidepressants), the risk of suicide once more becomes serious as retardation fades."

Some patients taking psychiatric drugs develop extra pyramidal side effects including akathisia. Some persons who develop akathisia kill themselves and kill others. Most persons who develop akathisia have violent thoughts, homicidal and suicidal ideation. Many people with akathisia have personality changes towards becoming aggressive.

In my experience of making visits to see clients in NSW Jails, 9 out of ten persons I see are suffering from drug induced akathisia[25] and many have come into prison following acts of violence committed in that state and akathisia violence is not being recognised and they get more drugs that make them more violent and suicidal. This is tragic, as they are doubly mistreated.

Drugs that cause violence have been written up in PLOS.

http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0015337

This was taken up in TIME Magazine and should be common knowledge but psychiatrists just do not believe it as they are trained to diagnose mental illness not side effects.

http://healthland.time.com/2011/01/07/top-ten-legal-drugs-linked-to-violence

10. **Desvenlafaxine (Pristiq)** An antidepressant that affects serotonin and noradrenalin, this drug is 7.9 times more likely to be associated with violence than other drugs.

9. **Venlafaxine (Effexor)** A drug related to Pristiq in the same class of antidepressants, both are also used to treat anxiety disorders. Effexor is 8.3 times more likely than other drugs to be related to violent behavior. (**More on Time.com:** Adderall May Not Make You Smarter, But It Makes You Think You Are)

8. **Fluvoxamine (Luvox)** An antidepressant that affects serotonin (SSRI), Luvox is 8.4 times more likely than other medications to be linked with violence

7. **Triazolam (Halcion)** A benzodiazepine which can be addictive, used to treat insomnia. 0.Halcion is 8.7 times more likely to be linked with violence than other drugs, according to the study.

6) **Atomoxetine (Strattera)** Used to treat attention-deficit hyperactivity disorder (ADHD), Strattera affects the neurotransmitter noradrenaline and is 9 times more likely to be linked with violence compared to the average medication.

5) **Mefoquine (Lariam)** A treatment for malaria, Lariam has long been linked with reports of bizarre behavior. It is 9.5 times more likely to be linked with violence than other drugs.

4) **Amphetamines: (Various)** Amphetamines are used to treat ADHD and affect the brain"s dopamine and noradrenaline systems. They are 9.6 times more likely to be linked to violence, compared to other drugs.

3) **Paroxetine (Paxil)** An SSRI antidepressant, Paxil is also linked with more severe withdrawal symptoms and a greater risk of birth defects compared to other medications in that class. It is 10.3 times more likely to be linked with violence compared to other drugs. (**More on Time.com:** Healthland"s Guide to Life 2011)

2) **Fluoxetine (Prozac)** The first well-known SSRI antidepressant, Prozac is 10.9 times more likely to be linked with violence in comparison with other medications.

1) **Varenicline (Chantix)** The anti-smoking medication Chantix affects the nicotinic acetylcholine receptor, which helps reduce craving for smoking. Unfortunately, it"s 18 times more likely to be linked with violence compared to other drugs — by comparison, that number for Xyban is 3.9 and just 1.9 for nicotine replacement. Because Chantix is slightly superior in terms of quit rates in comparison to other drugs, it shouldn"t necessarily be ruled out as an option for those trying to quit, however.

Akathisia is one of the extra pyramidal side effects. The others are dyskinesia (acute, tardive, chronic), neuroleptic malignant syndrome, and drug induced Parkinson"s symptoms.

Product Information (PI) and current practice suggests that extra pyramidal side effects are dose dependent.

However, these extra pyramidal side effects are not only dose dependent but idiosyncratic. That is, if you give any person too much they will develop all of these side effects. Some persons develop them on low doses.

Since the availability of the discipline of pharmacogenetics, it is known that there is a thousand-fold variation in metabolic rates for some drugs among people and this is caused by genetic factors. We can test for these problems buy buccal swab and $290, half the cost of a day in hospital.

There is a huge literature on this. There are textbooks on this published by the American Psychiatric Press. All this knowledge seems to have escaped psychiatrists in Australia.

Extra pyramidal side effects (akathisia, dyskinesia) are not only dose dependent but idiosyncratic. These formerly regarded as idiosyncratic are attributable to diminished metabolism at cytochrome P450 and perhaps at the phase two metabolism of UGTs. Where they are not due to overdosing, size of dose, co-prescribed cytochrome inhibitors and inducers, removal of inducers, competition for substrate enzymes they are understood by doing genetic testing and examining drug drug interactions.

Australian psychiatrists are poorly educated about akathisia. I have rarely had a reasonable conversation with an Australian trained psychiatrist about the condition. Even though the world expert Professor Perminder Sachdev is at University of NSW. Neuroleptic-induced and SSRI-induced akathisia has been in the DSM at 333.99 since 1994. Key opinion leaders who are favourites of the pharmaceutical industry also educate Australian psychiatrists and much of the literature about these drugs has been ghost written over their well-remunerated signatures. For example, PHaRMAs that commission who publish efficacy studies feel no obligation to report side effects, strokes, deaths, violence. I can provide detailed evidence of this for a number of drugs.

There have been homicides and suicides in clinical trials for SSRIs and atypicals.

Homicide on psychiatric drugs has been well reported since 1975. Homicide is the tip of an iceberg of aggression and violence and that is what this Inquiry should be about.

Akathisia became epidemic after the introduction of Prozac (fluoxetine) in 1990. There was and akathisia rate of 27% for antidepressants and variable rates in atypical antipsychotics, 27% akathisia for Zyprexa at 15 mg daily is reported in US product information, Australian PI is inadequate.

Indeed, the Diagnostic and Statistical Manual says that akathisia rates are 25% - 75% of users depending on criteria.

Neurotoxic side effects appear to be the cause of the crisis in mental health and the increasing violence, suicide and homicide among mental health patients. This seems to be better known in the United Kingdom and the United States than in Australia. In Australia, the notion that these drugs have any side effects at all has been strongly resisted by peer reviewers in various situations. I enclose some papers from the New York Review of Books.

Here are footnoted some questions in New South Wales Parliament which were asked last year.

10218—PSYCHIATRIC DRUGS
Mr. Daryl Maguire to the Deputy Premier, and Minister for Health—

Has the Minister and her predecessors been warned by individuals that suicides committed by patients and clients under mental health care could be caused by psychiatric drugs:

That affect persons who have a genetically determined inability to metabolize them;

That such persons should be recognized by their adverse medication responses?

How many persons have committed suicide whilst under mental health care in the years 2003 to 2008?

How many have committed homicide?

Do these figures represent a deterioration or improvement in the numbers of suicides under mental health care:

Before 1990;

Before 2002?

Answer—

I am advised:

NSW Health advises me that there has been correspondence to previous Health Ministers in relation to this issue. I have also received such correspondence. The Chief Psychiatrist in consultation with the NSW Mental Health Clinical Advisory Council is currently considering these issues.

According to the Mental Health Client Incident Information System, there were 937 notifications of suspected suicides of persons under mental health care that were reported to the NSW Health Department between 1 Jan 2003 and 31 Dec 2008.

According to the Mental Health Client Incident Information System, there were 43 notifications of suspected homicides by persons under mental health care that were reported to the NSW Health Department between 1 Jan 2003 and 31 Dec 2008.

It is not possible to compare the data over this time period due to the fact that different methodology was used to collate this data.

This is not entirely true, as the Sentinel Events Committee itself charted a rising rate of suicide and homicides under state mental health care; they also occur under private care, where coroners pay no attention.

From Tracking Tragedy reports

Reported suicide deaths of patients in contact with mental health services, and all suicide deaths in NSW 1993-2001.[25],[25]

Year	Suicides in NSW	Suicides in mental health care	Percent of all NSW suicides
Suicides include inpatient suicides and suicides within 28 days of contact with mental health care. (Updated numbers in brackets)			
1993	676	68	10%

1994	798	72	9%
1995	747 (748)	100	13%
1996	811 (817)	136	17%
1997	946 (950)	166	18%
1998	827 (832)	143	17%
1999	846 (854)	173	20%
2000	738	156	21%
2001	775 (789)	159	21%
2002	643	117	?
2003	?	?	?
2004			
In 2004, the mode of counting changed to counting mental health and suicides of inpatients or within 7 days of contact with mental health care.			
2005		80-110	Information requests for this data have been denied
2006		80-110	
2007		80-110	
2008			
2009			

Between 2002 and 2009 the NSW Mental Health Sentinel Events Review Committee recorded well over 9 suicides and 38 homicides committed by persons under public sector mental health care. It did not examine medication.

Suicide numbers under mental health care in NSW rose from 68 in 1993 to 173 in 1999 and 159 in 2001, a proportional increase from 10% to 21% of all suicides in NSW and one would expect pro rata to population rises in

The Review Committee found in that half the sample of patients died by suicide before the tenth day of their stay in mental health facilities, and 30% died within the first three days of their episode of care. By 2008, this Review Committee also examined 38 homicides committed by persons under public sector mental health care and nearly 2000 suicides.

A Victorian psychiatric unit had 13 suicides in 13 months in 2002-3 but this did not attract inquiry.[2525]

Leaving aside suicide and its underpinning presentations and correlates, outcomes other then suicide for treated mental illness have been deteriorating.

The number of people under mental health care has also increased.

Question asked on 13 May 2010 (session 54-1) and published in Questions & Answers Paper No. 197 <http://bulletin/prod/la/lapaper.nsf/V3QnBySN/541~197/$file/197-QA-S.pdf>.

Further problems include that there is a poor understanding in Australia of either therapeutic window of opportunity or half lives of drugs. These determine dosing. As a result, doses are very large and often cumulative.

For instance, Product Information (PI) on Zyprexa (olanzapine) (which causes hallucinosis in 4% of the population who have never hallucinated before and has an akathisia rate of 27% o in clinical trials on 15 mg daily)) PI states the following. The following information comes for both Australian and American product information:

Oral Administration

Olanzapine is well absorbed and reaches peak concentrations in approximately 6 hours following an oral dose. It is eliminated extensively by first pass metabolism, with approximately 40% of the dose metabolised before reaching the systemic circulation. Food does not affect the rate or extent of olanzapine absorption. Pharmacokinetic studies showed that ZYPREXA tablets and ZYPREXA ZYDIS (olanzapine orally disintegrating tablets) dosage forms of olanzapine are bio-equivalent. Olanzapine displays linear kinetics over the clinical dosing range. Its half-life ranges from 21 to 54 hours (5th to 95th percentile; mean of 30 hr), and apparent plasma clearance ranges from 12 to 47 L/hr (5th to 95th percentile; mean of 25 L/hr).

Administration of olanzapine once daily leads to steady-state concentrations in about one week that are approximately twice the concentrations after single doses. Plasma concentrations,

Half-life, and clearance of olanzapine may vary between individuals on the basis of smoking status, gender, and age (see Special Populations).

The significance is if a drug has a half life of more then 24 hours it accumulates in the body as only half of what is there is excreted in next 24 hours, and it accumulates to toxic levels. Doses should be decreased and sooner or later more than half if its users become toxic, as therapeutic level is low 9-29 ng/mL, this overloading by people who still believe that 100 ngm/ml is a therapeutic level accounts of a lot of aggression, too high blood levels and other forms of idiosyncrasy.

The half-life of Clopixol (zuclopenthixol depot) is 19 days. It is almost inevitably given fortnightly with resulting accumulation, increasing violence as akathisia toxicity develops. It was being done in your prison hospital when I visited a patient. He was on another antipsychotic, amisulpride, as well. There is no guideline in the world that would permit that. It is an undisclosed experiment for which consent was being daily refused by his better informed guardian.

There is no culture of therapeutic drug monitoring in Australia. Australian psychiatrists show no inclination to learn new material. My experience is that I

might as well be talking about star signs when I tell my colleagues that someone is a poor metaboliser.

I believe that the Federal Government needs to hold a Royal Commission into pharmaceutical industry fraud misinformation and the practice of psychiatry, and education of psychiatrists and role of coroners in investigating this evidence in suicide inquests. So far they simply refuse to hear it, refuse. Coroners investigate these matters in USA and UK, why no there?

In the United States, qui tam whistleblower cases are netting literally billions of dollars for the state. This still does not compensate a country like Australia which funds public health cares while drug companies get privatised profits and socialised costs.

I am happy to give evidence at any open hearing.

I am happy to provide peer reviewed evidence for everything that I have said here.

Yours sincerely,

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[44] SUMMARY OF SCIENTIFIC EVIDENCE REGARDING SEROTONIN ANTIDEPRESSANT SUICIDALITY from CLINICAL TRIALS. 1990 -2003.

THIS IS NOT EXHAUSTIVE as there are 120 such publications

There is a great deal of information on SSRIs, and great deals of 'knowledge' of what people do with them. This is divided into 'anecdotal', which includes papers such as' I have treated thousand people with Prozac and I found no problems,'

We are looking at a catastrophic side effect, suicide that occurs in 500, to small for clinicians to see, and this is a province for statisticians and epidemiologists. Epidemiologists can also tell about untreated patients n the same category, and can see in properly set up studies that those treated with sugar pills, and the same population which taking sugar pills is not committing suicide.

We are also looking at massive amounts of 'endorsement' papers paid for but the drug companies and it is necessary to examine each for their content and origins.

To give another example, when the atypicals had been trailed, the FDA advised the pharmaceutical companies that they were not to claim that these medicines were better than cheaper old ones, as they had not been found to be an improvement on them. So, the pharmaceutical companies paid doctors huge sums of money to endorse these drugs in the medical press as this bypassed the FDA order.

In order to assess this huge 'literature' one has t read and evaluate the science behind each paper.

Emergence of intense suicidal preoccupation during fluoxetine treatment. Teicher MH, Glod C, Cole JO.Department of Psychiatry, Harvard Medical School, MA. 1990: Am J Psychiatry. 1990 Feb;147(2):207-10.

Six depressed patients free of recent serious suicidal ideation developed intense, violent suicidal preoccupation after 2-7 weeks of fluoxetine treatment. This state persisted for as little as 3 days to as long as 3 months after discontinuation of fluoxetine. None of these patients had ever experienced a similar state during treatment with any other psychotropic drug.

Suicidality and fluoxetine: is there a relationship?Fava M, Rosenbaum JF. 1991 J Clin Psychiatry. 1991 Mar;52(3):108-11. Clinical Psychopharmacology Unit, Massachusetts General Hospital, Harvard Medical School, Boston 02114.

A recent report of six depressed patients who developed intense, violent suicidal preoccupation after 2 to 7 weeks of fluoxetine treatment prompted the authors to survey 27 psychiatrists who treated 1017 depressed outpatient with antidepressants during 1989: 3.5% (8/231) of those treated with fluoxetine alone, 6.5% (4/62) of those treated with fluoxetine and tricyclics, 1.3% (5/385) of those treated with tricyclics alone or with lithium, and 3.0% (3/101) of those treated with other antidepressants became suicidal only after treatment with these antidepressants was initiated. None of these patients, however, reported intense suicidal thoughts of the degree described in the previously reported six cases. The difference in incidence of suicidal ideation occurring only after initiation of treatment was not significant between patients treated with fluoxetine alone and those receiving the other antidepressant treatments.

Emergence of self-destructive phenomena in children and adolescents during fluoxetine treatment. 1991: J Am Acad Child Adolesc Psychiatry. 1991 Mar;30(2):179-86. King RA, Riddle MA, Chappell PB, Hardin MT, Anderson GM, Lombroso P, Scahill L.

Yale Child Study Center, Yale University School of Medicine, New Haven, CT 06510-8009.

Self-injurious ideation or behavior appeared de novo or intensified during fluoxetine treatment of obsessive-compulsive disorder in six patients, age 10 to 17 years old, who were among 42 young patients receiving fluoxetine for

obsessive-compulsive disorder at a university clinical research center. These symptoms required the hospitalization of four patients. Before receiving fluoxetine, four patients had major risk factors for self-destructive behavior including depression or prior suicidal ideation or self-injury. Three hypotheses concerning the apparent association between fluoxetine and these self-injurious phenomena are discussed: (1) coincidence; (2) disorganization of vulnerable individuals secondary to drug-induced activation; and (3) a specific serotonergic-mediated effect on the regulation of aggression.

Comparison of frequencies of suicidal tendencies among patients receiving fluoxetine, lofepramine, mianserin, or trazodone. 1992 Pharmacotherapy. 1992;12(6):451-4Jick H, Ulcickas M, Dean A.Boston Collaborative Drug Surveillance Program, Boston University Medical Center, Lexington, Massachusetts 02173.

To evaluate whether fluoxetine causes an important increased risk of suicidal behavior, we compared the frequency of attempted suicide, suicidal ideation, and aggressive behavior in persons who received fluoxetine, lofepramine, mianserin, and trazodone, based on information available on general practitioners' computers provided by Value Added Medical Products, Ltd. The frequency of these events was higher in fluoxetine users in the year prior to first treatment than in users of the other three antidepressants. The frequency of these events in the 90 days after the study drug was started was similar for the users of all four drugs. These data indicate that fluoxetine does not directly cause suicidal behavior at a substantially higher frequency than do lofepramine, mianserin, and trazodone.

Jick SS, Dean AD, Jick H.1995 BMJ. 1995 Jan 28;310(6974):215-8Antidepressants and suicide.Boston Collaborative Drug Surveillance Program, Boston University Medical Center, Lexington, MA 02173.

OBJECTIVE--To estimate the rate and means of suicide among people taking 10 commonly prescribed antidepressant drugs: dothiepin, amitriptyline, clomipramine, imipramine, flupenthixol, lofepramine, mianserin, fluoxetine, doxepin, and trazodone. DESIGN--Open cohort study with a nested case-control analysis. SETTING--General practices in the United Kingdom that used VAMP computers to maintain their patient records from January 1988 to February 1993. SUBJECTS--172,598 people who had at least one prescription for one of the 10 antidepressants during the study period. MAIN OUTCOME MEASURE--Suicide confirmed by general practitioner or on death certificate, or both. RESULTS--143 people committed suicide. The overall rate of suicide was estimated to be 8.5 per 10,000 person years (95% confidence interval 7.2 to 10.0). Rates of suicide were higher in men than women (relative risk 2.8 (95% confidence interval 1.9 to 4.0)), people with a history of feeling suicidal (19.2 (9.5 to 38.7)), and people who had taken several different antidepressants (2.8 (1.8 to 4.3)). People who received high doses of antidepressants and those who had had a prescription in the 30 days before they committed suicide were also at higher risk than those who had received low doses and had had their prescriptions 30 or more days previously (2.3 (1.4

to 3.7) and 2.3 (1.6 to 3.4)) respectively. Rates of suicide were higher in patients who received fluoxetine, but this may be explained by selection biases which were present for those drug users. CONCLUSION--Several factors correlate with the risk of suicide in people taking antidepressants. After controlling for these factors, the risk of suicide was similar among the 10 study antidepressants. Overdose with antidepressants accounted for only 14% of the suicides.

The Jick study was undertaken in British primary care[44]. This investigated the link between antidepressant prescriptions in 143 suicides from over 200,000 patients. It produced a statistically significant doubling of the relative risk of suicide on Prozac compared with the reference antidepressant, dothiepin, when calculated in terms of patient exposure years. Controlling for confounding factors such as age, sex and previous suicide attempts, left the relative risk at 2.1 times greater for Prozac compared to dothiepin and greater than for any other antidepressant studied, although statistical significance was lost in the process. Controlling for confounding factors in the case of mianserin and trazodone, however, led to a reduction in the relative risk of these agents compared to dothiepin in a way that did not happen for Prozac.

To provide comparability with other figures, healy recalculated the data from Jick in terms of absolute numbers and have separated the figures for Prozac from other figures

Suicides on Antidepressants in Primary Care in the United Kingdom: **Jick et al**

Drug	Suicide Rate/ 100,000 Patients	Absolute Suicide Numbers
Dothiepin	**70 (C.I. 53 – 91)**	**52 Suicides in 74,340 Pts**
Lofepramine	**26 (C.I. 8 – 61)**	**4 Suicides in 15,177 Pts**
Amitriptyline	**60 (C.I. 41 – 84)**	**29 Suicides in 48,580 Pts**
Clomipramine	**80 (C.I. 38 – 144)**	**9 Suicides in 11,239 Pts**
Imipramine	**47 (C.I. 20 – 90)**	**7 Suicides in 15,009 Pts**
Doxepin	**69 (C.I 17 – 180)**	**3 Suicides in 4,329 Pts**
Flupenthixol	**78 (C.I. 43 – 129)**	**13 Suicides in 16,599 Pts**
Trazodone	**99 (C.I. 31 – 230)**	**4 Suicides in 4,049 Pts**
Mianserin	**166 (C.I. 86 – 285)**	**11 Suicides in 6,609 Pts**
Fluoxetine	**93**	**11 Suicides in 11,860 Pts**
Total excluding Fluoxetine		**132 Suicides per 195,931 Patients** **67 Suicides per 100,000 Patients**

The figures in the Jick study allow comparisons between antidepressants. They shed no light on the comparison between treatment with antidepressants and non-treatment or on the efficacy of antidepressants in reducing suicide risk in primary care. The Jick study also provides a good estimate of the rate at

which suicides can be expected in UK primary care in the course of treating mood disorders.

Drug Safety Research Unit Studies of SSRIs

A third data source was from the Drug Safety Research Unit (DSRU) in Southampton, a prescription event monitoring service. DSRU tracks the effects of drugs new to the market during the early months of a drug's life. In the case of the SSRI drugs, this exercise was carried out for Prozac, Faverin/Luvox, Paxil/Seroxat, Lustral/Zoloft, giving a total of 50,540 patients, whose profiles illustrate how many patients typically drop out of treatment after a one, two, three, four, five or six months etc. DSRU studies also give the number of deaths, including deaths by suicide. This profile is confirmed by a good deal of other research in the field.

Drug Safety Research Unit Studies of SSRIs & Mirtazapine in Primary Care in the United Kingdom.

Drug	No. Patients	No. Suicides	Suicides/ 100,000 Patients
Fluoxetine	**12692**	**31**	**244 (C.I. 168 – 340)**
Sertraline	**12734**	**22**	**173 (C.I. 110 – 255)**
Seroxat/Paxil	**13741**	**37**	**269 (C.I. 192 – 365)**
Fluvoxamine	**10983**	**20**	**183 (C.I. 114 – 274)**
Total SSRIs	**50150**	**110**	**219/100,000**
Mirtazapine	**13,554**	**13**	**96 (C.I. 53 – 158)**

There are two points to note about these studies. First, they do not prove there is not a problem with SSRIs, as SSRI companies claim. What they indicate is that SSRIs do not differ one from the other – although there may be differences from Mirtazapine. The critical issue in assessing these results is to ask what would have the suicide rate been for these patients if left untreated.

A second point to draw from these studies is that the suicide rate in UK primary care on these antidepressants is of the order of 200/100,000 patients.

1993 Int J Neurosci. 1993 Jan;68(1-2):73-84.

Fluoxetine and suicidal ideation--a review of the literature.

Crundwell JK.

Department of Psychology, University of Lancaster, Bailrigg, England.

The emergence of suicidal ideation has been noted in some case studies, where fluoxetine administration appears to be the precipitating agent. However, these observational claims are not supported by the clinical trial literature. A review of some of the trials and the case histories is followed by an assessment of the evidence, and possible explanations for the discrepancy. It is concluded that a definite link between fluoxetine and emerging suicidal ideation cannot be ascertained, but that further research is indicated. Vigilance

in prescribing any antidepressant medication, including fluoxetine, is recommended.

Healy D.

North Wales Department of Psychological Medicine, University of Wales College of Medicine, Bangor, UK. [redacted]

BACKGROUND: There has been a long-standing controversy about the possibility that selective serotonin re-uptake inhibitor (SSRI) antidepressants might induce suicidality in some patients. METHODS: Starting from the clinical studies that gave rise to this issue, this paper reviews an unselected cohort of randomised clinical trials (RCTs), a series of meta-analyses undertaken to investigate aspects of the problem, studies in recurrent brief depressive disorders, epidemiological studies and healthy volunteer studies using SSRIs to shed light on this issue. RESULTS: The original clinical studies produced evidence of a dose-dependent link, present on a challenge, dechallenge and rechallenge basis, between SSRIs and both agitation and suicidality. Meta-analyses of RCTs conducted around this time indicate that SSRIs may reduce suicidal ideation in some patients. These same RCTs, however, yield an excess of suicides and suicide attempts on active treatments compared with placebos. This excess also appears in the best-controlled epidemiological studies. Finally, healthy volunteer studies give indications that SSRIs may induce agitation and suicidality in some individuals. CONCLUSIONS: The data reviewed here, which indicate a possible doubling of the relative risk of both suicides and suicide attempts on SSRIs compared with older antidepressants or non-treatment, make it difficult to sustain a null hypothesis, i.e. that SSRIs do not cause problems in some individuals to whom they are given. Further studies or further access to data are indicated to establish the magnitude of any risk and the characteristics of patients who may be most at risk. Copyright 2003 S. Karger AG, Basel

Deliberate self-harm and antidepressant drugs Investigation of a possible linkSTUART DONOVAN, PhD and RICHARD MADELEY, FFPHM School of Community Health Sciences, Division of Public Health medicine and Epidemiology, University Hospital, Queen's Medical Centre, Nottingham; ANDREW CLAYTON, MRCPsych, MIN BEEHARRY, DipNurse, SHERON JONES, DipPsychTech, CHRIS KIRK, DPSN, KEITH WATERS, DipNurse, DAVID GARDNER, BSc and JUNE FAULDING

Deliberate Self Harm Team, The Litchurch Centre, Southern Derbyshire Mental Health Trust, Derby

ABSTRACT

Background It is not clear if the frequency of deliberate self-harm (DSH) is the same in patients taking different pharmacological classes of antidepressant drugs.

Aims To compare the frequency of DSH in patients who had been prescribed a tricyclic antidepressant (TCA) or a selective serotonin reuptake inhibitor (SSRI) prior to the DSH event.

Method This was a prospective study in 2776 consecutive DSH cases attending an accident and emergency department. The incidence of DSH in TCA-treated cases and SSRI-treated cases is expressed as number of DSH events per 10 000 prescriptions of each antidepressant.

Results Significantly more DSH events occurred following the prescription of an SSRI than that of a TCA (P <0.001). The occurrence of DSH was highest with fluoxetine and lowest with amitriptyline.

Conclusions Merely prescribing safer-in-overdose antidepressants is unlikely to reduce the overall morbidity from DSH.

Venlafaxine and Suicide / Homicide

There has been substantial evidence since 1990 that the selective serotonin reuptake inhibiting (SSRI) group of drugs of which Venlafaxine is one can trigger suicidal and/or homicidal ideation. There has however been an even more substantial campaign on the part of the pharmaceutical companies producing these drugs to keep the evidence out of the therapeutic domain and to minimise the problems.

The scientific evidence for problems with the group of drugs consist of challenge, de-challenge and re-challenge experiments in which the problem appears on treatment clears up once treatment is discontinued and reappears on the reinstitution of treatment. Evidence of this sort appears to be available for all of the drugs in the SSRI group of drugs. In all cases company personnel appear to have made judgements that their drugs have caused suicidality and aggressive behaviour based on just such considerations – viz challenge-dechallenge-rechallenge evidence - but these judgements on the part of company personnel have not been made public.

It can be noted that in several of these cases, we are dealing with what appears to be a clear case of a problem appearing on challenge, clearing up on dechallenge with one drug (Aropax) and reappearing on rechallenge with another agent from the same group of drugs (Efexor).

A further method of determining causality is the use of dose response relationships. In this case, assessors of causality look for a problem that may not be apparent at one dose of the drug but appears when the dose is put up higher. This is one of the clearest indicators in pharmacology that a drug may be causing a problem. It appears to be present for all of the major SSRIs and problems such as suicidality and homicidality.

In some of these case there appears to be clear evidence that her condition that one or later and another SSRI was ineffective or her depression had worsened with increasing doses of each of these drugs.

Of equal importance is the fact that in the clinical trials done and lodged with regulators from the United States (the FDA) through to Australia (the TGA) the data from these trials shows a higher rate of suicides and suicidal acts on active drug than on placebo. I enclose a table to indicate this. This is taken from Healy D, Whitaker CJ (2003) Antidepressants and suicide; Risk-Benefit Conundrums. J Psychiatry and Neuroscience 28 (5) 331-339. From this table it will be clear that the problems of suicidality with Venlafaxine are as severe and frequent if not more so than for many of the other drugs in the group.

September 2003, Antidepressants and suicide: risk–benefit conundrums

David Healy, MD; Chris Whitaker

Incidence of Suicides and Suicide Attempts in Antidepressant Trials Submitted to FDA

Investigational Drug	Patient No	Suicide N	Suicide Attempt No	Suicides & Attempts as a % Patient No
Sertraline	2,053	2	7	0.44%
Active comparator	595	0	1	0.17%
Placebo	786	0	2	0.25%
Placebo Washout		0	3	
Paroxetine	2,963	5	40	1.52%
Active comparator	1151	3	12	1.30%
Placebo	554	0	3	0.54%
Placebo Washout		2	2	
Nefazodone	3,496	9	12	0.60%
Active comparator	958	0	6	0.63%
Placebo	875	0	1	0.11%
Mirtazapine	2,425	8	29	1.53%
Active comparator	977	2	5	0.72%
Placebo	494	0	3	0.61%
Bupropion	1,942	3	----	
Placebo	370	0	----	
Citalopram	4,168	8	91	2.38%
Placebo	691	1	10	1.59%
Fluoxetine	1,427	1	12	0.91%
Placebo	370	0	0	0.00%
Placebo Washout		1	0	
Venlafaxine	3082	7	36	1.40%
Placebo	739	1	2	0.41%
All New Drugs	21,556	43	232	1.28%
All SSRIs	13,693	23	186	1.53%
Total Placebo	4,879	2	21	0.47%

Only one third of clinical trials for SSRIs have been reported to the FDA. it is not unreasonable to expect that they have been the ones that showed the best results.

A further piece of evidence that can be brought to bear on this issue stems from a consideration of clinical trials recently undertaken by Wyeth, the makers of Venlafaxine, efexor in children. The full details of these trials have not been made public and indeed are unlikely to be made public.

One of the four trials has been published however in an article that claimed that the drug was safe and well-tolerated, whereas it is not the case and hostility and irritability and homicidal ideation had been prominent. (Mandoki MW, Tapla MR, Tapla MA, Sumner GS, Parker JL. Venlafaxine in the treatment of children and adolescents with major depression. *Psychopharmacology Bull* 1997; **33**, 149-154.)

However, when the regulators in both the UK and the US got to view the raw data the result was that the company voluntarily wrote to healthcare professionals at least in the US and the UK, indicating that Venlafaxine was unsuitable for the treatment of children and adolescents as it appeared ineffective on the one hand but also appeared to double the rate of suicidality and hostility. Kuslak V. Letter to Physicians. Wyeth Pharmaceuticals, August 22 2003 www.rphlin.com/wyethpharmaceuticals.html

There are few, if any, experts who would consider that a problem such as this appearing in minors (up to the age of 18) would not also be likely to occur in individuals over the age of 18. There is equally little reason to believe that a problem like this will only occur with one drug from a group of drugs that in general appear to have a common set of side effects and where regulators have stipulated that one of these common side effects is an induction of agitation.

From Science Base to these cases

From the above it should be clear that there is a substantial science base to support the observations of nurses and other clinicians who have been involved in these cases that the treatments may have played a part in the events that unfolded. The science base outlined here is one that holds true, other things being equal.

The evidence outlined here simply makes it possible to implicate a drug where this is otherwise indicated but does not in any way suggest that the drug caused the problem without good indicators from the pattern of events as they unfolded that

All Serotonin drugs including Efexor can cause suicidal and homicidal ideation. They do so in a variety of ways, listed below .:

Teicher and Cole (1993) delineate 9 “clinical mechanisms” by which SSRIs can induce or exacerbate suicidal tendencies **by:**

(1) energizing depressed patients,
(2) paradoxically worsening their depression ,
(3) inducing akathisia,
(4) inducing panic attacks,
(5) switching patients to mania or hypomania,
(6) causing insomnia or interfering with sleep architecture (esp. with REM sleep),
(7) inducing an organic obsessional state,
(8) promoting personality disorder with borderline traits,
(9) producing EEG or other neurological disturbances.

There is good evidence that these patients were suffering from symptoms of SSRI induced toxicity, namely akathisia.

Bearing in mind the factors of dose escalation, a reasonable case can be made that SG’s, DS’s, JR’s JH’s and possibly DM’s disturbed behaviours involving suicidal acts occurred in conjunction with recently increased doses of the SSRI medication. There are warnings about how to prescribe.

Furthermore, the levels of medication that had been prescribed would be regarded as quite high and the co-prescribing of Zyprexa, Olanzapine for SG and Risperidone for DS would have resulted in a synergy. They were

unlawfully prescribed The adverse interaction of Efexor and Zyprexa is documented in MIMS, and it was an issue in JH Olanzapine and DS, Risperidone. Such prescribing would in general be regarded as high and as quite likely to induce problems such as these in individuals vulnerable to such effects.

September 2003, Antidepressants and suicide: risk–benefit conundrums

This galvanised attention on the relative risk of suicide on these medications based on studies that had been presented to the FDA ten years earlier. There were calls for the resignation of the FDA which had licensed these drugs and congressional hearings on the issue of licensing. .Major inquiries took place in the united states united kingdom.

Much of the evidence to that inquiry is available on the open web as well as in the medical literature.

In March 2004, the United States Food & Drug Administration issued warnings advising of the worsening or emergence of suicidality in users of SSRI drugs in both adults and children

Pharmaceutical companies followed on May 3, in the strongest possible terms advising the prescriber to warn, not only the patient but the relatives to observe for the emergence of irritability which is a precursor of the other measurable effects.

There have been a significant number of law suits brought overseas against the manufacturers of these drugs, including a law suit by the attorney general of new york, Elliott Spitzer against GlaxoSmithKlein for fraud in that it did not disclose all its clinical trail data in Paxil studies. Similar cases will follow as only one third of clinical trials done ion these drugs and they might reasonable be expected to be the better ones.

This information has been reported on radio National, in the Sydney Morning Herald, Financial Review and The Australian and has been readily available on the net. Professor Gordon Parker also alluded to this in the RANZCP journal, whereas Professor Ian Hickie believes that because suicide rates have fallen in Australia (as well as many European countries) and the volume of SSRI prescription has increased, that thee might be a cause and effect relationship. Dr Campbell alluded tho this paper that had been published in the BMJ in March of 2003, buts tis citation base does not contain any specific studies or any science based investigations that could negate his positive hypothesis.

A search of SSRI suicide on Google finds some 37,000 hits, all the law suits and all Daubert hearings, the majority of the verdicts and all the scientifically set up trials. Scientific evidence alone is allowed into courtrooms, not large series of successfully treated patients. The null hypothesis that SSRIs do not cause suicide has repeatedly been discredited and this scientific evidence is all that is allowed into courtrooms. Daubert hearings and this means that it is the only scientific evidence on this issue and the only evidence admissible in courtrooms.

In NSW in 2001, Hawkins, aged 70, a man of exemplary character from Tumbarumba killed his wife after taking five Zoloft tablets. The judge found that he would not have done it but for Zoloft.

In Western Australia, MB who tried to ill herself and her three children while suicidal and violent on Efexor was sentenced on May 29 by Malcolm j the Chief Justice. None of the six psychiatrists in that state had been able to provide relevant, up to date or scientific evidence on SSRI suicidality and homicidal ideation. The judge accepted the report of David Healy.

Hundreds of similar cases had been won or settled overseas against drug manufacturers as product liability cases. Some are afoot in Australia against doctors. Eli Lilly has lost or settled in excess of 200 cases.

A further complicating factor in this series is the use of Zyprexa and Risperidone unlawfully. Recent re-evaluation of the trials presented to the FDA indicates that Zyprexa was the most suicidogenic drug in clinical trial history, with 12 suicides in 2,500 subjects and suicidal acts were not reported at all. Risperdal is not far behind. these drugs produce akathisia and act synergistic ally with antidepressants and warrant s warnings but it seems the FDA can only deal with one issue at once. Most of the antipsychiotic trials have not been published and are unlikely to be better than the published ones. the FDA told the manufacturer that they were not to claim that these drugs were better than old ones as they were not. so they paid doctors to make e such claims in the literature.

the therapeutic goods Administration has not yet responded with warnings about antidepressants such as those provided by th FDA in March, but it does issue cautions about their use in children.

Antipsychotic Drugs FDA Trials source FDA, David Healy analysis

DRUG	PATIENT NO	SUICIDES	SUICIDAL ACTS
Risperdal	**2607**	**9**	**43**
Comparator	**601**	**1**	**5**
Placebo	**195**	**0**	**1**
Zyprexa	**2500**	**12**	**67 overdoses of zyprexa***
Comparator	**810**	**1 (2)**	**??**
Placebo	**236**	**0 (1)**	**??**
Seroquel	**2523**	**1**	**4**
Comparator	**426**	**0**	**2**
Placebo	**206**	**0**	**0**
Sertindole	**2194**	**5**	**20**
Comparator	**632**	**0**	**2**
Placebo	**290**	**0**	**1**
Geodon	**2993**	**6**	**??**
Comparator	**951**	**1**	**??**
Placebo	**424**	**0**	**??**

* see us precscriber information where these are put forward to show how safe zyprexa is as only one died. These were depression suicides, akathisia suicides or confusion suicides.

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[81] A **strategic lawsuit against public participation** (**SLAPP**) is a lawsuit that is intended to censor, intimidate, and silence critics by burdening them with the cost of a legal defense until they abandon their criticism or opposition.[1] … The plaintiff's goals are accomplished if the defendant succumbs to fear, intimidation, mounting legal costs, or simple exhaustion and abandons the criticism. In some cases, repeated frivolous litigation against a defendant may raise the cost of directors and officers liability insurance for that party, interfering with an organization's ability to operate. [2] A SLAPP may also intimidate others from participating in the debate. A SLAPP is often preceded by a legal threat. *https://en.wikipedia.org/wiki/Strategic_lawsuit_against_public_participation*

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Part 4

The magnitude and enormity of the problems and their preventable causes

The fourth part of this submission invites the attention of the Royal Commission to what I believe to be necessary changes in the practice of mental health to bring it up to best, evidence-based practice and to prevent iatrogenic illness, death, suicide and homicide. These catastrophic adverse drug reactions are strongly associated with the extra pyramidal adverse effect, akathisia, which can be caused by the vast majority of drugs used in mental health services.

Akathisia is associated with aggression to self as suicidality and violence and to others as aggression, right up to homicide and mass homicide. Ikt is fgund an d fluctuating in all the iatrogenic mental conditions (substance/medication inducecd disorders the mental illnesses) that have blown out costs and demand.

I have based this part on the PowerPoint presentation ACADEMY 6 where it might be easier to read

Google to "Drugs that cause akathisia" and suicide.

Most are not even mental health drugs

https://www.google.com.au/search?ei=WKYeXb-lHdf79QPjj4u4BA&q=Drugs+that+cause+akathisia+suicide&oq=Drugs+that+cause+akathisia+suicide&gs_l=psy-ab.3..33i160.48804.55158..57365...0.0..0.220.1737.0j9j1.....0....2j1..gws-wiz.....0i71j0i13j0i13i5i30j0i8i13i30j33i21.DKP0cvHsx2w

THE MAGNITUDE OF THE PROBLEM

SSRI STORIES: ANTIDEPRESSANT NIGHTMARES

More than 6000 accounts, from 1966, collated from newspapers, TV, and scientific journals, thousands of suicides and homicides, weird behaviours, antidepressant-induced massacres, homicides, and school shootings

A\long with the drugs that were in use, which were mostly antidepressants and psychostimulants, ADHD drugs), and some legal defences

https://ssristories.org

https://www.google.com.au/search?ei=jKUeXY-4Loj59QOuypG4Bw&q=SSRI+STORIES%3A+ANTIDEPRESSANT+NIGHTMARES+&oq=SSRI+STORIES%3A+ANTIDEPRESSANT+NIGHTMARES+&gs_l=psy-ab.3..0i22i30.201910.201910..203075...0.0..0.179.179.0j1.....0....2j1..gws-wiz.XklPmPoyFtQ

THE ENORMITY OF THE PROBLEM

2001 USA: Andrea Yates drowned five kids taking Effexor venlafaxine pnpolypharmacy

Homicidal ideation" was added to the Efexor label, but only in USA. NOT IN AUSTRALIA. Huge differences in product information between USA and Australia.

Princess Diana cut her wrists and threw herself down the stairs while on Prozac.

Michael Huchence on Prozac (fluoxetine) 60 mg) and Rene Rivkin, (Aropax 60 mg) huge doses, both committed suicide.

Actor Robin Williams hanged himself on antidepressants and provided a textbook description of akathisia. No one joined the dots.

Pilot of Lufthansa German Wings who crashed a commercial flight deliberately into a mountain had long history of unsuccessful antidepressant treatment and polypharmacy.

https://www.perthnow.com.au/news/south-west/margaret-river-massacre-depression-drug-clue-to-grandfathers-murder-of-family-ng-b88840726z

Mr Harvey pled guilty to senseless murder of his belobed family. The community is not yet ready to accpoet an involuntary intoxication and non-insane automatism defence and lay blame where it belongs: on the pharmeceiutical.

Safety pharmacy pharmacogenetics of drugs used in psychiatry.

Recommendations have been made by a NSW parliamentary committee that a pharmacologist be available in each region.

In my experience, most pharmacologists do not know this discipline but over 1000 home medication review trained pharmacists do and several taught me,

I have an autodidactic temperament and have been able to learn this discipline and publish the largest series in the literature and more in peer reviewed journals.

Google scholar to Lucire CYP450

https://scholar.google.com.au/scholar?hl=en&as_sdt=0%2C5&q=Lucire+CYP&btnG=

Influential members of the RANZCP have advised health departments, regulators and coroners what I say is nonsense, delusional and I "need to be placed under supervision" although I have never caused a patient harm. Pharmacogenetics is the basis of personalized or genomic medicine.

The principles of pharmacogenetics (PGX)

There is a literature on the catastrophic adverse effects that psychiatric medication has for some people. Most can be found in Product information

The magnitude and enormity of the problem is seen in Australian publications the most recent being and ABS report cited earlier.

http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/C1B13D1668F508A3CA258195000EFA03/$File/mortality%20of%20people%20using%20mental%20health%20services%20and%20prescription%20medications,%20analysis%20of%202011%20data.pdf

This public health problem came about through drug company fraud, cronyism, conspiracy and corruption. In short well placed money.

Examples of the explanatory power of PGX: Lucire & Crotty's 2011 Akathisia Homicides

We examined the pre-medication history of 85 persons who had developed suicidal and/or homicidal ideation and acts only after being prescribed antidepressants for stressful human events, for worrying about something, having been bullied, having been sexually abused, marital problems, and for being substance or alcohol abusers.

75 definitely had no mental illness before medication.

We examined their drug metabolizing genes, 25 alleles of the cytochrome P450 metabolizing genes and compared our results to a medical population in central Melbourne.

We found huge differences in numbers of defective alleles: research gold dust.

The odds ratio for this comparison was 19.3 (95% CI: 2.57–144.5; *P* = 0.00014; Fisher two-tailed probability test, this difference in variant allele frequency between the two samples occurred by chance alone can be safely dismissed. (Could have occurred by chance in one in 6000 trials)

Pharmacogenetics is the study of genetic differences in drug metabolic pathways.

Pharmacogenetics has explanatory power, clinical and forensic usefulness.

Google Scholar to safety pharmacogenetics psychiatry, about 108,000 results

https://scholar.google.com.au/scholar?hl=en&as_sdt=0%2C5&q=safety+pharmacogenetics+psychiatry&btnG=

PGX is researched at many Australian universities. Action was recommended in 2008 by the Australian Centre for Health Research but never taken

Improving the Quality Use of Medicines in Australia Realising the Potential of Pharmacogenomics October 2008.

https://www.google.com.au/search?source=hp&ei=z5ceXdK6LYL-9QPGk4GgCQ&q=Improving+the+Quality+Use+of+Medicines+in+Australia+Realising+the+Potential+of+Pharmacogenomics+October+2008&oq=Improving+the+Quality+Use+of+Medicines+in+Australia+Realising+the+Potential+of+Pharmacogenomics+October+2008&gs_l=psy-ab.3...1856.1856..3049...0.0..0.0.0.....1....2j1..gws-wiz.....0.

The report was not acted on.

PRINCIPLES OF PHARMACOGENETICS

80 % of exotoxins and 60% of drugs used in psychiatry are metabolised by the cytochrome P450 system in which there is a 1000-fold variation between individuals.

Each drug is metabolised preferentially by an enzyme, but if that one or inhibited by a co-prescribed drug, others are promiscuous and take over albeit less efficiently. All enzymes are important.

Adverse drug reactions such as suicide and violence occur with levels over the “therapeutic window of opportunity” as well as with sudden changes up or down as brain neurotransmitters cannot keep up. Starting and stopping are danger periods

Genetically determined enzymes metabolize toxins and medicines.

In 2003, Dr Allen Roses, while Senior Vice President of **Genetics** at GlaxoSmithKline stated in public:

"90% of drugs only work in 30%-50% of people."

Genes encode enzymes that break down medicines (toxins) so the body can get rid of them. The enzyme is released from the DNA strand. mNot everyone has all the genes and all the enzymes.

The majority of us have some "defective" alleles which make some drugs, not others, problematic.

Heritable problems in metabolism have been recognized since the time of Pythagoras, FAVISM, and an a question in my physiology exam in 1958, pharmacogenetics was established as a discipline in the 1960s.

Test (SWAB) at NSW Health and MyDNA in Melbourne for less than $100.

The patient's genotype is the formerly invisible factor that explains why some people react badly to doses and combinations and others do not.

Major Use of this evidence in deflecting medical negligence cases onto the pharmaceutical industry which has failed to warn and has educated negligently.

In USA, both doctor and Drug Company are sued. Doctor side steps, takes the "Learned Intermediary defense:" "I was not told, I have been lied to.

Living and dead subjects with medication-induced problems appear in every civil and criminal jurisdiction.

Problems with clinical practice guidelines:Texas Medication Algorithm Project

Texas Medication Algorithm Project (TMAP) was a consortium of PharMAs that promoted "NEW GENERATION" drugs by "ENDORSEMENT SCIENCE."

TMAP commissioned draft Clinical Practice Guidelines for Australia (US and UK) to be signed, ENDORSED by "Key Opinion Leaders."

The reference base of Guidelines bears no relationship to their text

TMAP has been sued for fraud. FALSE CLAIMS ACT litigation in USA reaps billions for taxpayers & millions for whistle blowers.

GUIDELINES have been accepted by our institutions as "evidence." They are ENDORSEMENT SCIENCE, PharMA SCIENCE

RANZCP, a professional association, has been declared to be "the expert" by our regulators.

E**xpert** - a person who is very knowledgeable about or skillful in a particular area.

An ALGORITHM is a set of rules to be followed in calculations, by a computer. Clinical practice guidelines recommend algorithmic doses, averages

For example: I have my hand on a burning hot plate, and my feet in a bucket of iced water, and, on the average, I am quite comfortable.

Metabolism varies 1000-fold between individuals in any population.

An algorithmic dose would rarely be right. An Algorithm is an obscenity when applied to a dose of medicine

TMAP IN THE REAL WORLD

“Algorithms” assume the patient to be an extensive metabolizer, not taking other medications.

Only 9 % of my 250 gene-tested subjects were not taking something else when they got psychiatric drugs

Guidelines contain no warnings of medication-induced sucidality, violence, or aggression, nor of their effects on all organ systems nor of Drug-induced dementia.

https://www.google.com.au/search?source=hp&ei=ULQeXcWqNIey9QOmj4S4DQ&q=drug+induced+dementia&oq=Drug-induced++dementia.+&gs_l=psy-ab.1.0.0i22i30l10.2630.2630..10358...0.0..0.176.176.0j1.....0....2j1..gws-wiz.....0.6CjfAJugaZ0

Guidelines contain no warnings about withdrawal difficulties or “addiction.”

They contain few examples of interactions. They are silent about defective metabolizers.

Guidelines recommend drugs in doses and combinations that set up a quagmire of drug-drug interactions. If prescribers follow guidelines, patients get polypharmacy.

Failure To Warn” And Negligence

The High Court of Australia has determined:

> “A doctor has a duty to warn a patient of a material risk inherent in the proposed treatment;

I invite the attention of the Royal Commission Royal Commission to the question:

Does the RANZCP have a duty to warn about catastrophic adverse drug to the drugs their CPGs recommend for “Depression that is common serious and treatable and affects 1 person in 25 each month” (Source: Summary Guideline)?

Does a drug company that provides state-approved education programs have the same duty? Do the regulators who protect the public?

Does *beyondblue?* Does The Therapeutic Drug Administration*?* Or does the Black Dog institute? Or does Headspace? Or do the Early Psychosis Prevention and Intervention Centre (EPPIC) guidelines for which Professor McGorry is responsible? Or does Professor Hickie who leads the National Mental Health Commission? Or does any other policy or educational body? Or do the psychologists who publish under Commonwealth auspex’s pamphlets on posttraumatic stress disorder and recommend antidepressant medications?

Not one of these “Educators” or policy bodies warns of material risk.

FDA Advisories and institutional response

FDA Public Health Advisory - 2004

> FDA Public Health Advisory
>
> March 22, 2004
>
> Subject: WORSENING DEPRESSION AND SUICIDALITY IN PATIENTS BEING TREATED WITH ANTIDEPRESSANT MEDICATIONS

Google to https://www.google.com.au/search?source=hp&ei=iaUeXYbIB8GP9QPr9JeABw&q=Suicide+Warning+for+Prozac+March+25%2C+2004&oq=Suicide+Warning+for+Prozac+March+25%2C+2004&gs_l=psy-ab.3...1764.1764..2931...0.0..0.189.189.0j1.....0....2j1..gws-wiz.....0.Z82s4Pp5Xsk

The Australian; Suicide Warning for Prozac March 25, 2004

Dr. Bill Lyndon, chair of the psychotropic drugs committee of the Royal Australian and New Zealand College of Psychiatrists, said he welcomed any move that raised awareness about SSRIs and encouraged caution.

"I'm aware of a link between SSRIs and suicidal thoughts in adults, as well as adolescents, but the evidence is ***not conclusive***," Dr Lyndon said.

THE MAGNITUDE OF THE PROBLEMSSRI STORIES: ANTIDEPRESSANT NIGHTMARES www.ssristories.com

Coroners should be canaries in the coalmine. But they refuse to listen. Rules of evidence do not prevail.

ABS 4329.0.00.006 - Mortality of People Using Mental Health Services and Prescription Medications, Analysis of 2011 data

At the instigation of the National Mental Health Commission, the Australian Bureau of Statistics in September 2017 published that in 2012, 14.8% of the population had accessed mental health services and had been dispensed one or more of the five groups of mental health drugs on the Pharmaceutical Benefits Scheme. These were antidepressants, antipsychotics benzodiazepine sedatives like Valium, non-benzodiazepine sedatives like Zolpidem, and psychostimulants for ADHD, all of which increase mortality in using populations

Usually in polypharmacy mixes

49.6% of the deaths (n=153,451) in age range 15-75.

52% of the suicides (n= 2,295).

That is, 75,000 deaths and 1145 suicides were associated with five groups of drugs

Three times as many ex-servicemen have committed suicide since coming home than died in Afghanistan.

The absolute number of suicides in Australia increased by 732 between 2012 and 2016, well in excess of the population increase.

Epidemics are either infectious or iatrogenic, i.e. Caused by treatment

Most patients were not mentally ill before they got medications. Demand and costs quadrupled

Schizophrenia affects 1% of the community, intermittently, across cultures and decades.

Bipolar affects 0.5% across cultures and decades.

10% of American children get that diagnosis and pills to match.

Suicidality was three times the placebo rate in clinical trials presented for the “approval” of antidepressants.

Suicidality was six times placebo rate in trials that got atypical antipsychotics approved.

Zyprexa was the most suicidogenic drug in the history of clinical trials with Risperdal not far behind.

A COMMONWEALTH INITIATIVE: MINDFRAME

Murdoch Press will never publish adverse information about drugs (money)

Mindframe, a Commonwealth initiative, more like a D-Notice ensures that suicides and homicides are always attributed to mental illness in the press

Unless party drugs are used

Lane RM. SSRI-induced extra pyramidal side-effects and akathisia: implications for treatment. Pfizer Inc., New York, NY 10017, USA. *Psychopharmacology*. 1998;12(2):192-214. This 1998 paper from Pfizer provides a review of antidepressant induced akathisia and suicide and its relationship to drug metabolism.

Basic pharmacogentics that need to be known by all.

Four enzymes CYP2D6, CYP2C19, CYP3A4 and CYP1A2 cover 95% of variance.

The population can be divided into metabolic types

Extensive (normal or (EM)

Intermediate (IM)

Poor (PM)

Ultra-rapid metabolizers (UM)

Information source: Pharmacogene **Var**iation (**PharmVar**) Consortium at www.PharmVar.org provides details and research and curated data bases

Extensive metabolizers (*1*1) comprise about 70% of the population for each enzyme .

The drug is not fit for purpose for the other 30% unless the dose is tailored to metabolism.

EMs common in Caucasians, rare in East Asians.

Since adopting Western medications, China, like Australia, is having an epidemic of something that looks like “mental illness.”

75% of Asians are low metabolizers.

Pharmacogenetic research is advanced in China, Inner Mongolia, Bosnia and Iran but not yet made it from bench to bedside

Nor will it if Big PharMA gets its way and controls post graduate medical education

POOR METABOLISERS (PMs) 2 inactivating variants and no functional enzyme. The Literature is substantial and no longer controversial. They cannot clear medications and experience life-threatening ADRs. 3-10% Caucasians, 30% in Eastern Europe are PMs @ 2D6 They cannot convert prodrugs, codeine, tramadol, oxycodone, into analgesic morphine so get no benefit

Australian Prescriber Information says very little about Poor Metabolizers. Eli Lilly in USA markets Prozac Weekly for Poor Metabolizers. Tiny dose, slow release

That's good to know for a negligence suit against the drug company

ULTRA RAPID METABOLIZERS (UM)

Duplication of a 2D6 enzyme. 3% of Caucasians, 20% of North Africans and Swedes

Suicide and death are both caused by toxicity and sudden even daily changes up or down Pro-drugs, opiates, are heavily implicated in deaths in UMs If breast feeding UMs take codeine, babies can and do die.

Swedish morgue studies showed that ultra rapid metabolizers at 2D6 are 15 times more likely to die from intoxication and 15 times more likely to die from suicide than Extensive metabolizers.

INTERMEDIATE METABOLISERS (IMs)

1 normal allele and 1 inactive or low.

Wide range of enzyme activity.

Some metabolize normally, others like PMs.

IM and EM genotype Plus inhibitor may convert EMs and IMs into PM phenotype over time. Either strongly or mildly, all antidepressants inhibit at least one cytochrome enzyme and reduce metabolising capacity in a dose-dependent way. Strong inhibitors include methadone, Aropax, Prozac, Digesic

PERSONALISED MEDICINE VERSUS EVIDENCE-BASED MEDICINE

Evidence-based medicine is based on averages. Ignores outliers. The majority are outliers.

Robert Whitaker MAD IN AMERICA:*The madman of our nightmares is not a schizophrenic but an akathisiac, having just taken, or taken himself off, prescribed medication.*[#]

#Whitaker, R. (2001). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. Basic Books. Cited by 657

DO ILLICIT STREET DRUGS CAUSE SCHIZOPHRENIA?

Yolande Lucire and Christopher Crotty

Why do some people believe that they do?*

What is the link between illicit street drug use and being diagnosed with "treatment-refractory schizophrenia"?#

Does pharmacogenetics answer these questions?

This presentation links street drugs, impaired CYP450 metabolism, atypical antipsychotics and "treatment-refractory schizophrenia."

*Large M, Sharma S, Compton MT, Slade T, Nielssen O. Cannabis use and earlier onset of psychosis: a systematic meta-analysis. Arch Gen Psychiatry. 2011Jun;68(6):555-61

see www.trsconsensus.com.au Targeting Treatment-RefractorySchizophrenia: A multidimensional outcomes approach to the diagnosis and management of incomplete recovery Professor Tim Lambert The Brain and Mind Research Institute.

CYP450 Metabolism of atypicals, SSRIs and illicits

	CYP450 ENZYMES				
PARTY DRUG	1A2	2D6	2C9	2C19	3A4
cocaine	ind	Sub	inh		
meth/amphetamine	Sub inh	Sub			
MDMA		Sub			
cannabis		Sub	Sub	Sub	inh
"ATYPICALS"					
olanzapine	Sub	Sub inh	inh	inh	inh
quetiapine	Sub	Sub inh		Sub	Sub
risperidone		Sub inh [b]			Sub inh
clozapine	Sub inh	Sub inh [c]	Sub inh	Sub inh	Sub inh ind
NEW ANTIDEPRESSANTS					
fluoxetine		Sub inh [a]	Sub Inh [b]	Sub	Sub inh [b]
paroxetine		Sub Inh [a]	Inh [c]	Inh [c]	Sub inh [b]
sertraline	Inh [c]	Sub inh [a]	Sub inh [b]	Sub	Sub inh [c]
"TYPICAL" ANTIPSYCHOTIC					
chlorpromazine	Sub	Sub inh [a]			Sub ind

[a] weak, [b] intermediate and [c] strong inhibition. Weak inhibitors are strong in high doses

Sources: Wynn GH, Oesterheld, JR Cozza, K Armstrong SC Clinical Manual of Drug Interaction Principles for Medical Practice. American Psychiatric Publishing Inc 2009. **Supercyp website: http://bioinformatics.charite.de/supercyp/**

◆16 persons suffering from adverse effects of "party" drugs

◆Were given atypical antipsychotics and/or antidepressants

◆Party drugs, antipsychotics and antidepressants all interact with CYP450 enzymes as either substrates (S), inhibitors (Inh), or inducers (ind) .

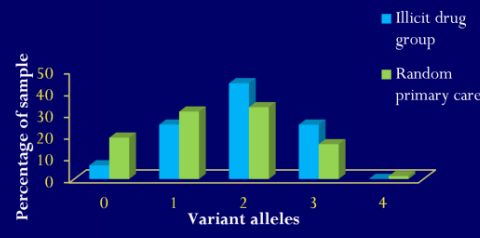
◆All developed neurotoxic symptoms: akathisia, confusion/hallucinosis, delirium.

◆All but 1 (who had 2C19*17) had impaired CYP450 metabolism due to variant CYP450 alleles. See chart ➔

◆All 16 eventually received a diagnosis of "treatment-refractory schizophrenia."

◆The toxidrome first manifested because of impaired CYP450 metabolism for party drugs.

Prevalence of variant alleles in Illicit drug group compared with primary care population



Drug users with variant alleles

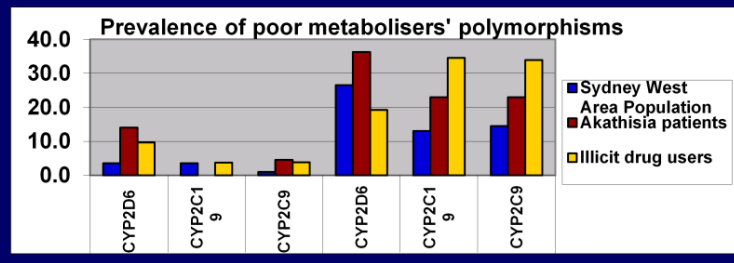
Number of variant alleles	Number/16
1	4
2	6
3	5
4	1

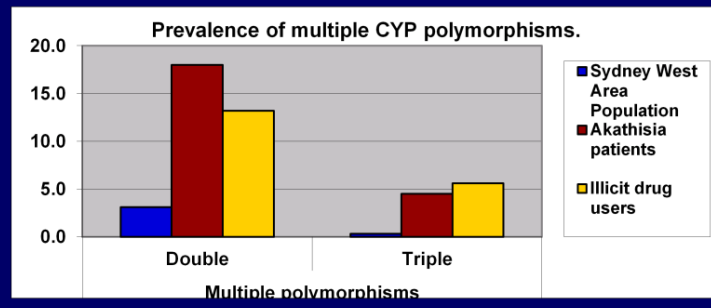
Piatkov et al 2009, compared CYP450 variant allele incidence in a sampled population, our akathisia patients, and those in drug clinics.[¶]

- Several other studies in drug clinics show a similar increased incidence of multiple mutations.
- Drug users who have become psychotic and attend clinics are likely to have impaired drug metabolism.
- The likelihood of multiple CYP450 mutations makes CYP450 worth investigating in substance-induced conditions.

In any case

- It makes no sense to treat a toxic state with medicinal toxins which demand the same metabolic pathways.
- And also inhibit them!





[¶] Piatkov I Jones, T. Rochester C. Cytochrome P450 loss-of-function polymorphism genotyping on the Agilent Bioanalyzer and clinical application Pharmacogenomics 2009 10:12, 1987-1994

◆THE TOXIC PSYCHOSES	THE FUNCTIONAL PSYCHOSES
◆**akathisia,** restlessness, obsessive preoccupation with death, dying, and suicide, ◆**inexplicable impulse to kill people one most loves,** violence, **behavioural dyscontrol**, **confusion/ambulant delirium,** manic shift, ◆**weird violent dreams**, insomnia, ◆**Sick**, vomiting, racing heart, loss of coordination, **cognitive impairment** memory problems. ◆Confabulations, **shifting false reports,** misinterpretation, serotonin toxicity or neuroleptic malignant syndrome.	◆absent causation. ◆clear sensorium, absent confusion. ◆absent physical / neurological disease. ◆absent substance/medication use. ◆specific voices 3rd party or conversation. ◆fixed delusions, correctly defined. ◆mania or depression.

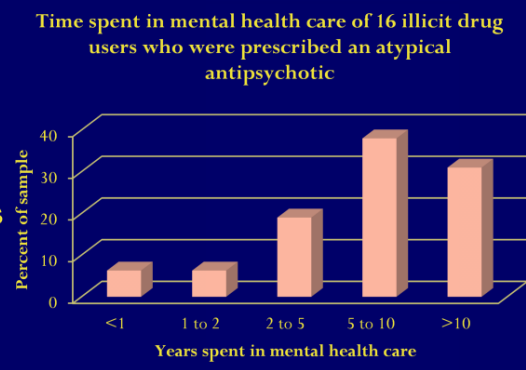
ICD F10 - F19 MENTAL AND BEHAVIOURAL DISORDERS DUE TO PSYCHOACTIVE SUBSTANCE USE PROMINENT: CONFUSION, LACK OF CORDINATION MEMORY/COGNTION IMPAIRED	ALL "FUNCTIONAL PSYCHOSES" CARRY THE EXCLUSION "NOT CAUSED BY SUBSTANCE OR MEDICATION" ABSENT: CONFUSION, LACK OF CORDINATION, OTHERWISE CLEAR THINKING to the first one as well is
333.99 Neuroleptic and SSRI- Induced Akathisia	295 Schizophrenia
292.81 Substance - Induced Delirium	295.40 Schizophreniform Disorder
292.84 Substance – Induced Mood Disorder	297.1 Delusional Disorder
292.83 Substance- Induced Persisting Amnesic Disorder/Dementia	298.8 Brief Psychotic Disorder
292.11 Substance - Induced psychotic disorder, with delusions/hallucinations	296 Manic Episode
995.2 Adverse Effects of Medication NOS	296 Major Depressive Episode

On the basis of the history of 16 cases, investigated with history and CYP450 testing.

- Illicit "party" drugs do not cause schizophrenia.
- Party drugs cause side effects which are toxic psychoses.
- "Treatment refractory schizophrenia" is a toxic psychosis caused by treatment in a person who cannot metabolize psychiatric drugs.
- Impaired CYP450 metabolism + amphetamine, MDMA, or cocaine + cannabis ➔➔➔ toxicity.
- Interactions are made worse by giving more drugs metabolised by CYP450. Cannabis, risperidone and olanzapine all inhibit the "sink" enzyme CYP450 3A4 which should pick up metabolism if others are defective.
- Party drugs are all metabolised by CYP450 with 2D6 being common to all. Risperidone, olanzapine and quetiapine are metabolised by CYP450 2D6.
- Risperidone, olanzapine and haloperidol all inhibit CYP450 3A4. Chlorpromazine also inhibits 2D6 but not 3A4.
- Defective CYP2C9 (*2) (2/16) was associated with cannabis toxicity (psychosis)/withdrawal psychosis
- Non-recovery from party drugs was not known in the 1960s, 70s and 80s when party drug induced states were treated with masterly inactivity.
- Nor was "treatment refractory schizophrenia" known.
- Cannabis is stronger now. Is inhibition of 3A4 stronger too?

The burden on mental health from these 16 alone is massive. We submit that.....

- Knowledge of pharmacogenetics
- Knowledge that diminished metabolism is not rare, causes toxicity and warrants special care
- Application of exclusion criteria for drug induced toxicity before diagnosing mental illness
- ... Can reverse this misdiagnosis problem and save millions in mental health care costs
- And effect cures



- These 16 patients needed a drug detoxification service, not more toxins.
- Instead they got, unlawfully, on the Pharmaceutical Benefits Scheme, for no payment, "not TGA or FDA approved," i.e. "off label," hugely hyped, atypical "antipsychotics," which used up residual CYP450 metabolic capacity while some inhibited CYP450 3A4 even more.
- Atypicals have never been approved for drug-induced psychoses.
- Because they have not been tested for it, or have been found to be ineffective or harmful.

2019 Submission - Royal Commission into Victoria's Mental Health System

Organisation Name
N/A

Name
Dr Yolande Lucire

What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
yes

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
a lot described in my submission

What is already working well and what can be done better to prevent suicide?
Nothing

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.
"the problems I describe are internal to the practice of psychiatry and cannot be resolved by manipulation of circumstances. they are fundamental in understanding why mental health services have produced a public health problem associated with deaths, suicides, violence, aggression, homicides and epidemic of iatrogenic illness and endless costs producing only worse outcomes"

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
Drug company influence and doctor who mistake the effects of substance abuse with mental illness

What are the needs of family members and carers and what can be done better to support them?
not in this submission

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
"better information, better education "

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
"this is admirable but if their meds are causing tehm to be sick, it is not so relevant"

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
"radical changes to the Pharma dominated paradigm of a drug for everything,. redefine mental illness and set up education in Critical psychiatry listen to patients have a royal commission into regulators as two Senate inquiries suggested"

Is there anything else you would like to share with the Royal Commission?
all in my submission./ do not listen to those who caused this problem