



Suicides & Psychiatric Drugs

**A report based on data from
The National Board of Health and
Welfare in Sweden**

By Janne Larsson

Introduction

This is a unique report about suicides and psychiatric drugs.

It gives detailed data about the treatment preceding death for around one third of all persons who committed suicide in Sweden in 2007.

This data could have or should have been published by the responsible agency, the National Board of Health and Welfare¹. It was not. The facts presented here were gathered directly from data existing in the files and registries of the Board.

All cases where a person has committed suicide while undergoing health care, or up to four weeks after their last health care visit, are to be reported to the National Board of Health and Welfare for further investigation². Thanks to these reporting requirements, unique information is available.

The data in this report has not previously been published by the authorities. Their focus has been on *form* of health care given. The *content* of that health care has not been analysed, even if the content reasonably would be the most important thing in cases where the health care ended with the death of a person.

As the authorities have avoided a description and analysis of the actual content of the care given, they have also avoided the important questions that otherwise should have been raised. Thus the question has not been posed if the actual *content* of the psychiatric treatment given was what gave the tragic end result – suicide. That question is raised here.

An important part in the analysis of the results of treatment should be the reports about suspected adverse effects from different drugs submitted to the responsible medical agency – in Sweden, the Medical Products Agency (MPA). However the current system is of such a bad quality that only some percentage of the actual harmful effects is reported. Actually, after what is now revealed, one can say that the system *has broken down completely*. Doctors are not even reporting the cases where psychiatric drugs have caused or strongly contributed to a fatal result in the form of suicide. This catastrophic situation becomes clear for any and all who read this report.

It is my hope that the data presented will lead to politicians, officials, journalists and others starting to demand basic changes in the ways persons with mental problems are taken care of.

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¹ See information in English on the web site of the Board <http://www.socialstyrelsen.se/en/>

² This according to the regulations in The Act on Professional Activity in Health and Medical Services (called Lex Maria). The reporting requirements are in effect since February 2006; the year 2007 is the first full year for these requirements.

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Chapter 1

The study

According to the publication *Suicides 2006, reported per Lex Maria*³ (in Swedish), the number of reports of suicides submitted to the National Board of Health and Welfare per the reporting requirements is estimated to be 400 per year. Around 1200 suicides are committed in Sweden in a year. Thus about one third of all suicides get reported to the National Board of Health and Welfare, and it is for these cases that quite comprehensive information exists.

For this study, data about the cases reported to the six regional offices of the National Board of Health and Welfare for 2007 was requested using the Freedom of Information Act (FOIA). Focus was on the psychiatric drug treatment that the persons received within one year of their suicides.

In total, according to the data received, 393 cases were reported to the six regional offices for 2007.

The study includes the following:

1. Reports for 2007

The number of reported cases for 2007 divided between the six regional offices:

Umea:	29
Orebro:	101
Stockholm:	81
Jonkoping:	46
Gothenburg:	67
Malmo:	69
Total	393

2. The information in these cases has been analysed with regard to what psychiatric treatment preceded the tragic suicide in each of the cases. Data has been compiled about the *classes* of psychiatric drugs used (neuroleptics, antidepressants, benzodiazepines etc.) and about the *individual* drugs used.

³ National Board of Health and Welfare, *Sjalvmord 2006 anmalda enligt Lex Maria*, (2007), <http://www.socialstyrelsen.se/Publicerat/2007/9671/2007-109-22.htm>

3. Where possible, the drugs prescribed at the time of the suicide and those prescribed earlier within one year of the suicide have been divided up (this was only possible in about 60 percent of the cases).

The result

The analysis of the treatment given shows the following:

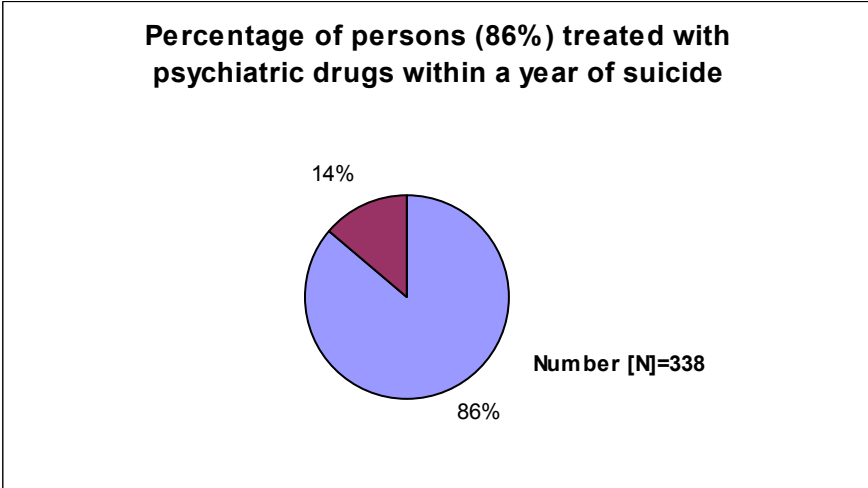


Diagram 1. Percentage of persons treated with psychiatric drugs within a year of their suicide.

In 338 of the 393 cases – 86% of the cases – the persons were treated with psychiatric drugs within a year of their suicide.

In 304 cases (77%) the persons were treated with antidepressant drugs *and/or* neuroleptics.

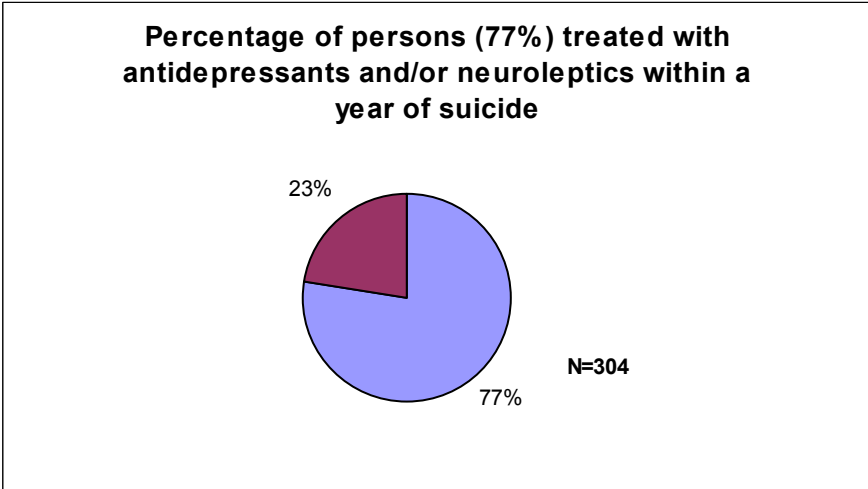


Diagram 2. Percentage of persons who were treated with antidepressant drugs *and/or* neuroleptics within a year of their suicide.

In 246 cases (63%) the persons were treated with antidepressant drugs.

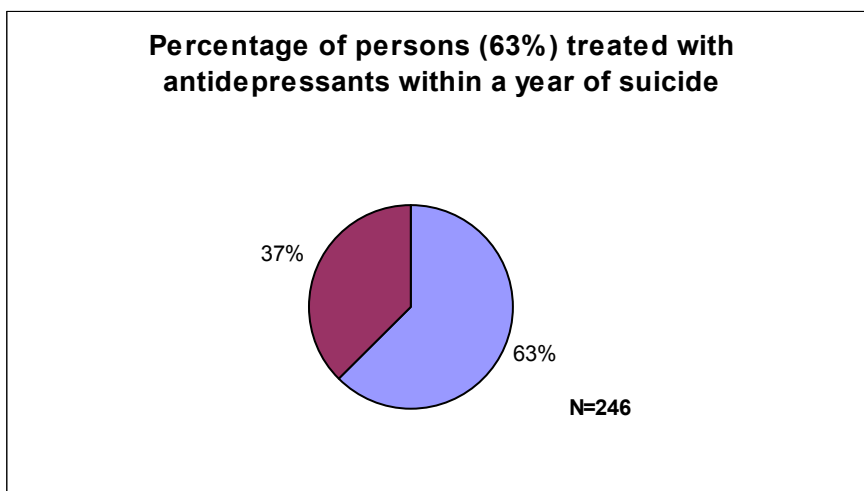


Diagram 3. Percentage of persons who were treated with antidepressant drugs within a year of their suicide.

In 164 cases (42%) the persons were treated with neuroleptics.

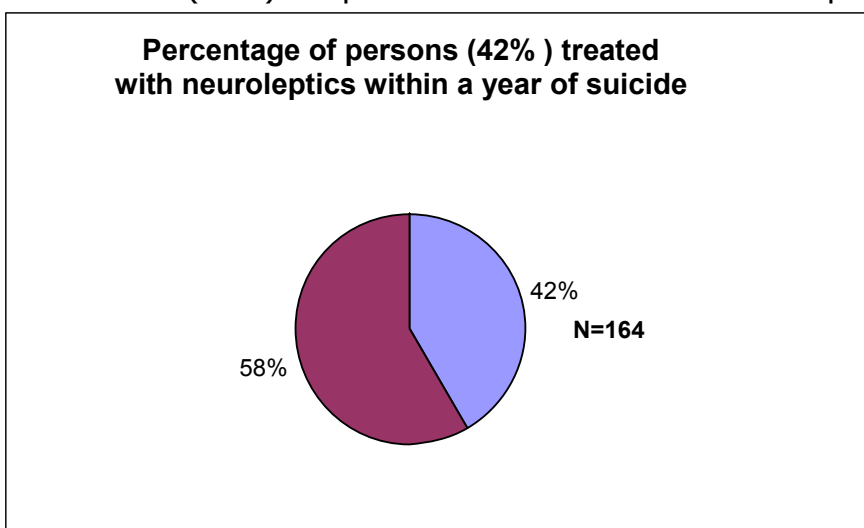


Diagram 4. Percentage of persons who were treated with neuroleptics within a year of their suicide.

In 261 cases (66%) the persons were treated with tranquilizers/hypnotics; drugs of the class benzodiazepines or similar newer compounds.

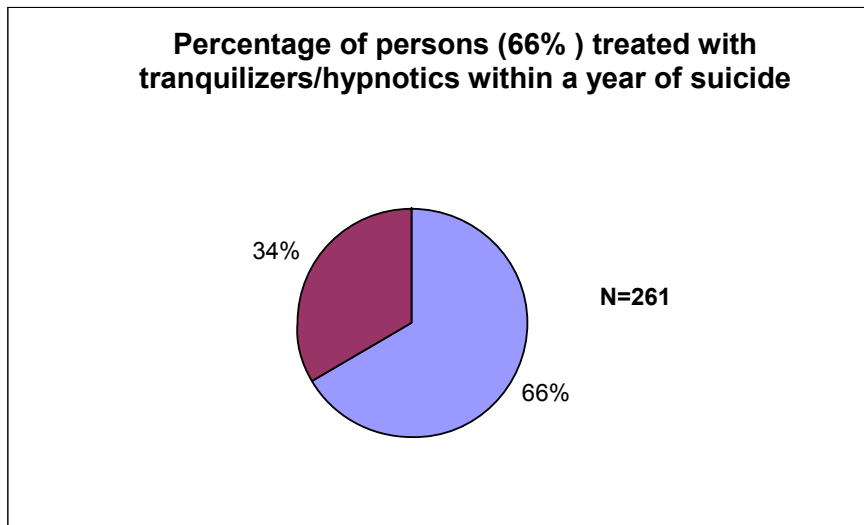


Diagram 5. Percentage of persons who were treated with tranquilizers/hypnotics within a year of their suicide.

In addition to the above: In 115 cases (29%) the persons were treated with psychiatric drugs of other classes. This were drugs such as epileptic drugs recently started to be used as "mood stabilizers" (Lyrica, Lamictal), "ADHD drugs" (Concerta, Ritalin, Strattera), and other types of psychiatric drugs like Buprenorfin and Antabuse.

The total amount of psychiatric drugs used

What best shows the real situation is *the total amount of psychiatric drugs prescribed* for these persons.

"The amount of treatment" can be expressed in that the 338 persons (of 393) who got psychiatric drugs *on the average* got 4 different drugs in the year before the suicide.

From the diagrams above it can be understood that many persons got psychiatric drugs of *different classes* (not only *different tranquilizers* or *different antidepressants*). So, for example, 29% (98 persons) of the 338 persons prescribed psychiatric drugs got treatment with neuroleptics *and* antidepressants *and* tranquilizers/hypnotics in the year before the suicide.

This does not mean that when one drug was prescribed another was taken away. On the contrary, in most of the cases the person got many different psychiatric drugs *at the same time*.

Example 1: In the area of one regional office the persons treated with psychiatric drugs were taking (on average) 3.2 different drugs *at the time of their suicide*. 36% were taking 4 drugs or more.

Example 2: In the area of another regional office the persons treated with psychiatric drugs also were taking on average 3.2 different drugs *at the time of their suicide*. 32% were on 4 drugs or more.

Of the 338 persons receiving psychiatric drugs, 39 (12%) were reported to have received electroshocks (ECT) in the year before the suicide – one person had received a series of 12 electroshocks and 15 different psychiatric drugs within a year. These 39 persons had concurrently with the shocks been prescribed on average 5.6 different psychiatric drugs within a year.

Only 37 persons (11%) of the 338 had only taken 1 psychiatric drug during the year before the suicide.

The facts are obvious: The men and women in this group, in an overwhelming high degree, had committed suicide after having been treated with large amounts of psychiatric drugs in the year before and at the time of their suicide.

Chapter 2

Psychiatric drugs and suicide

The persons described above received "adequate treatment" – in the meaning used in psychiatry. There was not any "undertreatment".

They also got:

- the new antidepressant drugs (Cymbalta 23 persons, Effexor 41, Zoloft/Sertralin 49, Cipralex 33),
- the new forms of neuroleptics (Risperidon 31, Zyprexa 52,)
- the new hypnotics, similar to benzodiazepines (Zopiclone/Imovane 128, Stilnoct [Ambien] 53),
- the new "mood stabilizers" (Lamictal 21, Lyrica 19).

And the persons who got this treatment were given on average 4 different psychiatric drugs in the year before their suicide.

A good example of how treatment with psychiatric drugs *is said to* relate to suicide can be found in the "information material" produced by pharmaceutical companies:

In the Journal of the Swedish Medical Association, doctors (with an accompanying picture of a grave and a photo of a person who had committed suicide) got the message: "A depression can end unexpectedly fast." It is the pharmaceutical company Wyeth who, with reference to the internationally known Swedish psychiatrist Goran Isacson, wants doctors to understand that the company's antidepressant drug Effexor gives *protection* against suicide: treat with Effexor and you can avoid that a depressed condition ends in suicide.

41 persons of the 393 who committed suicide in 2007 and were reported to the National Board of Health and Welfare *got* treatment with Wyeth's drug Effexor.

There are – if one wants to *understand* the results presented in the earlier chapter – better sources of information than advertisement from the pharmaceutical companies and articles from the biological psychiatrists who have built their careers on promoting the message in Wyeth's advertisement.

Better sources of information are the *unpublished* clinical trials of psychiatric drugs done by pharmaceutical companies, and the important studies done by independent researchers.

A number of these studies show that antidepressants and neuroleptics *increase the risk of suicidal behaviour and directly cause effects that lead to suicide*.

Some of the articles in which these results are described – articles that give *lots of* references for persons wanting to know more – are: Healy, *Antidepressants and*

Violence: Problems at the Interface of Medicine and Law, (2006) ⁴; Breggin, *Suicidality, violence and mania caused by selective serotonin reuptake inhibitors, (SSRIs): A review and analysis*, (2004) ⁵; Whitaker, *Affidavit* (A formal sworn statement of facts) about neuroleptics (2007) ⁶.

One of the phenomena described in the articles above is the *extreme inner restlessness*, which can be *caused* by neuroleptics and antidepressant drugs. The affected persons cannot sit still, feel compelled to move about, feel tortured from within. The condition is called akathisia (from Greek *a* [not] and *káthisis* [sitting]) and is caused by the drugs (not by any form of "underlying disease").

That the phenomenon doesn't have anything to do with the person's mental problems – but is exclusively caused by the drugs – has been shown in studies where healthy subjects have taken the drugs and then manifested these effects. Akathisia is a condition that is known to drive persons to suicide (and to violent acts against others).

The condition is also described in the official product information for neuroleptics, where it is even said to be *common* (occurring in 1-10% of the cases who get the drugs; see for example the text for Zyprexa ⁷). Akathisia is also created by antidepressant drugs, which report the additional *common* harmful effect of *agitation*, (see for example the text for Cymbalta ⁸). Akathisia and agitation are part of a spectrum of adverse effects of antidepressant drugs, starting with insomnia, nervousness and irritation, then progressing towards more serious effects like agitation, aggression, akathisia and mania ⁵.

In the articles above the harmful effects of antidepressants and neuroleptics become visible. The ways in which these drugs contribute to or directly cause phenomena leading to suicide are also well described.

The long known harmful effects of tranquilizers and hypnotics (benzodiazepines) – including risk for suicide – are taken up in *Brain-Disabling Effects of Benzodiazepines* (1997) ⁹.

Psychiatric drugs are not in any case natural substances produced by the body that may be deficient, or vital substances that must be supplied to the body. The drugs

⁴ Healy, *Antidepressants and Violence: Problems at the Interface of Medicine and Law*, PLoS Medicine (2006), , visited 24 July 2008, <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0030372>

⁵ Breggin, *Suicidality, violence and mania caused by selective serotonin reuptake inhibitors, (SSRIs): A review and analysis*, International Journal of Risk & Safety in Medicine 16 (2003/2004) 31–49, visited 24 July 2008, <http://www.breggin.com/31-49.pdf>

⁶ Whitaker, *Affidavit* (A formal sworn statement of facts) about neuroleptics, (2007), visited 24 July 2008, <http://psychrights.org/Litigation/WhitakerAffidavit.pdf>

⁷ Medicines Compendium, UK, Zyprexa, visited 24 July 2008, <http://emc.medicines.org.uk/emc/assets/c/html/DisplayDoc.asp?DocumentID=614>

⁸ Medicines Compendium, UK, Cymbalta, visited 2 August 2008, <http://emc.medicines.org.uk/emc/assets/c/html/DisplayDoc.asp?DocumentID=15694>

⁹ Breggin, *Brain-Disabling Effects of Benzodiazepines* (1997), from the book *Brain-Disabling Treatments in Psychiatry*, (Second edition 2008) visited 24 July 2008, <http://www.benzo.org.uk/breggin.htm>

given for “mental diseases” cannot in any way be compared to the insulin that a person with diabetes gets, or with the vitamin C human beings must have to not die from scurvy.

The idea that depressed persons are suffering from a “chemical imbalance”, that they are lacking serotonin, has been marketed by the pharmaceutical companies selling antidepressant drugs (in the class SSRI, as Zoloft/Lustral, Seroxat/Paxil, Celexa, Prozac) for over a decade. The intensive marketing has made people believe that feeling bad is a deficiency disease – and that it is vital to supply the substance curing this deficiency – the antidepressant drug. Doctors have been subjected to “blackmail” of the type described in Wyeth’s “gravestone ad”: Prescribe antidepressant drugs or the depression can end unexpectedly fast; the person can commit suicide.

However, there is no scientific evidence that feeling bad is caused by any form of “chemical imbalance” in the brain ¹⁰ ¹¹. The hypothesis has been rejected in the following sententious way by one of the most renowned persons in the area of psychopharmacology: “The serotonin theory of depression is comparable to the masturbatory theory of insanity.” ¹²

Psychiatric drugs *always* have a toxic effect on the brain and on the body in general; a toxic substance being defined as “a substance that causes death or harm when introduced into or absorbed by a living organism”. And psychiatric drugs *always* cause harm to the brain – often the openly admitted *aimed at effect*: the “zombie effect” elderly persons are subjected to in elderly homes, or the “chemical lobotomies” persons having psychotic reactions are given with neuroleptics ⁶.

In the cases of suicide for 2007 reported to the National Board of Health and Welfare in Sweden, the persons received on average 4 psychiatric drugs in the last year. The persons had in lesser or greater degree been subjected to poisonous effects.

But if the effects described above are the “contributions” psychiatric drugs made to the subsequent suicides – how were these effects reported to the registry for adverse effects in Sweden (called SWEDIS), at the Medical Products Agency (MPA) [comparable to MedWatch in the US and the Yellow Card Scheme in UK]? And how has the National Board of Health and Welfare considered these effects in its investigations about the suicides?

¹⁰ Leo/Lacasse, *The Media and the Chemical Imbalance Theory of Depression*, Society, (2007) visited 27 July 2008, <http://www.springerlink.com/content/u37j12152n826q60/fulltext.pdf>

¹¹ Leo/Lacasse, *Serotonin and Depression: A Disconnect between the Advertisements and the Scientific Literature*, PloS Medicine, (2005), visited 27 July 2008, <http://medicine.plosjournals.org/perlserv/?request=get-document&doi=10.1371/journal.pmed.0020392>

¹² Healy, as quoted in the article *Ads for SSRI antidepressants are misleading, say researchers*, Medical News Today, (2005), visited 27 July 2008, <http://www.medicalnewstoday.com/articles/33290.php>

Chapter 3

The breakdown of the reporting system

In 86% of the cases of suicide reported to the National Board of Health and Welfare for 2007 – that is in 338 of 393 cases – the persons were treated with psychiatric drugs.

In 0% (!) of these cases the matter was reported as a drug adverse event to the registry for drug adverse events at the Medical Products Agency (MPA).

In not a single one of all these cases of suicide did the responsible doctor (in most cases psychiatrists) consider that the tragic result could have been caused by the psychiatric drug or that the drug was a suspected contributory factor for the fatal result.

Not a single adverse event report was submitted about the 338 persons who committed suicide after having been prescribed psychiatric drugs!

If anything should be held up as an evidence for the complete breakdown of the adverse event reporting system, it must be this. If not even fatal results in the form of suicides following extensive treatment with psychiatric drugs are reported to the registry for adverse drug events, how should it then be with all other harmful effects patients are subjected to?

Doctors are to report all suspected serious drug effects to the Medical Products Agency. This reporting requirement must also reasonably be extended to the physicians at the National Board of Health and Welfare investigating the reported cases of suicide. But none of these doctors has considered that the extensive treatment with psychiatric drugs could have caused or strongly contributed to the fatal result. None of them submitted an adverse event report.

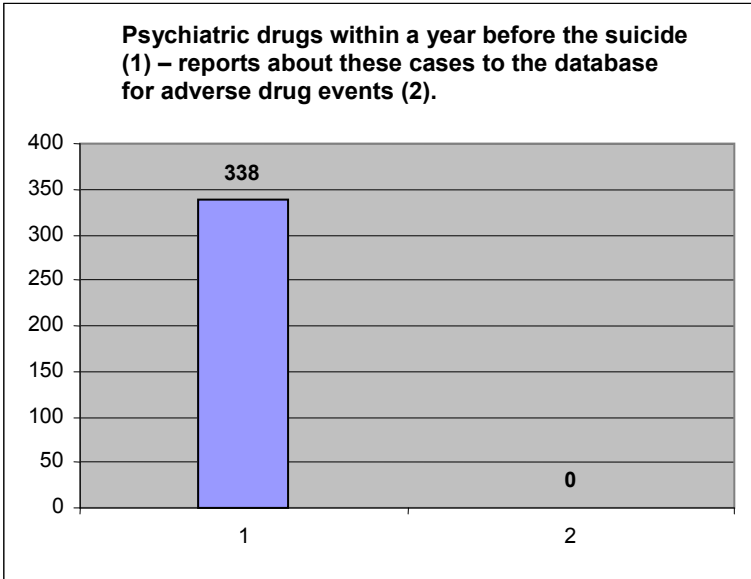


Diagram 6. Number of cases receiving psychiatric drug treatment and committing suicide (338) compared to the number of reports to the registry for adverse drug events for these cases (0).

Chapter 4

The "adequate drug treatment"

In the investigations about these suicides done by the National Board of Health and Welfare one thing is consistently lacking: The question if the *content* of the psychiatric treatment could have caused or contributed to the tragic end result – suicide. And the *content* was in 86% of the cases psychiatric drugs.

Instead of challenging the role of the psychiatric drugs, the reporting psychiatrists and the doctors at the National Board of Health and Welfare agree – as evidenced in the investigation material and in the complete lack of reports to the registry for adverse drug events – that the persons committing suicide got "adequate drug treatment".

The officials at the National Board of Health and Welfare know that the psychiatric drugs can induce suicidality or increased suicidality (especially in the beginning, when doses are increased/lowered, when other drugs are added, or during the withdrawal phase). They are aware about the now accepted serious harmful drug effect *akathisia* as an underlying cause in cases of suicide and violence against others. They know that serious physical and mental conditions can be caused by the use of several psychiatric drugs at the same time and, as written before, the "adequate drug treatment" among the persons committing suicide was on the average four different psychiatric drugs the preceding year. There is in the material submitted to the Board about the treatment an abundance of evidence that harmful effects induced by the drugs are seen as even more "symptoms" – and that these harmful effects are then handled with even more drugs, with a fatal outcome.

But the psychiatric drugs are not challenged. No questions are asked about their role in the subsequent suicides. And the very reason for this is that old myths about the protective effect of antidepressants and neuroleptics against suicide – directly taken from the false marketing material of the pharmaceutical companies – still govern the activities at the top of the National Board of Health and Welfare.

Epilogue

Considering the results presented in this report it is no longer possible to say that "more" of the same sort is the solution to the problem. It's not "more psychiatry" – more psychiatric drugs – that is the solution.

Politicians, trying to surpass each other in demanding more funds for a psychiatric industry that only means more "treatment" with psychiatric drugs should know that they directly contribute to harming people and to the creation of more "results" of the sort presented in this report.

Subservient nodding and voting when psychiatric opinion leaders require changes in law so that people can be drugged with force in their homes, and so that "drug treatment without exceptions" can be given for people with mental problems only lead to an increase in the psychiatric results described earlier.

This report clearly shows one thing: Almost all persons committed suicide after having had "adequate drug treatment" – in the meaning used in psychiatry; the very treatment that should *prevent* suicide.

There is no reason to believe that the reporting system for adverse drug effects work better in other countries. The catastrophic state of these "surveillance systems" makes it possible to keep destructive drugs on the market year after year. All it takes is for pharmaceutical companies to show that many persons have been exposed to these drugs, and that almost no adverse event reports have been submitted, so the drugs must be "safe and effective".

This example from Sweden shows that in 338 cases persons committed suicide after having been prescribed psychiatric drugs – and *none* of these cases were reported to the registry for adverse drug events. Instead of Eli Lilly claiming that the drug Zyprexa was involved in 0 cases of suicide in Sweden 2007, the fact was that the drug was involved in 52 cases in this group of 338 persons. Instead of Wyeth claiming the same for Effexor, the fact was that the drug was involved in 41 cases in this group.

The reporting system must be completely reformed right away. It must be made mandatory for health care professionals to directly report all suspected serious adverse drug effects, and persons not reporting must be disciplined. Patients must be fully informed about the actual harmful effects of the drugs and given the right to report these effects to the adverse events registry with the promise of effective follow-up. The reformed system must not give room for the now ruling psychiatric concealment ideology, where obvious harmful effects of psychiatric drugs are treated as "symptoms" requiring more drugs. Instead *all* these effects must be reported as suspected harmful effects by the drugs.

And, most importantly, the data presented in this report must lead to *basic changes* in the ways in which persons with mental problems are being cared for.