General Practitioner, Dr C

A Medical Centre

A Report by the

Health and Disability Commissioner

(Case 13HDC00015)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. Mr A had a history of depression which was first recognised when he was a teenager.

2. In 2012, on 12 Month1[1] Mr A was assessed by Dr E at an accident and medical centre. Mr A told Dr E that he had been having concentration difficulties at work and was feeling depressed. The accident and medical centre specialises in emergency and acute care and does not provide treatment to patients for on-going medical problems. Dr E therefore wrote a referral for Mr A to give to a general practitioner (GP), who would be in a better position to provide him with on-going care.

3. On 23 Month1 Mr A took the referral letter to another medical centre (Medical Centre 2), where he was assessed by Dr C. During that consultation Mr A told Dr C that his primary complaint was being "slow due to concentration defect", and advised that he had experienced approximately seven years of low mood, which remained unchanged. Dr C undertook a physical and psychological examination, and concluded that Mr A was experiencing mild depression.

4. Mr A advised Dr C that his preference was for counselling rather than medication. Mr A was not immediately eligible for fully funded counselling as he was not an enrolled patient at Medical Centre 2 at that time. Dr C and Mr A discussed the commencement of antidepressants, which Mr A agreed to. Dr C therefore prescribed Mr A with a two-month course of the selective serotonin reuptake inhibitor (SSRI) antidepressant citalopram, at a light dose of half a 20mg tablet per day. Dr C recalls that he recommended that Mr A return for a review at the end of the following month (Month2). The clinical notes record that the review was to take place in "Month3". Dr C recalls telling Mr A to come in earlier if he developed side-effects from the citalopram.

5. On 6 Month3 Mr A telephoned Medical Centre 2 and asked the practice nurse for a same-day repeat prescription of citalopram. If Mr A had been taking his medication as directed he would have had two weeks' supply of citalopram remaining at that time. The practice nurse printed a two-month prescription for citalopram, which Dr C signed. Dr C was aware that he had not reviewed Mr A since the initial prescription was provided six weeks earlier, but balanced his desire to review Mr A with his view that it would be unwise for Mr A to be without citalopram. In reaching that decision, Dr C assumed that Mr A was "deriving a positive response" from the medication, on the basis that he had not reported any side-effects.

6. During the evening, later in Month3, Mr A committed suicide after a heavy drinking session.

Decision summary

7. Following an initial prescription of an antidepressant medication, patients should be reviewed within one to two weeks. This is because, even in adults with only mild depressive symptoms, suicidality can be an emergent symptom where a patient is

[1] Relevant months are referred to as Months 1 – 3 to protect privacy.

prescribed antidepressant medication for the first time. A further review should then be carried out to assess the medication's efficacy and appropriate dosage.

8. Dr C did not have in place an appropriate plan for timely follow-up of Mr A after his initial two-month prescription of citalopram on 23 Month1. This was a breach of Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code). In addition, Dr C's provision of a further two months of citalopram on 6 Month3, without undertaking a review of Mr A, was also a breach of Right 4(1) of the Code.

9. It is not the role of the Commissioner to make findings of causation. Accordingly, the breach findings against Dr C should not be interpreted as having any implication as to the cause of Mr A's death.

10. Medical Centre 2 was not directly or vicariously liable for Dr C's breach of the Code.

Complaint and investigation

11. The Commissioner received a complaint from Mr and Mrs B about the services provided to their son, Mr A, by Dr C at Medical Centre 2. The following issues were identified for investigation:

- *Whether Dr C provided an appropriate standard of care to Mr A from 23 Month1 until his death in Month3.*
- *Whether Medical Centre 2 provided an appropriate standard of care to Mr A from 23 Month1 until his death in Month3.*

12. The parties directly involved in the investigation were:

Medical Centre 2	General practice medical centre/provider
Mr B	Complainant/consumer's father
Mrs B	Complainant/consumer's mother
Dr C	General practitioner/provider

13. Also mentioned in this report:

Child and Adolescent Mental Health Service	Mental health service provider
Medical Centre 1	General practice medical centre
Accident and medical centre	Accident and urgent medical centre
Mr D	General Manager of Medical Centre 2
Dr E	General practitioner

[2] Right 4(1) of the Code states that "every consumer has the right to have services provided with reasonable care and skill".

14. Independent expert advice was obtained from my in-house clinical advisor, general practitioner Dr David Maplesden (attached as **Appendix A**).

Information gathered during investigation

Background

Child and Adolescent Mental Health Services

15. In 2005 Mr A, then a teenager, was referred by his school guidance counsellor to a Child and Adolescent Mental Health Service (CAMHS), a service provided by the DHB. The referral documentation recorded that Mr A had divulged suicidal thoughts to his school guidance counsellor, and had been noted to behave violently towards others when angry.

16. In 2005 Mr A was seen with his parents, Mr and Mrs B, by a family therapist at CAMHS. The therapist recorded that Mr A had experienced severe bullying in the past, and diagnosed parent/child relational issues. The therapist recommended treatment involving individual therapy sessions and enrolment in a therapeutic storytelling intervention group (TSI group) run at Mr A's school.

17. During 2005 Mr A was seen at CAMHS for individual therapy on five further occasions. The relevant clinical notes indicate that Mr A underwent cognitive behavioural therapy, and that issues of worry, anxiety, anger management and feelings were discussed and addressed. During that period Mr A also attended at least one session with the TSI group.

18. Mr A was not medicated at the time of the above therapy sessions, which he appeared to respond to positively. The clinical notes from Mr A's last individual therapy session in 2005 recorded that Mr A was doing well.

Medical Centre 1

19. Between 1994 and 2011 Mr A was enrolled as a patient at a medical centre (Medical Centre 1), and saw the doctors at that practice regularly during that period. Although it does not appear that Mr A's general practitioner (GP) at Medical Centre 1 was involved in his mental health treatment at CAMHS, medical records show that his GP was notified that he had been referred to CAMHS. The clinical notes from Mr A's last appointment at Medical Centre 1, in late 2011, noted that he "lives far away now and will be transferring out".

12 Month1 2012 — Presentation to accident and medical centre

20. On 12 Month1 2012 Mr A, then in his early twenties, attended an accident and medical centre, where he saw Dr E. The accident and medical centre is an emergency and after-hours clinic that primarily deals with casual patients for episodic or urgent care. Although Mr A had attended principally for a chest infection, Dr E's notes from that consultation recorded the following:

> "Also having concentration issues at work, says that he is feeling depressed, and has done for 7 years. NO exacerbating factors, no thoughts of self-harm, (no history of this either) — for referral to GP for management — advice re cutting down on alcohol, regular exercise, not keen for medication.
>
> **Plan:** Augmentin
> Oral fluids and rest
> Panadol
> GP referral for depression symptoms — given a letter
> Advised about websites
> Not keen for AD meds at present?"

21. Dr E provided a referral letter for Mr A to give to his GP, which reiterated the following consultation details and additional history:

> "He tends to drink large amount of alcohol at the weekend and has a history of cannabis use, but he has now stopped this. He occasionally takes pills at the weekend (around six times a year). He is not keen to start anti-depressant medication, but is keen for referral to someone so that he could discuss some of his issues. I have advised for him to see his GP so that his symptoms can be followed up and monitored."

22. The accident and medical centre later advised the Coroner that, because of the nature of the clinic, it does not usually seek a patient's previous medical records or treat patients for on-going medical complaints. For that reason, Dr E referred Mr A to his GP, who would be better positioned to provide on-going care.

22 Month1 — Enrolment at Medical Centre 2

23. Medical Centre 2 is a general practice medical centre.

24. On 22 Month1 Mr A filled out enrolment forms for Medical Centre 2, which were sent to the Ministry of Health.[3]

23 Month1 — Presentation to Medical Centre 2

25. On 23 Month1 Mr A presented at Medical Centre 2 with the referral letter from Dr E. Mr A was seen by GP Dr C.[4] Prior to that consultation, Mr A and Dr C had not met. Dr C recalls that Mr A's primary complaint was being "slow due to concentration defect".

26. Dr C conducted a physical examination, which revealed normal blood pressure and heart rhythm. When Dr C could not find a physical reason for Mr A's symptoms, he asked Mr A questions using the Kessler Psychological Distress questionnaire.[5] The

[3] Enrolment applications are forwarded to the Ministry of Health on a quarterly basis and, depending on the date of enrolment application and when quarterly applications are forwarded (as much as six weeks prior to the end of that quarter) it could be up to four and a half months from the time of application to the time a patient is regarded as enrolled.
[4] Dr C is registered with the Medical Council of New Zealand in the general scope of practice.
[5] This questionnaire is a screening tool used to assess the severity of a patient's psychological distress levels.

clinical notes show that Mr A recorded a score of 23 out of 50 in the questionnaire, indicating mild distress.[6] Dr C's notes of the consultation read as follows:

> "LOW mood, reported yesterday to the accident and medical centre, advised to see GP (scanned document)
> sleep well
> no change of mood
> FHx; brother bipolar
> smoks 10cig/day
> Alcohol box beer 10–12 bottels a night at week end, occasional drinks during hte week. [sic]
>
> no suicidal ideation
> \BP 120/70
> body wt: 61 kg
> No focal neurology sign
> no clinical sign of anaemia
> heart: NDR
> imp: depression, impact on performance, slow due to concentration defect
> plan: referral to [psychologist] not funded (not enrolled).
> Plan: Citalopram
> Rv in [Month3]
> Rx: Citalopram 20 mg Tab — 0.5 Tabs, Once Daily — 30"

27. Dr C informed HDC that his impression was that Mr A was suffering from mild depression, had no suicidal ideation (he recalls asking Mr A this specifically) and was at low risk of suicide.

28. Dr C advised that he discussed counselling with Mr A, as Dr E's referral letter indicated that this was Mr A's preference. Patients enrolled at Medical Centre 2 were eligible for free sessions with a psychologist, and Dr C advised Mr A of this. Dr C recalls that Mr A's clinical records showed that he was a casual patient and so he advised Mr A of his options of funding counselling sessions himself, or becoming an enrolled patient with Medical Centre 2 so that he could obtain free counselling.[7] The clinical notes do not record the details of this discussion.

29. Dr C informed HDC that during the consultation he also discussed with Mr A the use of antidepressant medication, and Mr A consented to the use of citalopram. It was therefore agreed that Mr A would commence on a two-month course of citalopram at half a 20mg tablet daily, and he would make an appointment with Dr C for review. Dr C recalls that the review was to take place at the end of the following month (Month2). The clinical notes, however, record that the review was to take place in "Month3" (this would accord with the course of medication prescribed). Dr C informed HDC that he advised Mr A to come in earlier if he felt worse or if he developed any side-effects from the citalopram.

[6] The Kessler score indicated that Mr A was likely to have a mild mental disorder (range 20–24).
[7] As noted at footnote 3, Mr A was not yet enrolled with Medical Centre 2.

30. Mr A's Citalopram container stated in bold font "limit alcohol" and "TAKE HALF a tablet ONCE DAILY."

Citalopram

31. Citalopram is an antidepressant drug of the selective serotonin reuptake inhibitor (SSRI) class, and is commonly used in New Zealand for treating adult[8] depression. SSRIs are a first-line treatment for an adult with moderate depression, coupled with psychological therapy.[9]

6 Month3 — Repeat prescription

32. On 6 Month3, six weeks after Mr A's initial consultation with Dr C, Mr A called the practice nurse at Medical Centre 2 and asked for a repeat prescription for citalopram to be provided for him that day. If Mr A had been taking his medication as directed, he should have had approximately two weeks' supply remaining at that date.

33. The practice nurse noted in the clinical record that Mr A had been last seen by Dr C in Month1, and generated a repeat two-month prescription for citalopram for Dr C to sign. Dr C signed the repeat prescription without any further assessment of Mr A having taken place. Dr C advised HDC that "[w]hen Mr A called for a repeat script he did not want to come in for a consultation". However, the clinical records do not contain any account of Mr A saying this. Dr C also advised as follows:

> "As [Mr A] had not reported any side-effects from the Citalopram, it indicated to me that he was deriving a positive response from the medication. As such, I signed the prescription."

34. When Dr C was asked to clarify the basis for his impression that Mr A was "deriving a positive response from the medication", he advised as follows:

> "… the basis of my assumption that [Mr A] was responding well to the Citalopram was that I had specifically told him to consult with me earlier than a month if he developed any side effects or was concerned about anything following taking Citalopram. I considered [Mr A] to be a responsible young man who was old enough to do so, indeed, he had taken the initiative to consult with a doctor in the first place with his mild depression. There was no indication that he would not similarly present if he had any concerns following the prescription for Citalopram that I had initially provided him with."

35. Dr C said that he asked the receptionist to advise Mr A to "see a doctor for the next prescription". However, there is no record in the clinical notes of either Dr C's instruction to the receptionist, or whether that message was passed to Mr A.

Month3

36. Sadly, in late Month3, Mr A committed suicide after a heavy drinking session. He was in his early twenties at the time.

[8] 18 years and over.
[9] BPAC Journal (Special Ed), *Adult Depression*, July 2009.

Further comments

23 Month1 consultation

37. Regarding Mr A's initial two-month prescription on 23 Month1, Dr C advised that "… the antidepressant effect of citalopram usually sets in after [two] to [four] weeks. A treatment period of at least six months is usually necessary to provide adequate maintenance against the potential relapse according to the Med Safe Data Sheet of citalopram." Later in the investigation Dr C again stated that "[t]he New Zealand [MedSafe Datasheet] of citalopram clearly indicates that a treatment period of at least [six] months is usually necessary to provide adequate maintenance against the potential for relapse".

38. Despite what is set out above, Dr C also advised that he should not have left the decision to Mr A to re-present earlier if his condition deteriorated or if he developed any side-effects from the citalopram; rather, Dr C said that he should have prescribed for a shorter period of time (one month) and then arranged for a consultation following that period. Dr C said that he is "certainly conscious of that now".

39. Medical Centre 2 advised HDC that, in the course of an internal review into the standard of care provided to Mr A by Dr C (referred to below), Dr C was advised that he "… could expect to be criticised about initially prescribing two months' worth of Citalopram rather than one month's …".

6 Month3 repeat prescription

40. Regarding Mr A's request for a repeat prescription on 6 Month3, and Dr C's provision of a two-month prescription, Dr C emphasised Mr A's unwillingness to present for an appointment, and advised: "While it was my preference … for [Mr A] to be reviewed again prior to the next prescription being provided, it was also important that I did not leave [Mr A] without medication." Later in the investigation, Dr C accepted that "best practice" would be to have seen Mr A before issuing the repeat prescription. However, Dr C stated: "[I]f I had decided to insist on a consultation with the patient and he had not presented, I would have then deprived him of medication that was needed which also would have resulted in an abrupt stop to the medication which literature says should be avoided at all costs." Dr C referred to the MedSafe Datasheet on citalopram (the MedSafe Datasheet) in this regard.

41. However, Dr C also said that, with the benefit of hindsight, he should have prescribed only a further two-week prescription for citalopram on 6 Month3, rather than a further two-month prescription, and should have tried to consult with Mr A after issuing the repeat prescription.

42. Medical Centre 2 advised HDC that, in the course of its internal review into what had occurred, Dr C was advised that he "… could expect to be criticised … that a repeat prescription should possibly have been for a shorter period also".

Relevant policies at Medical Centre 2

43. Medical Centre 2 provided this Office with two policies relevant to the care provided by Dr C, which were in place at the time of events — one entitled "Prescribing in the

Absence of Direct Patient Contact", and the other entitled "Repeat Prescribing". The most relevant policy for this case is the "Repeat Prescribing" policy.

Repeat Prescribing policy

44. The Repeat Prescribing policy at Medical Centre 2 set out the following:

> "4.2. … long-term repeat prescribing and repeat prescribing in the absence of consultation can be undertaken provided that a medical review has… taken place within the previous six months. This will always be a matter of professional judgement and should be exercised at the discretion of the medical practitioner.
>
> 4.3. The exercise of professional judgement must stand up to scrutiny against accepted standards of best practice in the medical profession.
>
> …
>
> 5. Procedure
>
> …
>
> 5.6. The doctor reviews all relevant patient notes, ensures the medication has been previously prescribed and that the request is within clinical guidelines.
>
> 5.7. In the absence of a face-to-face consultation, prescriptions should only be provided if reasonable care and skill have been exercised.
>
> 5.8. All prescribing will comply with legal, professional, ethical and other relevant standards. This will also be provided in a manner consistent with the patient's needs, minimising potential harm and optimising quality of life."

Subsequent events/changes made

Dr C

45. Dr C advised HDC of the following steps he has taken following Mr A's death:

> "I am more vigilant with patients with any form of mental health following this tragic and very sad outcome. I have discussed the case numerous times with colleagues and have worked (and continue to work) with our practice manager to amend and update our policy on repeat prescriptions. I have also read and am familiar with the BPAC publication[10] to which Dr Maplesden refers and I frequently read articles regarding mental health when they come up in publications from time to time."

46. Dr C also advised of the implementation of a new prescribing policy at Medical Centre 2 dated 10 December 2012 (the "Repeat Prescription Standing Orders", referred to below).

[10] BPAC Journal (Special Ed), *Adult Depression*, July 2009.

Medical Centre 2

47. The General Manager of Medical Centre 2, Mr D, advised Mr and Mrs B and HDC of the following changes that have been implemented at the practice following Mr A's death:

- The use of telephone consultations as a part of follow-up.
- Referral for urgent counselling (when clinically indicated) via WINZ, to help with funding.
- Provision of the Mental Health Crisis Team's telephone number (in cases of high concern or risk).
- Seeking permission from patients to inform next of kin or other support people, when there are concerns about the patient's well-being.
- Appointment of a social worker at Medical Centre 2.

48. Mr D advised HDC that an internal review of the care provided to Mr A had been conducted, and the matter had been discussed with Dr C "on a number of occasions" (the review's specific comments regarding the prescriptions on 23 Month1 and 6 Month3 have been set out above). Mr D went on to advise that "… Dr C has taken this case extremely seriously and has been an advocate for changes in policy manuals and making others aware of the case and its difficulties". In terms of specific changes made at Medical Centre 2, Mr D advised as follows:

> "The matter was further discussed with all the doctors in the practice at peer review meetings and the consensus was that with a new diagnosis of depression a prescription of two weeks (or up to a month where the patient is known to present when required) should be issued and the patient instructed to return for follow up. If the patient should not turn up but request a repeat prescription then the doctor has two options. The first option would be to refuse until the patient presents again or secondly to issue a further prescription for two weeks but that the doctor or nurse should in the interim phone the patient to determine the reason for not attending and to ascertain if there have been any side-effects or changes of symptoms. No further repeat should be issued until the patient has been seen."

49. Medical Centre 2 also provided a copy of its Repeat Prescription Standing Orders. The Standing Orders have been signed by the nurses employed at Medical Centre 2, but presumably apply to the doctors as well (given that they are required to sign off all prescriptions). The Repeat Prescribing Standing Orders set out the following:

> "An appointment is always needed for certain medications such as antibiotics and antidepressants. (In certain circumstances these can be repeated, for example, if a patient is on long term antidepressants and they are stable.)"

50. Medical Centre 2 further advised that it is in the process of developing a "drop box" on its computer system, which will guide doctors in their decision-making for patients with depression.

Other relevant standards

51. The Medical Council of New Zealand publication *Good Prescribing Practice,* issued in April 2010, provides the following prescribing standards:

> "You should only prescribe medicines or treatment when you have adequately assessed the patient's condition, and/or have adequate knowledge of the patient's needs and are therefore satisfied that the medicines or treatment are in the patient's best interests. Alternatively you may prescribe on the instructions of a senior colleague or a practice colleague who can satisfy the above criteria, as long as you are confident that the medicines or treatment are safe and appropriate for that patient and the patient has given his or her informed consent. Medicines or treatment must not be prescribed for your own convenience or simply because patients demand them. To ensure that your prescribing is appropriate and responsible you should:
>
> …
>
> - Be familiar with the indications, side effects, contraindications, major drug interactions, appropriate dosages, effectiveness and cost-effectiveness of the medicines that you prescribe …
>
> …
>
> - Consider whether a prescription is warranted given the nature of the patient's complaint and presentation, and whether a non pharmacologic treatment could be as effective and safe.
> - Ensure that the patient (or other lawful authority) is fully informed and consents to the proposed treatment and that he or she receives appropriate information, in a way they can understand, about the options available; including an assessment of the expected risks, side effects, benefits and costs of each option. Satisfy yourself that the patient understands how to take any medicine prescribed and is able to take it.
> - Never prescribe indiscriminately, excessively or recklessly.
> - Prescribe in accordance with accepted practice and any relevant best practice guidelines. Prescribing outside of accepted norms should only occur in special circumstances with the patient's informed consent. In such circumstances, it might be useful to discuss the proposed treatment with a senior colleague before completing the prescription.
> - Periodically review the effectiveness of the treatment and any new information about the patient's condition and health if you are prescribing for an extended period of time. Continuation or modification of treatment should depend on your evaluation of progress towards the objectives outlined in a treatment plan.
>
> …"

Response to provisional opinion

52. Mr and Mrs B's and Dr C's responses to my provisional opinion are summarised below.

Mr and Mrs B

53. With reference to Mr A's 2005 referral to CAMHS, Mr and Mrs B "absolutely refute" that their son behaved violently towards others when angry, and say that "he did not actually have suicidal thoughts but dark moods". Otherwise, Mr and Mrs B reiterate the concerns set out in their original complaint regarding the standard of care their son received.

Dr C

54. Dr C's response to the substantive aspects of my provisional decision have been incorporated into the "information gathered" section of the report, where relevant. In addition, Dr C provided to HDC:

- a written apology, to be forwarded to Mr and Mrs B; and
- a certificate of completion of a course on "QPR Suicide Prevention Training, Screening and Triage", dated 10 June 2013.

Medical Centre 2

55. Medical Centre 2 advised that they had "no further comment" in relation to my provisional opinion.

Opinion: Dr C — Breach

Care provided on 23 Month1

Prescription of citalopram — no breach

56. On 23 Month1 (following referral from the accident and medical centre) Mr A attended a consultation with Dr C at Medical Centre 2, as he was experiencing concentration issues and feelings of depression. During that appointment Dr C conducted a physical examination and, in the absence of finding a physical reason for Mr A's symptoms, assessed his psychological distress levels using the Kessler Psychological Distress questionnaire. Following that assessment Dr C concluded that Mr A was suffering from mild depression. Dr C discussed treatment options with Mr A, whose preference was for counselling rather than medication. However, as Mr A was not eligible for funded counselling at that time, he agreed to commence citalopram, at a low dose of 10mg per day.

57. I am satisfied that Dr C's examination and discussion with Mr A on 23 Month1 regarding treatment options was consistent with expected standards. My expert advisor, Dr David Maplesden, confirmed that Dr C's diagnosis was appropriate given his assessment findings, including the results of the Kessler Psychological Distress questionnaire. Given Dr C's understanding that Mr A was suffering from mild

depression with no suicidal ideation, there was no indication for acute or urgent referral to mental health services at that time.

58. Dr Maplesden advised that the initiation of an SSRI was a "reasonable therapeutic option" in this case, and Dr C's recommendations for its use were consistent with expected standards. Dr C commenced Mr A on a low dose of citalopram, which Dr Maplesden advised was a reasonable strategy until tolerance and impact of the SSRI therapy could be assessed.

Documentation regarding prescription for citalopram — adverse comment

59. Dr C advised HDC that, having discussed the options of counselling and the use of antidepressant medication, Mr A consented to the use of citalopram.

60. With reference to Dr C's clinical notes from that consultation, the discussion is recorded simply as: "plan: referral to [psychologist] not funded (not enrolled). Plan: Citalopram." I am critical of the absence of any detail recorded in the notes regarding that discussion. Dr Maplesden advised:

> "The occurrence and nature of the discussion is not recorded in the contemporaneous notes and this is a mild departure from expected standards."

61. I agree with Dr Maplesden, and would expect Dr C to be mindful of his professional obligations regarding documentation of accurate patient records.

Duration of prescription/lack of review within that period — breach

62. Dr C provided Mr A with an initial two-month prescription for citalopram, and advised him to come in earlier if he felt worse or if he developed any side-effects.

63. I am concerned about the duration of the initial course of citalopram prescribed to Mr A, without any face-to-face consultation arranged within that period, for two reasons.

64. First, Dr Maplesden advised that, where a patient is prescribed an SSRI medication for the first time, a clinical review should occur within one to two weeks of prescription, for reasons that include the emergent risk of suicidality (even where that risk was not present initially). That advice is consistent with both the BPAC Journal on Adult Depression (BPAC Journal)[11] and the MedSafe Datasheet. In particular, the BPAC Journal advises:

> "An adult starting antidepressant treatment who is not considered at increased risk of suicide should be reviewed by the health practitioner within 1–2 weeks …
>
> …
>
> Early contact in the first week of treatment is important to enquire about suicidal ideation and about any increase in symptoms.
>
> In the first few days of treatment with an SSRI an increase in anxiety, restlessness or agitation may occur. This can be very distressing and may be associated with increased suicidality."

[11] BPAC Journal (special ed), *Adult Depression*, July 2009.

65. The MedSafe Datasheet similarly refers to the "… longstanding concern that some antidepressants may have a role in the emergence of suicidality in some patients".

66. Dr Maplesden advised that, irrespective of Dr C's assessment of mild depression and low risk of suicide regarding Mr A, the prescription given was not appropriate in the context of his "… failure to review [Mr A] within a reasonable length of time after the commencement of his medication".

67. Secondly, Dr Maplesden advised that a further clinical review is usually carried out after four to six weeks in order to "assess efficacy and adjust the dose as required". The BPAC Journal similarly advises that an adult starting antidepressant treatment should be "monitored at least two weekly until there is clear improvement". Dr Maplesden noted that Dr C had prescribed a low dose of citalopram (10mg daily, where the therapeutic dose is 20–40mg). While noting that this was appropriate initially (until tolerance and effect of the medication could be assessed), Dr Maplesden advised that generally such a low dose would be continued only if it was shown to be effective and an increase to the normal therapeutic dose was not required.

68. Dr C acknowledged that he could have given Mr A a one-month prescription for citalopram and requested that he return for further assessment prior to the prescription expiring. However, Dr C justified the length of the initial prescription, and the lack of further assessment of Mr A within the first two weeks or after that to assess efficacy, with reference to the MedSafe Datasheet's statement that "[a] treatment period of at least six months is usually necessary to provide adequate maintenance against the potential for relapse".

69. The relevance of Dr C's submission regarding the recommended minimum treatment period for citalopram, in the context of considering when he should have reviewed Mr A following the initiation of citalopram, is unclear and somewhat concerning. The issue of how long a patient should remain on citalopram is unrelated to, and separate from, the issue of the known risks that can emerge within the initial treatment period, and the consequent need for those risks to be monitored by the prescribing doctor.

70. In addition to my concern about the duration of the initial course of citalopram prescribed without any face-to-face consultation during that period, I am also concerned about the lack of a plan regarding what was to occur at the end of the prescription period.

71. While I acknowledge that Dr C advised that he asked Mr A to return for a further assessment before his prescription ran out, it does not appear that any steps were taken to ensure that this occurred. In the context of a first-time prescription for an SSRI medication, and the undesirability of a prescribing doctor in those circumstances being asked to provide a repeat prescription over the telephone (which occurred here and is addressed below), the lack of a follow-up plan following the expiration of the initial prescription was unacceptable. I agree with Dr Maplesden's advice that "… the lack of structure in the recorded follow-up advice … was a moderate departure from expected standards under the circumstances".

72. With reference to the expert advice obtained and the literature referred to, I am of the view that, in the context of having commenced Mr A on citalopram, Dr C should have arranged a follow-up assessment within two weeks of issuing the prescription, and then reviewed Mr A again after a further short period, to assess efficacy. Dr C also should have put in place a plan regarding what was to occur at the end of the initial two-month prescription. In not doing so, Dr C failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

Care provided on 6 Month3

Repeat prescription — breach

73. On 6 Month3 Mr A called Medical Centre 2 and requested a repeat prescription for citalopram. Dr C complied with that request and issued a further two-month prescription.

74. In the absence of a face-to-face consultation with Mr A, and in the context of what is set out above, I do not consider that Dr C's actions in this regard were appropriate. I agree with Dr Maplesden's advice that

> "… the provision of a further two months of antidepressant medication without undertaking review of the patient when response to the medication has never been formally assessed since its initiation, and the patient should have had a two week supply of the medication on hand if he was adhering to the prescription instructions, was a moderate departure from expected standards … an anticipated four month gap between initiation of an SSRI, even for mild symptoms, and first review is not consistent with expected practice."

75. Dr C advised HDC that, while it would have been "best practice" to have reviewed Mr A before issuing the repeat prescription, he issued the repeat prescription following Mr A's phone call because:

- he was concerned that Mr A would not attend a consultation;
- not issuing a repeat prescription "would have resulted in an abrupt stop to the medication which literature says should be avoided at all costs"; and
- he presumed that Mr A was deriving a positive response from the medication.

76. In relation to the first point, Dr C's recollection that Mr A told the practice nurse he was unwilling to attend an appointment on 6 Month3 (and that the receptionist informed Mr A that he would need to "see a doctor for the next prescription") is not supported by the clinical notes, which do not record any such information.

77. In relation to the second point, I am not satisfied that Dr C's concern about Mr A experiencing an "abrupt withdrawal" from the medication justified his decision to issue a two-month repeat prescription on 6 Month3. Any concern Dr C may have had about abrupt withdrawal does not account for the fact that Mr A should have still had two weeks of medication remaining from his initial prescription, nor does it explain Dr C's decision to prescribe such a long course (a further two months) of the medication. In addition (and for the avoidance of doubt), I note that, while the BPAC Journal and the MedSafe Datasheet do acknowledge that "abrupt cessation" of SSRI

therapy may produce withdrawal reactions, both publications describe those reactions as "mild", with identified symptoms including dizziness, headache and nausea.

78. I am also concerned by Dr C's submission that he issued the repeat prescription because he assumed that Mr A was deriving a positive response from citalopram, based on the fact that Mr A had not reported any side-effects or concerns. Having not had any contact with Mr A, I do not consider Dr C's assumption to have been reasonable.

79. Finally, although the Repeat Prescribing policy at Medical Centre 2 allowed for repeat prescribing in the absence of patient contact where a medical review had taken place within the previous six months, that general position was qualified as follows:

> "This will always be a matter of professional judgement and should be exercised at the discretion of the medical practitioner.
>
> The exercise of professional judgement must stand up to scrutiny against accepted standards of best practice in the medical profession…
>
> In the absence of a face-to-face consultation, prescriptions should only be provided if reasonable care and skill have been exercised.
>
> All prescribing will comply with legal, professional, ethical and other relevant standards. This will also be provided in a manner consistent with the patient's needs, minimising potential harm and optimising quality of life."

80. In my view (and for the reasons set out above), Dr C's provision of a two-month repeat prescription of citalopram on 6 Month3 was not appropriate in light of the Repeat Prescribing policy at Medical Centre 2.

81. Overall I am of the view that Dr C should not have prescribed Mr A a further two months of citalopram in the circumstances. In doing so Dr C failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code.

No finding regarding causation

82. It is not my role to make findings of causation. Accordingly, the breach findings against Dr C should not be interpreted as having any implication as to the cause of Mr A's death.

Opinion: Medical Centre 2 — No breach

83. Medical Centre 2 had a duty to Mr A to provide services that complied with the Code. In addition, under Section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), employers can be found vicariously liable for any breach of the Code by an employee. However, under Section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the

act or omission of an employee who breached the Code. This Office has previously found providers not liable for the acts or omissions of staff, when those acts or omissions clearly relate to an individual clinical failure made by the staff member.[12]

Care provided on 23 Month1 and 6 Month3

84. In my view, Dr C's failures to provide services to Mr A with reasonable care and skill on 23 Month1 and 6 Month3 were matters of individual clinical error. Medical Centre 2 was entitled to rely on Dr C to provide care in accordance with well established clinical guidelines and with reasonable care and skill. Accordingly, I do not find Medical Centre 2 directly or vicariously liable for Dr C's breach of the Code.

Comment on subsequent events/changes at Medical Centre 2

85. I am pleased that Medical Centre 2 has formulated specific guidance regarding the prescribing of antidepressant medication, and the re-prescribing of that medication in the absence of face-to-face consultation with the patient (see paragraphs 46 to 49 of this report).

86. While I consider aspects of the further guidance formulated by Medical Centre 2 to be appropriate, I do note that it enables a doctor to prescribe "up to a month" of medication following a new diagnosis of depression, without the patient being reviewed during that time. As stated by Dr Maplesden, an initial review should occur within one to two weeks, with further review to assess efficacy in the weeks following.

87. I also note that, with reference to paragraph 47 of this report, the further guidance appears to have been discussed with doctors in the context of peer review meetings, but does not appear to have been formally recorded in a specific policy. Also, while the new Repeat Prescribing Standing Orders (which specifically address antidepressants) have been formally recorded in writing (see paragraph 48), they have not been signed off by doctors.

Recommendations

Dr C

88. Dr C has already reviewed the BPAC publication *Adult Depression* released in July 2009 to ensure that he is aware of expected standards of management of adults with depression, and has undergone further professional training in this area.

89. In response to my first provisional opinion, Dr C provided HDC with a written apology for his breaches of the Code, to be forwarded to Mr A's family.

90. In light of the above, I do not consider any further recommendations regarding Dr C to be necessary.

[12] See opinion 12HDC01483.

Medical Centre 2

91. I recommend that, as an accompaniment to its Repeat Prescribing policy, Medical Centre 2 formally record the specific guidance it has developed regarding the prescribing and repeat prescribing of antidepressants, insofar as that guidance accords with accepted standards of care. That policy should be provided to HDC within **one month** of the date of the final report.

92. I recommend that Medical Centre 2 arrange for all doctors at the practice to sign the Repeat Prescribing Standing Orders, within **one month** of the date of the final report.

Follow-up actions

- A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and they will be advised of Dr C's name.

- A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be sent to the District Health Board, and it will be advised of Dr C's name.

- A copy of the final report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent medical advice to the Commissioner

On 28 March 2013 the following expert advice was obtained from my in-house Clinical Advisor, general practitioner Dr David Maplesden:

"1. Thank you for providing this file for advice. I have reviewed the information on file: complaint from [Mr and Mrs B], parents of [Mr A] (dec); response from [Medical Centre 2] per [general manager]; response from [Dr C]; statement from [Dr C] regarding his clinical experience in mental health; various Coronial documentation including autopsy report, medical provider statements and historical mental health service records; GP records. [Mr and Mrs B] complain about the management of [Mr A] by [Dr C] with respect to assessment and management of [Mr A's] depression from [23 Month1]. Sadly [Mr A] [committed suicide]. I have included general discussion on depression and suicidality in sections 16 to 18 as a basis for the comments included in the body of this report.

2. I have examined historical GP notes (April 2000 to late 2011 — [Medical Centre 1]) and these contain no reference to presentations for, or symptoms of, depression or any related mental health issues other than a note from [the DHB] indicating a referral had been received [in] 2005 and assigned to *MH Paed* (see below). The content of the referral was not discussed. On 18 August 2011 (consultation for flu-like symptoms) GP notes include the comment *friend [committed suicide] last week*. However, there is no elaboration on what effect this was having on the patient or why it was mentioned. Consultation notes for late 2011 (chest infection and migraine) include the comment *Lives far away now and will be transferring out*. [Mr A] was not seen subsequently at [Medical Centre 1]. There is no record that the notes were requested by, or transferred to, another practice. However, [Dr C] states in his response that records were received in late 2012.

3. I have examined records and a statement provided by [the DHB] relating to contact [Mr A] had with DHB Youth Mental Health Service [in] 2005. [Mr A] ([a teenager] at the time) had been referred by a counsellor at his school after divulging a history of suicidal thoughts since the beginning of the year. Family were involved in his initial assessment. He underwent psychotherapeutic intervention including cognitive behavioural therapy and involvement in a TSI (therapeutic storytelling intervention) group although he failed to complete the latter intervention. He was not medicated. A diagnosis was made of *parent-child relational issues* and a past history of peer bullying was noted. He appeared to respond positively to therapy and there was no contact with the DHB service after [late] 2005. It does not appear the GP was involved in treatment, but notification that [Mr A] had been referred to the DHB service was received by the practice [in] 2005.

4. [Mr A] attended [the accident and medical centre] on 12 [Month1] 2012 seeing [Dr E]. Nurse triage notes record the presenting complaint as *Chest infection for 5/7*. Vital signs were normal. [Dr E] has recorded an appropriate respiratory history and examination and determined that [Mr A] was suffering from a chest

infection. Antibiotics (Augmentin) were prescribed for this with the instruction *review if no improvement in 2/7*. Additional history was then obtained from [Mr A] as *Also having concentration issues at work, says that he is feeling depressed, and has done for 7 years. NO exacerbating factors, no thoughts of self harm (no history of this either) — for referral to GP for management — advice re cutting down on alcohol, regular exercise, not keen for medication …* [Plan] *GP referral for depression symptoms, given a letter. Advised about websites. Not keen for AD meds at present*. The referral letter provided by [Dr E] for [Mr A] to give to his GP reiterates the consultation details and includes additional or elaborated history of *He tends to drink large amounts of alcohol at the weekend and has a history of cannabis use, but he has now stopped this. He occasionally takes pills at the weekend (around 6 times a year). He is not keen to start antidepressant medication, but is keen for referral to someone so that he could discuss some of his issues. I've advised him to see his GP so that his symptoms can be followed up and monitored.* The medical centre response notes they do not treat patients for ongoing medical complaints and do not usually seek old notes because of the nature of consultations provided (casual patients for episodic or urgent care). This is why [Dr E] referred [Mr A] to a GP providing regular care to address his depressive symptoms.

Comment: The management of [Mr A] by [Dr E] was consistent with expected standards. He had some longstanding depressive symptoms. He was not overtly distressed and had presented to [Dr E] with a respiratory problem, the depressive symptoms being addressed separately. [Dr E] ascertained that [Mr A] did not appear to be at immediate risk of self-harm and recognised he would require ongoing medical input from a single practitioner which her clinic was not in a position to provide. She apparently discussed management options with [Mr A], noting his preference for counselling rather than medication, and provided additional information by way of direction to appropriate self-help websites and some practical advice regarding alcohol and exercise. Her referral letter was informative and was supplied in a timely manner. Her expectation was that [Mr A] would see his GP who would then provide appropriate ongoing care and I think this was a reasonable expectation under the circumstances. Statements from family and co-workers support the impression that [Mr A] was not overtly depressed or distressed over this period. However, in hindsight it appears the symptoms for which he was referred to mental health services in 2005 had never completely resolved.

5. As per [Dr E's] advice, [Mr A] presented to [Dr C] at [Medical Centre 2] on 23 [Month1], the day following his consultation with [Dr E]. Notes are reasonably comprehensive and history includes *sleep well, no change of mood … no suicidal ideation … FHx: brother bipolar …* smoking and alcohol history confirmed and general physical examination undertaken (nil abnormal of note). A Kessler-10 (K-10) questionnaire has been performed with score of 23 obtained[1] equating to the

[1] The Kessler-10 questionnaire is a simple measure of general psychological distress without identifying its cause. It is a screening instrument to identify people in need of further assessment for anxiety and depression. The K10 measurement of clients' psychological distress levels can also be used

patient being likely to have a mild mental disorder (range 20–24). Impression is recorded as *depression, impact on performance, slow due to concentration defect. Plan: referral to [psychologist] not funded, not enrolled. Plan: citalopram. Rv in [Month3] Rx Citalopram 20mg tab — 0.5 tabs, once daily — 30.*

6. [Dr C] states in his response that his impression, based on interview and K-10 score, was that [Mr A] was suffering from mild depression and had no suicidal ideation and was at low risk of suicide. This impression would be consistent with the recorded examination and K-10 findings and also with the observations of [Mr A's] co-workers and family as recorded in the Coronial statements. I feel [Mr A's] assessment by [Dr C] was consistent with expected standards and his diagnosis was appropriate to the assessment findings. Based on the assessment and findings, I would not regard it as expected practice in this situation to speak with family or other support people unless a request was made spontaneously by the patient and consent granted for such contact. If there were significant concerns regarding patient wellbeing, such consent should be sought and appropriate contact made. There was no indication, based on the subjective and objective assessment made by [Dr C], for acute or urgent referral to mental health services.

7. [Dr C] states in his response that referral for psychological intervention was discussed with [Mr A] with the option of paying for such interventions discussed as [Mr A] was not immediately eligible for free counselling (through the scheme accessible to [Dr C]) until he was accepted as an enrolled patient. [Mr A] was provided with forms for enrolment and evidently did enrol at the practice[2] following the consultation. [Dr C] states that [Mr A] did not state he had medical insurance during the discussion regarding funding (although he apparently was covered through a family policy). It is clear psychotherapeutic intervention was discussed as an option and this was appropriate, particularly for mild to moderate depression (see discussion below). I think it was reasonable in this case to rely on [Mr A], as a competent young adult, to state he had medical insurance or was prepared to pay for treatment if he was keen on psychotherapeutic intervention but cost was presented as a potential obstacle. However, I think follow-up should have involved revisiting the option of psychotherapy (which is often used in conjunction with medication) particularly once [Mr A] became eligible for free treatment through the scheme used by the practice. In my experience it is often difficult to access funded expert psychological support for patients such as [Mr A] — subjective and objective assessments consistent with mild depression.

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as an outcome measure and assist treatment planning and monitoring. The scoring systems can vary (see the Australian Bureau of Statistics information: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4817.0.55.001Chapter92007-08).

[2] Confirmation of enrolment, to which funding and access to specific services is attached, is somewhat complex. Enrolment applications are forwarded to a Ministry of Health agency on a quarterly basis and, depending on the date of enrolment application and when quarterly applications are forwarded (as much as six weeks prior to the end of that quarter) it could be up to four and a half months from the time of application to the time a patient is regarded as 'officially' enrolled.

8. The initiation of an SSRI[3] was a reasonable therapeutic option in this case and its recommendation was consistent with expected standards. [Dr C] states he discussed the use of antidepressant medication with [Mr A], and [Mr A] consented to use of citalopram. The occurrence and nature of the discussion is not recorded in the contemporaneous notes and this is a mild departure from expected standards. I would expect discussion of the benefits and common adverse effects of SSRIs to be discussed prior to initiation, together with information regarding onset of action and recommended minimum duration of therapy. [Mr A] was commenced on a low dose of citalopram (10mg) and this is a reasonable strategy until tolerance and impact of the drug can be assessed. In general, the low dose would be continued only if the positive effects were such that increase to the recommended therapeutic dose (20–40mg) was not required.

9. As noted in the discussion below, development of suicidality can be an emergent symptom in depressed patients initiated on SSRI therapy even if such symptoms were not present initially, and this is one reason why review one to two weeks after initiation of therapy is recommended (see 17(ii)). Review at this stage is also used to assess general tolerability of the drug, with further review at four to six weeks used to assess efficacy and to adjust the dose if required. [Dr C's] recorded follow-up advice was *Rv in [Month3]* and [Mr A] was provided with a two month supply of medication at a low dose (equivalent to one month of the dose more commonly prescribed). While I would not regard as poor practice the provision of the equivalent of one month's supply of medication (at a normal therapeutic dose) to a patient who has been assessed as having mild depression and at low risk of suicide, I feel the lack of structure in the recorded follow-up advice, and the failure to review [Mr A] within a reasonable length of time after commencement of his medication, was a moderate departure from expected standards under the circumstances.

10. On 6 [Month3] (six weeks after his previous consultation) [Mr A] contacted [Medical Centre 2] for a repeat prescription of his citalopram. If he had been taking the medication as directed he would have had approximately two weeks' supply remaining although he evidently requested the prescription be supplied that day. The practice nurse recorded [Mr A's] request, noting he was last seen by [Dr C] in [Month1], and generated a repeat prescription of *Citalopram 20mg tab — 0.5 tabs, once daily — 30*. The prescription was presented to [Dr C] and signed by him. [Dr C] states he considered it unwise for [Mr A] to be without medication and balanced this against his preference which was to review him. He compromised by providing the prescription and *have the receptionist advise the patient to see a doctor for the next prescription.* He states he assumed [Mr A] had responded well to the medication as he had not re-presented and was requesting more of the medication. I feel the provision of a further two months of antidepressant medication without undertaking review of the patient when response to the medication has never been formally assessed since its initiation, and the patient should have had a two week supply of the medication on hand if he

[3] Serotonin reuptake inhibitor — a type of antidepressant including fluoxetine, paroxetine and citalopram.

was adhering to the prescription instructions, was a moderate departure from expected standards. Mitigating circumstances are the low dose of medication prescribed (equivalent of two to four weeks supply at recommended therapeutic dose), the initial diagnosis of mild depression and absence of suicidality, and the indication that [Mr A] was apparently well (as noted in the Coronial statements but not able to be ascertained, only assumed, by [Dr C]). However, an anticipated four month gap between initiation of an SSRI, even for mild symptoms, and first review is not consistent with expected practice.

11. [Dr C's] response indicated [Mr A's] old notes were not received until [the end of] 2012. Expected practice would be that old notes are requested at the time of enrolment and the practice should be asked to comment on whether their usual process was followed on this occasion. However, the old notes did not contain any accessible information likely to have influenced [Dr C's] management of [Mr A].

12. While I am critical of aspects of [Dr C's] management of [Mr A], it is not possible to state that 'best practice' management would necessarily have prevented the tragic events that unfolded, particularly as [Mr A's] act appears to have been impulsive and associated with an alcohol binge, with little notice to his family, friends or co-workers that he was planning such an act or that his mental health was deteriorating. Psychological therapy is not any more (or less) effective than SSRIs in treating mild to moderate depression. Suicidality as an emergent symptom related to SSRI use would be expected early in the course of SSRI therapy rather than after two months of low dose therapy. Nevertheless, I cannot exclude the possibility that formal assessment of [Mr A] by [Dr C] when the request for a repeat of medication was made might have led to additional psychological support and a different outcome.

13. [Dr C] states he has shared his learnings from [Mr A's] case with his GP peers and has increased his vigilance when consulting with patients with any form of mental illness. I think it would be appropriate for him to personally apologise to [Mr A's] family for any distress caused by his failure to ensure [Mr A] was reviewed at recommended intervals following initiation of his treatment. I recommend [Dr C] review the BPAC publication quoted below (footnote 4) to ensure he is aware of expected standards of management of adults with depression.

14. The [Medical Centre 2] response indicates changes have been made at a practice level as a consequence of this complaint. These include:

(i) use of telephone consultations as part of follow-up
(ii) referral for urgent counselling (when clinically indicated) via WINZ to help with funding
(iii) provision of the Mental Health Crisis Team contact number to mental health patients where appropriate
(iv) seeking permission to inform next-of-kin or other support people when there are concerns about a patient's wellbeing
(v) appointment of a social worker aligned to the practice

These are useful and appropriate service improvements. However, I feel the practice policy with regard to repeat prescribing of psychoactive medication should be reviewed also, and the policy (whether or not changes have been deemed necessary) forwarded to the Commissioner for comment.

15. I would like to pass on to [Mr A's] family my condolences at their tragic loss. The effects of such an event are profound and every parent's worst nightmare.

16. General background information — assessment of suicide risk
(i) There are several excellent local resources and guidelines available to GPs and from which the following information has been obtained. Assessment of suicide risk can be challenging as there is no evidence for absolute markers that indicate presence or intensity of suicide risk[4]. The low base rates of suicide make it difficult to predict tragedy. Despite best efforts, some people will complete suicide. The reasons for a person attempting suicide are usually complex. Understanding key risk factors making a person vulnerable to attempting suicide raises a clinician's index of suspicion for suicide risk[5].

(ii) Some risk factors for suicide include[6]: definite plan; hopelessness; severe depression; psychotic symptoms; recent discharge from a psychiatric unit; use of alcohol, street drugs, particularly recent escalation; recent suicide attempt; single men; young, older people; homelessness; medical illness; history of childhood abuse; recent suicide attempt by a whānau/family member or a friend. Deliberate self-harm, such as cutting, is a non-suicidal behaviour which is used as an attempt to cope and manage. It must be recognised that the emotional distress that leads to self-harm can also lead to suicidal thoughts and actions[1].

(iii) In the context of assessing suicide risk the most immediately important factors to consider are contextual triggering factors and current mental state including intent/definite plan, lethality of likely means, access to means, presence of risk factors (see above), hopelessness, psychosocial triggers and lack or presence of protective factors (eg children) [1]. It is important to realise that any individual's suicide risk may increase as a consequence of an acute stressor or situation. For example chronic risk factors such as male gender, childhood adversity or chronic pain remain static but an acute stressor such as a relationship breakdown or drinking binges may rapidly elevate the person's risk of suicide. Therefore recognition of potential dynamic factors is important in any management plan.

17. General background information — treatment of adult depression in New Zealand. Current recommended best practice regarding assessment and treatment of adult depression in New Zealand was summarised in an article sent to all GPs in June 2009[1]. Some relevant recommendations include:

[4] BPAC. Adult Depression. Best Practice June 2009. Available at www.bpac.org.nz
[5] NZGG. The Assessment and Management of People at Risk of Suicide. 2003 Ministry of Health
[6] NZGG. Identification of Common Mental Disorders and Management of Depression in Primary Care. 2008 Ministry of Health

(i) First-line treatment for an adult with moderate depression is either a selective serotonin reuptake inhibitor (SSRI) or a psychological therapy (e.g., 6–8 sessions of problem-solving or cognitive behavioural therapy over 10–12 weeks)

(ii) An adult starting antidepressant treatment who is not considered at increased risk of suicide should be reviewed by the health practitioner within 1–2 weeks and monitored at least 2 weekly until there is clear improvement

(iii) An adult considered at risk of suicide should be followed up more frequently based on assessment of risk and the likelihood of this changing

(iv) Practitioners should consider the use of a tool such as the Patient Health Questionnaire for Depression (PHQ-9) to assist monitoring treatment response in depressed adults

(v) If an adult on antidepressant medication has had only a partial response after 3–4 weeks, consider increasing the dose

(vi) If an adult on antidepressant medication has not responded to treatment by 4–6 weeks, review the diagnosis and the treatment plan and, if the diagnosis is unchanged, consider either increasing the dose, changing the antidepressant, or changing or adding a psychological therapy

(vii) An adult with depression who is responding to antidepressant treatment should normally continue to take the antidepressant for at least 6 months after remission in order to reduce the risk of relapse

(viii) Patients who have had two or more depressive episodes in the recent past, and who have experienced significant functional impairment during the episodes, should be advised to continue antidepressants for 2 years

(ix) Depressed adults who have not shown an adequate response to two full courses of treatment (psychological or pharmacological) should be referred for review by mental health services while continuing treatment

(xi) SSRIs are better tolerated and are safer in overdose than other classes of antidepressants. No single SSRI has a significantly better safety or effectiveness. If the first SSRI tried is not tolerated or does not work it is reasonable to try another SSRI.

18. Risk of suicidality and SSRIs

(i) A large meta-analysis conducted in 2009[7] concluded that *the relation between exposure to SSRIs and the risk of suicide is influenced by age. Exposure to SSRIs decreased the risk of suicide by over 40% among adults and decreased the risk by over 50% among elderly people. However, among adolescents, exposure to SSRIs almost doubled the risk of suicide. These results are consistent with the main conclusion of the recent FDA meta-analysis of clinical trial data* (referred to

[7] Barbui C, Esposito E, Cipriani A. Selective serotonin reuptake inhibitors and risk of suicide: a systematic review of observational studies. CMAJ. 2009; 180(3): 291–297 Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2630355/#r5-17 (accessed 28 March 2013)

below). *However, our risk estimates were very similar to those obtained by the FDA only for the elderly and adolescent groups. Although the FDA reported a neutral effect of SSRIs (or a promoting effect among adults aged 18–25), we found a strong protective effect associated with SSRI treatment.*

(ii) The US Food and Drug Administration (FDA) performed a meta-analysis of individual patient data from 372 randomized placebo-controlled trials of antidepressants with a total of nearly 100 000 patients[8]. This study reported that the incidence of reported suicidal behaviour was strongly related to age. The risk associated with antidepressant use relative to placebo was increased among patients aged 25 or fewer years, and it was reduced among patients aged 65 or more years. The risk among patients aged 25–64 years was neutral; however, risk was reduced when suicidal behaviour and ideation were considered together. Based on these findings, in May 2007 the FDA ordered that all antidepressant drugs carry an expanded black-box warning on their label that included information about increased risk of suicidal behaviour in young adults aged 18–24 years. The authors of the study referred to in 18(i) note: *a controversial point of the FDA analysis is that the included trials were not primarily designed to measure suicidality (a composite outcome that includes suicide ideas, preparatory acts, suicide attempts and deaths by suicide). Of all suicidality events, less than 30% were serious suicide attempts or deaths. Additionally, considering that suicidality was self-reported rather than observed by others in most clinical trials, it is possible that antidepressant treatment, particularly in younger individuals, enhanced communication about suicidality, which may have allowed them to become more articulate and open about their thoughts and actions. Alternatively, antidepressant treatment might have enhanced communication about suicidality in all age groups, but increased attention to adverse effects might have led to enhanced detection of suicidality in younger individuals.*

(iii) The Medsafe data sheet for citalopram[9] includes the following advice:

a. *In clinical trials, adverse events related to suicidality (suicidal thoughts and suicidal behaviours) and hostility (predominantly aggression, oppositional behaviour and anger) were more frequently observed in children and adolescents treated with SSRIs (and venlafaxine) compared to those treated with placebo. Consequently, citalopram should not be used in children and adolescents less than 18 years of age.*

b. *Patients of any age with major depressive disorder may experience worsening of their depression and/or emergence of suicidal ideation and behaviour (suicidality), whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Patients should be closely*

[8] Laughren T. Memorandum: overview for the December 13 meeting of Psychopharmacologic Drugs Advisory Committee. Food and Drug Administration; 2006. Available: www.fda.gov/ohrms/dockets/ac/06/briefing/2006-4272b1-01-fda.pdf (accessed 28 March 2013)

[9] Available: www.medsafe.govt.nz/profs/Datasheet/a/ArrowCitalopramtab.pdf (accessed 28 March 2013)

monitored, especially at the beginning of therapy or when the dose is changed, until such improvement occurs.

c. *There has been a long-standing concern that some antidepressants may have a role in the emergence of suicidality in some patients. The possible risk of increased suicidality in patients applies to all classes of antidepressant medicines, as available data are not adequate to exclude this risk for any antidepressant. Therefore, consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse or whose emergent suicidality is severe, abrupt in onset, or was not part of the patient's presenting symptoms. Generally, when stopping an antidepressant, doses should be tapered rather than stopped abruptly.*

d. With respect to recommended adult dosage: *Citalopram should be administered as a single oral dose of 20 mg daily. Dependent on individual patient response and severity of depression, the dose may be increased to a maximum of 40 mg daily. The maximum daily dose of citalopram should not exceed 40mg/day as doses above 40mg/day are associated with an increased risk of QT-prolongation*."