Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

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POC1_839556

Mr J Layton
Senior Coroner
Coroner's Office
Town Hall
Hamilton Terrace
Milford Haven
Pembrokeshire, SA73 3JW

31 MAR 2014

Dear Mr Layton,

Thank you for your letter following the inquest into the death of Lee Bonsall. In your report you conclude that the medical cause of death was asphyxia by hanging. I was very sorry to read of the events that led to the death of Mr Bonsall and wish to extend my sincere sympathies to his family.

I understand Mr Bonsall had been in the army from the age of 17 and served in Afghanistan. During his service he witnessed the death of a close friend. He was discharged from the army in September 2007 after being found temperamentally unsuitable for service. He continued to suffer depression, relocated to West Wales and registered with a surgery there in 2010. His GP assessed him and prescribed citalopram. He had a repeat prescription for this drug.

His GP considered counselling but did not refer Mr Bonsall for psychotherapy as there was a 10 month waiting list in that area of Wales. Mr Bonsall was found hanging by a ligature from a bannister rail at his home address on 3 March 2012.

You raise the following matters of concern:

- That citalopram was given on repeat prescription contrary to guidelines. You suggest that awareness of these guidelines needs to be raised so that GPs are aware that this drug should not be given on repeat prescription.
- The ten month waiting time for psychotherapy effectively means it is not a viable alternative to anti-depressant medication. You suggest that a review of these waiting times is appropriate.

As these tragic events took place in Wales and Mr Bonsall was under the care of the Welsh health service, you will appreciate that I cannot comment on matters that are the responsibility of the Welsh Government.

I therefore strongly recommend that your report is brought to the attention of the Welsh Assembly. The Minister for Health and Social Services, Mark Drakeford AM, can be contacted at the following address:

Welsh Government
5th Floor
Tŷ Hywel
Cardiff Bay
CF99 1NA

[redacted]

However, it may be helpful if I explain the situation in England. In England there are in general no national restrictions on which medicines can be prescribed under repeat dispensing arrangements. The exception is scheduled drugs or controlled drugs within the meaning of the Misuse of Drugs Act 1971. Citalopram does not fall within this category.

Responsibility for prescribing, including repeat prescribing, rests with the prescriber who has clinical responsibility for that particular aspect of a patient's care. This includes considering the suitability of prescribing a particular medicine for a particular patient in light of individual circumstances. In England it is the responsibility of local primary care organisations to ensure that adequate controls are in place. They may therefore issue advice to GPs on repeat prescribing mechanisms.

Comprehensive guidance is available to professionals about prescribing, including, for example, repeat prescribing issues, prescribing for certain categories of patient (including mental health) and prescribing of particular types of drugs, including anti-depressants. The National Institute for Health and Care Excellence (NICE), the General Medical Council and the British Medical Association have all produced guidance that specifically addresses assessing the risk of prescribing a particular medication for individuals at risk of self-harm. There is also specific product information available for citalopram itself covered in the manufacturer's Product Information Leaflet (PIL) and the Summary of Product Characteristics.

Relevant extracts from these sources are attached at **Annex A**. However, you will note that none of them specifically refers to repeat prescribing of citalopram.

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Although your letter mentions guidelines, we cannot therefore establish exactly what you are referring to. I would look into this matter further if you could supply the information and if it falls within my remit.

Likewise, on waiting times, the situation in England is that access to services, and the waiting times for those services, for people with mental health problems is unfortunately sometimes longer than for physical health services. Ensuring that mental health in England is treated equally with physical health means, for example, ensuring that people do not experience excessively long waits for treatment.

The Department and NHS England are committed to ending this imbalance. We believe that it is vital to develop and implement new access and waiting time standards to have true parity of esteem. We are committed to providing access to services and waiting times on a par with physical health.

NHS England is therefore developing options to improve access and waiting times standards for mental health services. There will be a phased approach to implementation of revised standards starting from April 2015.

Improving Access to Psychological Therapies (IAPT) is an NHS programme in England which supports the frontline NHS in implementing NICE guidelines for treating people suffering from depression and anxiety disorders. Despite the many success stories, the clear focus and the good progress that has been made to date, as IAPT expands new challenges emerge. The initial success of the programme in the provision of services to the adult population has led to a rise in demand as more people are offered this service.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Mr Bonsall's death to my attention.

Yours sincerely

Jeremy Hunt

JEREMY HUNT

Department of Health

ANNEX A – PRESCRIBING GUIDANCE

1) Repeat prescribing

General Medical Council guidance, *Good Practice in Prescribing and Managing Medicines and Devices (2013)*

http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

The section on repeat prescribing states:
Repeat prescribing and prescribing with repeats

55. You are responsible for any prescription you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any repeat prescription you sign is safe and appropriate. You should consider the benefits of prescribing with repeats to reduce the need for repeat prescribing.

56. As with any prescription, you should agree with the patient what medicines are appropriate and how their condition will be managed, including a date for review. You should make clear why regular reviews are important and explain to the patient what they should do if they:

a. suffer side effects or adverse reactions, or

b. stop taking the medicines before the agreed review date (or a set number of repeats have been issued).

You must make clear records of these discussions and your reasons for repeat prescribing.

57. You must be satisfied that procedures for prescribing with repeats and for generating repeat prescriptions are secure and that:

a. the right patient is issued with the correct prescription

b. the correct dose is prescribed, particularly for patients whose dose varies during the course of treatment

c. the patient's condition is monitored, taking account of medicine usage and effects

d. only staff who are competent to do so prepare repeat prescriptions for authorisation

e. patients who need further examination or assessment are reviewed by an appropriate healthcare professional

f. any changes to the patient's medicines are critically reviewed and quickly incorporated into their record.

58. At each review, you should confirm that the patient is taking their medicines as directed, and check that the medicines are still needed, effective and tolerated. This may be particularly important following a hospital stay, or changes to medicines following a hospital or home visit. You should also consider whether requests for repeat prescriptions received earlier or later than expected may indicate poor adherence, leading to inadequate therapy or adverse effects.

59. When you issue repeat prescriptions or prescribe with repeats, you should make sure that procedures are in place to monitor whether the medicine is still safe and necessary for the patient. You should keep a record of dispensers who hold original repeat dispensing prescriptions so that you can contact them if necessary.

Medical Protection Society

Repeat prescribing for GPs:

Care should be taken with any drug that is added to a repeat prescribing list. However, some drugs lend themselves more readily to a repeat prescribing approach, such as antihistamines, which require minimal levels of monitoring. Drugs that are not suitable for routine repeat prescribing include hypnotics, antidepressants and disease modifying agents, eg, methotrexate.

2) Use of anti-depressant drugs

The **British National Formulary** contains comprehensive advice about the use and management of anti-depressant (AD) drugs and advises that:

"patients should be reviewed every 1-2 weeks at the start of antidepressant treatment."

Guidance on the use and dosage of the specific AD drug, Citalopram is also included.

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3) Prescribing of Citalopram

The **Patient Information leaflet** for Citalopram offers the following warnings and advice about duration of treatment:

Warnings and precautions
Citalopram Tablets should be taken with caution if you:

- *suffer from **psychosis** with depressive episodes, because the psychotic symptoms may increase.*

How long should you take Citalopram Tablets
Your doctor will decide on the duration of treatment.
An improvement in depressive symptoms can take at least 2 weeks after starting of treatment. Treatment should be continued for at least 4-6 months. If you don't start to feel better after a couple of weeks, go back to your doctor who will advise you.

The **Summary of Product Characteristics** (SPC) for Citalopram includes the requirement for monitoring if suicide is a potential:

https://www.medicines.org.uk/emc/medicine/23861/SPC/Citalopram+20mg+Tablets/#POSOLOGY

Suicide/suicidal thoughts or clinical worsening
Depression is associated with an increased risk of suicidal thoughts, self harm and suicide (suicide-related events). This risk persists until significant remission occurs. As improvement may not occur during the first few weeks or more of treatment, patients should be closely monitored until such improvement occurs. It is general clinical experience that the risk of suicide may increase in the early stages of recovery.

Other psychiatric conditions for which citalopram is prescribed can also be associated with an increased risk of suicide-related events. In addition, these conditions may be co-morbid with major depressive disorder. The same precautions observed when treating patients with major depressive disorder should therefore be observed when treating patients with other psychiatric disorders.

Patients with a history of suicide-related events, or those exhibiting a significant degree of suicidal ideation prior to commencement of treatment are known to be at

greater risk of suicidal thoughts or suicide attempts, and should receive careful monitoring during treatment. A meta-analysis of placebo-controlled clinical trials of antidepressant drugs in adult patients with psychiatric disorders showed an increased risk of suicidal behaviour with antidepressants compared to placebo in patients less than 25 years old.

Close supervision of patients and in particular those at high risk should accompany drug therapy especially in early treatment and following dose changes. Patients (and caregivers of patients) should be alerted about the need to monitor for any clinical worsening, suicidal behaviour or thoughts and unusual changes in behaviour and to seek medical advice immediately if these symptoms present.