### Suicide rates

The national suicide rate was 11.3 in 1984 which antedated the general use of psycho stimulant drugs for ADHD but, at the same time, amphetamine use and opiate use in the community contributed to the increased national suicide rate. This increased steadily from 12.7 in 1990, to 14.6 in 1997 and 14.3/100,000 1998. Hanging, usually 10 percent, peaked at 50 percent of suicides in 1998.[[1]](#endnote--1) (Hanging is the most common method of suicide in akathisia.) In the 1920s, suicide accounted for approximately 1% of all deaths. In 1996 –1998, when the Government’s programs to address depression were well under way, suicide accounted for 2% of all deaths.[[2]](#endnote-0)

### Suicide in Care

In 1993, 68 persons committed suicide while being treated by NSW Mental Health and 173 persons committed suicide in 1999. Between 1996 and 2002, 1163 persons committed suicide within 28 days of contact with the service. Between 2003 and 2008, 937 more committed suicide, but in this new mode of counting, suicides were counted only if they occurred within 7 days of contact, to improve their figures; a total of 2000. More suicides and homicides were committed on medication that had been prescribed by NSW mental health services, outside of this highly restricted counting period.

Between 1993 and 2001, suicide numbers under mental health care trebled, increasing from 9 percent to 21 percent of all suicides in New South Wales. Increased suicide numbers in NSW were accounted for by the suicides under Mental Health care.[[3]](#endnote-1) Hospitalized suicide attempts in NSW increased three fold from 55/100,000 of population in 1989-90, to 155/100,000 of population in 2004-05, or 9,000 a year.[[4]](#endnote-2)

### Youth Suicide

Suicide in young people started to rise in the mid 1980s with a fashion to prescribe amphetamines for a checklist “diagnosis”, Attention Deficit Hyperactivity Disorder (ADHD), and methylphenidate whose side effects include sudden death, toxic psychosis, depressed mood, aggressive behaviour, visual hallucinations, insomnia, suicidal ideation and psychotic behaviour.[[5]](#endnote-3)

Youth suicide peaked in 1998 in the year after five new antidepressants and three atypical antipsychotics (of which none are approved for children) were made available on the Pharmaceutical Benefits Scheme. Professor McGorry’s guideline in the Early Psychosis Prevention and Intervention Program (EPPIC) still recommends the use of many drugs not approved for kids for a hypothetical *pre-psychosis syndrome* or for “psychosis” lasting over 24 hours.[[6]](#endnote-4)*.*

### One example: Study 239

In the infamous study 239, 11 children developed suicidal ideation on paroxetine and only one on placebo, but prescribers were told that it was safe and effective.[[7]](#endnote-5)[[8]](#endnote-6) A new meta-analysis of antidepressant drug trials included more data than the prior study, and found only a 1% difference in suicidal thought and behaviours between placebo (2%) and antidepressant treated (3%) groups. However this is playing with statistics. An increase from 2 percent to 3 percent is not a 1% difference but an increase of 50 percent, at least that is the way that risk used to be calculated.

Mental health patients became more violent.[[9]](#endnote-7) From 1999 and 2003, 36 patients who were being treated in the New South Wales Mental Health public sector committed homicide within 28 days of contact. Between 2003 and 2008, 43 more patients treated in the NSW public sector committed homicide, but these were counted if they occurred within seven days of contact, making a total of over 79 in ten years, an average of eight a year.[[10]](#endnote-8) More persons known to the author committed homicide after seven days on medication prescribed by NSW Health.

### Forensic facilities

Prisons and prison hospitals were overwhelmed with akathisia violence which they were unable to recognise. Statistics for suicides and homicide committed in prisons are not readily available. One patient committed suicide and two patients committed homicide in the Long Bay Forensic Hospital and one in the Victorian forensic hospital. The bed requirements for the forensic patient population (called criminally insane in USA) in New South Wales nearly trebled between 1992 and 2003.[[11]](#endnote-9) No one gets better anymore.

### Veterans

The number of Australian veterans committing suicide reached 3 times the number killed in Afghanistan.[[12]](#endnote-10)[[13]](#endnote-11) Some twenty veterans in USA kill themselves every day.

Mental health patients became more violent.[[14]](#endnote-12) In 2013, police in New South Wales received 38,000 mental health-related call outs for suicidality and violence. [[15]](#endnote-13)[[16]](#endnote-14)

### Workers compensation

In New South Wales “psychological injury” stress claims from bullying increased from 473 in 1991-2 to 3,202 in 2004-5. Claimants comprised 28 percent of this study sample. Many progressed to Australian Disability Support Pension for a adding to 258,640 persons or 31.3 percent of disability pensioners just as had been happening in USA.[[17]](#endnote-15) “Poorly defined psychological conditions” had overtaken musculoskeletal disability, formerly the major cause of disability for work. The minister threatened a “crackdown” and according to ABC’s 7.30 Program it was now on.[[18]](#endnote-16)

### Costs

The number of people requiring psychiatric treatment in emergency departments has increased significantly since the early ’90s, resulting in a dramatic upswing increasing in the cost of providing mental health services and medicines: from AU$550 million in 1992 to AU$1.4 billion in 2005.[[19]](#endnote-17) However the health benefits of these cost increases are hard to identify.

One third of admissions (192) to a rural ward in 2003-4 involved previously normal persons who suicidal and homicidal taking antidepressants.[[20]](#endnote-18)

Previously open wards were rebuilt with more than four times as many beds as were needed in 1992, and made into secure facilities.[[21]](#endnote-19)

The Royal Australian and New Zealand College of Psychiatrists advocates for the use of antidepressants for children even though their makers, the FDA and the TGA do not. *Clinical guidance on the use of antidepressant medication in children and adolescents”* appeared in a family medicine magazine. Nine influential child psychiatrists signed a document saying that antidepressants were important drugs for children, even though they had not been approved for that age group.[[22]](#endnote-20)

RANZCP is guided by Professors Hickie and McGorry, who are remunerated by both governments and drug companies.

They encourages family doctors to value thier personal opinions over Product Information, and over the research of Cochrane Collaboration, which examined all the raw data from clinical trials, *published and unpublished.*

Mental Health Review Tribunals enforce any treatment the psychiatrist wants to give.

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