It’s time to start saving lives … and money.

Dr Alan Howard, National Medical Director, KetaMIND July 2026

This has now become personal.

The loss last week of a close friend in his 50’s to suicide has left me somewhat stuck in the ‘anger’ stage: anger towards mainstream psychiatry, its baked-in convention bias, egos, and ivory tower dictates accepted without question by major funders.

As an inexact science lacking precise biomarkers and objective diagnostic tools, elements of psychiatry must rely largely on nebulous outcomes promoted as ‘evidence’. Outcomes like those still purported by the now undeniably fraudulent Star*D trial championed by Big Pharma. Moreover, free rein as ultimate arbiters of what is ‘normal’, the omnipotence afforded by a cache of psychotropic drugs riddled with addiction potential and side effects, and the power to institutionalize, affords many psychiatrists (in particular policy makers) enormous control over patient autonomy and their right to choose treatments (like Ketamine Infusions) that demonstrably and verifiably reverse or significantly reduce suicidality in nearly 80% of patients. If this wasn’t already established, the latest JAMA Psychiatry meta-analysis involving 1,166 patients and the global regulatory milestone realized in March when the French regulatory authority declared ketamine infusion for suicidality no longer ‘off-label’, should sway even the most ardent detractors.

That a few senior psychiatric policy makers have embraced this undeniable efficacy of ketamine yet lack the training and skill set to administer the infusions themselves but have nevertheless pursued their own ketamine enterprises (somewhat incestuously self-regulated with dubious adherence to their own decrees), remains anathema to me. (See article in Newsletter 28).

The medicalization of clusters of human emotions as mood ‘disorders’ is enshrined in the DSM-5, a compendium of contrived criteria developed to allegedly validate fabricated conditions for the ultimate benefit of Big Pharma. If this seems cynical, why is it then that 60% of the DSM-5-TR task force appointed by the APA pocketed over $14.2 million (undisclosed conflicts of interest) from pharmaceutical companies? *(BMJ, 2024)*.

With over 15000 ketamine infusions under our belt at 9-clinics in 4-provinces, I can attest (based on hundreds of testimonials from patients and their families) to the life-changing

potential of ketamine (compared with traditional treatments) for numerous suicidally depressed patients. For the most part, like my dead friend, these have trudged endlessly through the very predictable psychotropic smorgasbord of antidepressants, mood-stabilizers and atypical antipsychotics, to ultimately end up at an expensive rehab facility (whenever the annual PMB becomes available), where talk therapy and usually even more drugs in an entirely artificial environment away from the reality of work and home stressors paradoxically *increases* the risk of suicide after discharge. Yes, in the first 3-months after discharge, suicide rates spike to 100-times the global average, and for those admitted with established suicidal ideation 200-times. The risk remains 30-times higher for many years after discharge. *(JAMA Psychiatry)*.

So WHY do the likes of Discovery Health and other major funders persistently bend to the dictates and desires of SASOP rather than mandating a trial of safe outpatient ketamine infusions (coupled with psychotherapy) for their members with MDD and suicidality before a vastly more costly and usually less efficacious admission to an inpatient facility is ever approved? Ketamine will not work for all patients and genetic predisposition will inevitably account for some non-responders, however the enormous statistical advantage ketamine enjoys over traditional medication in inducing remission and reversal of symptoms should not be discounted. When independent researchers, not funded by drug companies, examine SSRI's, success rates are usually massively exceeded by ketamine.

In the last newsletter, we linked to an article in which a staggering reality about the suicide crisis in South Africa was revealed. Discovery Life noted that in 2024, insurance claims due to suicide were up 62% compared with the 5-year average, and that there were more deaths due to suicide amongst its clientele than motor vehicle accidents! Is there any cause of death more tragic yet preventable than that by one's own hand? There is no tumour metastasizing insidiously, nor a coronary artery inexorably clogging up until inevitable demise despite treatment. Reverse the suicidal ideation rapidly with the most effective tool at your disposal and buy the time needed to formulate and instigate a medium and long-term maintenance outpatient treatment and support strategy in an otherwise physically healthy patient, not yet another 3-weeks in a psychiatric facility, or another tweak to the conventional psychotropic regimen. Embrace the evidence rather than turning from it. Question the motives behind the detractors.

If there were a sudden uptick (say 62%) in deaths and life-insurance claims amongst Discovery Life's clientele due to colon or breast cancer, I'd bet that every imaginable screening tool would be mandated to allow for the earliest possible detection and treatment of the condition. Not because of some altruistic concern for members' longevity, but to save money and protect the bottom line. Yet, inexplicably, given the evidence for

ketamine infusion's efficacy, each new year heralds another tranche of mental health PMB's (with ketamine infusion at an approved outpatient provider conspicuously absent), more expensive psychotropics, and the inevitable annual reunion at the inpatient facility. Or, perhaps, too frequently, a completed suicide.

It is undoubtedly my background as a consultant in emergency medicine, and my time spent in the resuscitation room and teaching advanced life-support, that has inculcated a mantra of saving lives by employing the most effective available means at my disposal early and aggressively. Death is death, whether caused by a tension pneumothorax after a car crash or suicidal desperation. Procrastination kills in both instances, and death can be expensive. Pointing this out to funders (like Discovery Health and their life insurance arm) remains my last hope when appealing for a change in mindset and direction.

While quite clearly angry at psychiatric orthodoxy, unwavering adherence to convention and reluctance to acknowledge failings of their profession in adopting new approaches, there have been some exceptions and shining lights. To those in practice and academia who have researched and published outcomes from our clinics (SAJP), invited open discourse on podcasts and in other forums, I extend (along with numerous patients and their families) a heartfelt thank you.

To those who continue to protect their turf at all cost, refuse to engage meaningfully, endlessly procrastinate and persist with statements like: *"The diagnosis of TRD lives in the sole arena of psychiatrists, and I do not foresee this to change"* all I can appeal for is an open mind and willingness to embrace ketamine infusion as a safe and frequently life-saving intervention.

To funders (like Discovery Health), and for the benefit of the bottom line if for no other reason, I appeal for an independent 'new look' at the efficacy and cost-benefit of safe outpatient ketamine infusion for MDD and suicidality. At least consider mandating a trial of ketamine before signing off on yet another costly inpatient admission. Circumvent the dictates of the 'psychiatric policy establishment' or, at least, engage more assertively with evidence-based discussion and recommendations of your own.

Had this happened, I cannot help but wonder whether my friend (and many others) might not still be alive today.

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