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Prescribing benzodiazepines in general practice

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INTRODUCTION

Benzodiazepines are very widely prescribed in general practice. They have very effective anti-anxiety, sedative, anticonvulsant, and muscle-relaxant properties. Enormous divergence exists between best-practice guidance,[1,2] which generally recommends short-term use at the lowest possible dose for severe anxiety or insomnia, and the reality of general practice, where very large numbers of patients are known to be prescribed these drugs on a long-term basis, at high dosages, and for less than 'severe' indications.[3,4]

WHAT IS THE PROBLEM?

The recommendation to limit the use of benzodiazepines to the short term (for example, <2–4 weeks) is largely based on the issues of tolerance and dependence. Tolerance is a physiological response whereby, with continued use, a higher dose than that originally prescribed is required in order to achieve the identical original clinical effect. Thus, use beyond the short term often leads to dose escalation just to maintain the same effect originally brought about at a lower initial dose. The rate of development of tolerance is variable from one person to the next, but certainly can occur after just 3–4 weeks of use. Dependence can be considered in physiological and psychological terms. Physiological dependence refers to the experience of withdrawal symptoms on stopping the drug. Symptoms range from relatively minor (for example, headache, tremor, or sweating) to very serious and potentially life threatening (for example, seizures, psychosis, or delirium tremens). With psychological dependence, patients increasingly require their drug in order to cope with life events. Other negative effects resulting from long-term use include memory impairment in older patients, diminished sleep quality, daytime drowsiness, decreased reaction time, increased risk of accidents, and aggravation of existing depression or initiation of new-onset depression. All of those will most often gradually resolve within 6–12 months of drug cessation. Doctors should also be mindful of the risk of diversion, with prescription being the most common source of illicitly used benzodiazepines.

WHAT CAN A GP DO TO AVOID 'NEW' PRESCRIBING?

Anxiety and insomnia are both important health problems, commonly encountered in general practice, which can result in significant impact on quality of life and functional impairment. Although treatment for these conditions can include benzodiazepines, that should only be necessary in a very small minority of cases. The most appropriate first-line treatments for both mild anxiety and insomnia include counselling, cognitive behavioural therapy, sleep hygiene, and self-help strategies. Benzodiazepines should only be prescribed in the lowest effective dose for the short-term relief (maximum of 2–4 weeks) of severe anxiety or panic disorder, usually in an acute crisis situation. Benzodiazepines are never appropriate for the treatment of short-term mild anxiety. If prescribing benzodiazepines for short-term insomnia, intermittent use for <1 week is preferred. It should always be explained to patients that their treatment will be 'once off' (that is, for a limited time only). The GP should explain why a limited duration of treatment is necessary by discussing the risks associated with their use and that, although they provide symptomatic relief, they do nothing to address underlying causes for their symptoms. Patients should be advised of the risks with driving, using machinery, etc. Patients should be warned that the drugs are highly addictive. It is only in rare exceptional cases of treatment-resistant anxiety and insomnia that long-term benzodiazepine treatment is appropriate. Any decision to initiate benzodiazepines as a long-term treatment should be rare. In a small minority of patients, long-term benzodiazepine treatment might be considered justified on the basis of failure to respond to other treatments and an increase in quality of life with benzodiazepine use. In such cases, the

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GP should consider a second opinion from a relevant doctor (for example, psychiatrist, geriatrician, or addiction specialist), and the GP should always ensure that the decision to prescribe on a long-term basis is frequently reviewed and reassessed in the context of contemporaneous risks, negative side effects, and benefits to the individual. Review of available recommendations reveals consensus expert opinion that long-term treatment with benzodiazepines should: be at the lowest effective dose possible; involve regular patient review, usually monthly; involve regular attempts to reduce or stop treatment when conditions allow; ensure adequate patient education on risks of long-term use and documentation of same; where feasible, allow for prescription by a single designated practice/GP and dispensing by a single designated pharmacy; and consider phased dispensing (for example, <1 week supply at a time) in order to avoid street diversion.

Dependence is especially likely to occur in patients who have a previous history of alcohol or drug misuse and/or personality disorder, and therefore particular caution must be exercised when considering initiating benzodiazepines in these patients.

WHAT CAN A GP DO FOR THOSE WHO ARE ALREADY DEPENDENT?

Patients who are taking long-term benzodiazepines should be made aware of the negative effects of their treatment, if they are not already known to them, and the benefits of stopping. Discontinuation of long-term treatment usually leads to improved cognitive and psychomotor functioning. Patients should be regularly offered the opportunity to withdraw from long-term benzodiazepine use. That applies equally to all long-term users, including high-dose users and those who use benzodiazepines illicitly. Thus, patients should be asked if they want to withdraw and, ideally, be provided with a reputable source of patient information (such as https://patient.info/health/insomnia-poor-sleep/benzodiazepines-and-z-drugs). A brief intervention by a GP, in the form of a single consultation or patient letter that addresses long-term benzodiazepine use and associated side effects, has been shown to be an effective and efficient strategy to reduce or stop use.[5] Explanation of the withdrawal process should include discussion of gradual dose reduction and withdrawal symptoms. A slow reduction in dose is generally the most successful approach, giving patients as much time as necessary to adjust to life without benzodiazepines. The rate of tapering should be determined on a case-by-case basis, in conjunction with the patient, and may occur over weeks, months, or even years. Allowing patients to contribute to decision making, rather than imposing decisions on them, imparts a sense of control that promotes success. Switching from short-acting to longer-acting drugs is recommended; most commonly diazepam. The *British National Formulary* provides a suggested protocol for withdrawal from long-term use that involves stepwise switching to diazepam and then reducing the daily dose by 1–2 mg every 2–4 weeks.[6] If patients experience difficulty with dose reduction, delaying the next scheduled reduction in dose should be considered. However, in so far as possible, returning back to a higher dose should be rigorously avoided. Access to emotional or psychological support is important and lack of availability of cognitive behavioural therapy is a significant hindrance to addressing benzodiazepine dependence. Patients often need assistance with re-learning psychological coping strategies. Advice on techniques to reduce anxiety (for example, meditation or exercise) and to promote sleep (that is, sleep hygiene) should be offered. Any underlying condition (for example, anxiety, insomnia, or depression) should be treated, as failure to do so is regarded as the most common reason for detoxification failure. Be mindful of alcohol use, recognising that patients may start or increase consumption in lieu of benzodiazepines. Benzodiazepine detoxification will be time intensive for a GP, requiring frequent consultations with a potential myriad of challenges. However, longer-term workload may be reduced with fewer patients requiring repeat prescriptions. Where long-term users decline the offer of withdrawal, the GP should repeat the discussion on the risk and benefits of discontinuation at regular intervals.

OTHER PRACTICAL SUGGESTIONS FOR GPS

Patients who have used benzodiazepines often perceive them to be very effective medications. Some patients will place extreme pressure on GPs to prescribe benzodiazepines. GPs should never prescribe on the basis of pressure from a patient. Patients sometimes express considerable dissatisfaction when refused benzodiazepines, occasionally in the form of a regulatory body complaint. Refusal should be accompanied by explanation that benzodiazepines have short-term efficacy and suppress symptoms rather than treating the underlying problem. Group practices should consider implementing an agreed practice policy on benzodiazepine prescribing to ensure a consistent approach.