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BENZODIAZEPINES

A SUITABLE CASE FOR TREATMENT

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BENZODIAZEPINES: A SUITABLE CASE FOR TREATMENT

This paper examines the use of benzodiazepines and the problems that can arise for those prescribed them. It looks at what policies need to be followed to reduce prescribing levels and the support that needs to be provided for those who have become dependent on benzodiazepines.

The paper was written following the interest expressed at the 1987 Annual General Meeting of the ACHCEW in the workshop on benzodiazepines. CHCs are also likely to receive an increasing number of requests for information on this subject over the next year or so, following the series of television programmes run by the BBC and with the start of the legal test cases on benzodiazepine prescribing.

Attitudes to benzodiazepines prescribing have shifted markedly over the last decade. However, many of the statistics referring to benzodiazepines are unclear. It is not clear how many people are being prescribed benzodiazepines, who they are and why these prescriptions are being made. However, there is undoubtably scope for a further reduction in the prescribing of these drugs but this will involve investment in alternative care, such as counselling, the teaching of relaxation techniques and withdrawal support strategies.

What are benzodiazepines?

Benzodiazepines are most frequently used either as tranquillisers to reduce anxiety (anxiolytics) or as sleeping pills for insomnia (hypnotics). Benzodiazepines may differ slightly (1) (2). For instance, hypnotics tend to be shorter-acting and are more quickly eliminated from the body, but there are no major differences between these and benzodiazepines used as tranquillisers. (In this paper the term 'tranquilliser' will be used for benzodiazepines suppressing anxiety, the term 'hypnotic' will be used for benzodiazepines used to combat insomnia.)

Benzodiazepines do not 'cure' anxiety or insomnia, they are designed to remove the disabling effects of anxiety or insomnia, to allow a person to 'cope' during a crisis. Once the period of crisis has ended it is assumed that the individual's need for benzodiazepines will cease.

Benzodiazepines are also used for physical conditions as muscle relaxants, anticonvulsants and amnestics before surgery. Prescribing for these conditions is outside the scope of this paper.

Guidance on Benzodiazepines

The most recent authoritative guidance on benzodiazepine prescribing is found in the Committee on Safety of Medicines bulletin "Current Problems" number 21 which was published in

January 1988. It states that the use of benzodiazepines should be limited in the following ways:

As Anxiolytics

1) Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic or psychotic illness.

2) The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate and unsuitable.

As Hypnotics

3) Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to extreme distress.

The guidance specifically rejects the sole use of benzodiazepines in the treatment of depression, or anxiety associated with depression, as "suicide may be precipitated in such patients". Neither should benzodiazepines be used in the treatment of phobic or obsessional states and chronic psychosis. Warnings are also givenfor their use in "cases of loss or bereavement" as "psychological adjustment may be inhibited by benzodiazepines".

Changing Attitudes

Why do benzodiazepines warrant such a severe warning? Initially benzodiazepines were greeted with enthusiasm because they had fewer side-effects than barbiturates (which are no longer recommended in the treatment of anxiety or insomnia), and they were less dangerous in over-dosage. However, it has since been shown that benzodiazepines have three main draw-backs:

(A) their therapeutic effect decreases with time: it has been claimed that benzodiazepines are no longer effective after one to four months continuous use (3); tolerance towards benzodiazepines as hypnotics can occur more quickly, and may result in 3 - 14 days (4).

(B) they can sometimes cause unpleasant and dangerous side-effects either when taken over a long period (with repeated dosage over-sedation can occur) or in therapeutic dosages (eg the "hangover" effect of some hypnotics) (5). (See Appendix A for a full description of side effects.)

In the elderly over-sedation can occur on smaller doses than those given to younger adults. The effects of over-sedation can be particularly marked, eg severe confusion, poor memory and loss of physical co-ordination leading to falls. The British National Formulary specifically states that: "Hypnotics should be

avoided in the elderly, who are at risk of becoming ataxic and confused and so liable to fall and injure themselves".

(C) dependence may result, with possibly distressing symptoms occurring on withdrawal. (6)

Due to their severity, symptoms may on occasion be mistaken by those suffering from them and by their medical advisers, as physical symptoms requiring treatment or indicating a severe illness. A general practitioner unaware of the severe nature of withdrawal symptoms may increase the levels of benzodiazepines being prescribed or recommence the prescription, in the mistaken supposition that the person still 'needs' the drug (7). The very serious and frightening nature of the withdrawal symptoms and the possiblity of these being incorrectly dealt with (either due to a lack of support or misdiagnosis leading to inappropriate prescribing) are serious problems. Dependency may only become apparent when a person experiences difficulty ceasing to take the tablets. (See Appendix A for a fuller discussion of withdrawal symptoms).

Clearly, very great care should be taken with any drug for which the side effects may be worse than the initial symptoms, which can result in dependency and severe problems on withdrawal.

How big is the problem?

The number of prescriptions for tranquillisers, sedatives and hypnotics (the majority of which will be benzodiazepines) have fallen since 1979 when a record level of 31 million prescriptions were issued. In 1987 prescribing levels stood at 25.5 million, a small but not significant increase on the 1986 level of 25.4 million (8). What percentage of the total was accounted for by repeat prescribing is unknown at present. This data may be collected in future years. Some estimates claim that 75 per cent of tranquilliser prescriptions may be repeats (9). The Government envisages FPCs encouraging the development of repeat prescribing control systems (10). (See Appendix C for details).

There are an estimated 3 million chronic users (ie. people taking the drug for four months or more) in Britain (12). Other sources put the figure for long-term (one year or more) at 825,000 and 1,650,000 people (13). In a survey of all General Practices of the 15% who replied, 14% had more than 5% of patients on their personal list who were on long-term or repeat prescribing for hypnotics. More than half of respondents who had patients taking hypnotics said that fewer than 10% had been taking the drug for less than three months, almost 70% said that over half had been taking the drug for over a year (14). Clearly inappropriate long-term prescribing remains widespread.

Dependency

Dependency and consequent difficulty in withdrawing from

benzodiazepines has been estimated to affect between 15-45% of long-term users (over 12 months use), equivalent to 200,000 - 600,000 of the population (15). Some studies claim 100% of long-term users experience withdrawal symptoms when coming off benzodiazepines (16). However, others argue that as these results were observed at specialist clinics, the clients represented a highly selected sample and are therefore unrepresentative. The likelihood of experiencing withdrawal symptoms has also been calculated according to the length of time the drug has been taken, ie after six months 5-10% of patients may do so, after 2-4 years 25-45% and after 6-8 years of benzodiazepine use the withdrawal symptoms are experienced by 75% of people (17). Arguments as to how and why dependency occurs remain (see Appendix B).

Can particular groups be identified amongst benzodiazepine users?

If specific groups are identifiable, this may have repercussions for provisions of alternatives to benzodiazepines and support services.

Elderly people

Elderly people are major users of benzodiazepines for insomnia. In 1986, hypnotics or sleeping pills accounted for more than half of the prescriptions issued for benzodiazepines. In a survey of psychotropic drug prescribing in one General Practice, 75.5% of those receiving hypnotics were over 59 years of age (18). Another study concluded that 10-15% of the elderly population took a hypnotic drug each night, equivalent to approaching one million elderly people. The survey concluded that the guidance from the Committee on the Review of Medicines in 1980 that hypnotics should be prescribed to the elderly only "for short periods of time and then only with careful consideration" had been ignored. (19)

Research has been undertaken into the role insomnia plays in the life of elderly people and one study found that types of sleep disturbance which affect elderly people most are: onset insomnia (difficulty in sleeping on going to bed), sleep maintenance (wakefulness during the night), and sleep efficiency (the time spent asleep as a percentage of time in bed). The reasons for lack of sleep maintenance included pain, discomfort and worry, all of which may be reduced by psychological treatments, eg relaxation techniques. Instances of reading, smoking, eating and TV watching (usual sources of onset insomnia) were minimal. Elderly people living in sheltered accommodation worried less than those living alone. Further research aims to look at how to improve sleep patterns rather than counselling tolerance, whether relaxation techniques can assist in sleep-related problems and whether reading in bed serves to reduce sleep-related anxieties or stimulates sleeplessness (20). Such research could provide concrete strategies for dealing with insomnia based upon what elderly people know to work and find

acceptable. However, to be effective this research must be acted upon by GPs and others caring for the elderly.

Advice to the elderly does need to be based on strategies which have been tested, are acceptable to the elderly and have been shown to work. One edition of the Drug and Therapeutics Bulletin carried a major article on lessening the use of benzodiazepines, in the section on insomnia the guidance was as follows: "Insomnia can often be helped by avoiding coffee, tea, alcohol, exciting TV programmes, etc, before going to bed. In some people caffeine prevents sleep for six hours or more. A relaxing bath, a dull book, or sexual intercourse facilitate sleep. If one cannot sleep it is often better to get up and do something pleasant rather than to lie frustrated and angry in bed. If a hypnotic is prescribed it may be a good idea to use it only say one night in three". (21) While this advice will be beneficial for most people, it does not appear to address many of elderly people's particular needs. Strategies for coping with sleeplessness in the elderly need to be aware of the home circumstances of many elderly people, ie living alone on low incomes. Advice on insomnia must be tailored for specific client groups.

Elderly people are also users of benzodiazepines as tranquillisers. As users of hypnotics and tranquillisers, elderly people may account for over 50% of total benzodiazepine consumption (18). Over sedation can occur in the elderly on smaller doses than those given to younger adults. The effects of over sedation can be particularly marked, eg severe confusion, poor memory and loss of physical co-ordination leading to falls. Certain types of benzodiazepines may have particularly marked adverse effects amongst the elderly (22). Complete withdrawal in an elderly person may often be inadvisable although the dosage may be gradually reduced to minimise side-effects (23). However reserch findings from America challenge the idea that elderly people suffer worse side-effects on withdrawal than their younger counterparts (24). Withdrawal advice for the elderly may change in the future.

Benzodiazepine prescribing in residential homes needs to be kept under review. One study found that 23% of the 1888 residents of 55 homes were receiving hypnotic medicines (mainly benzodiazepines). The proportion of residents receiving sleep-inducing drugs in each home varied from 3.6% to 60.0%. The median duration of treatment varied depending on the generic drug being prescribed; for nitrazepam it was 2.5 years. Nitrazepam was being given to 7% of patients at levels which risked the onset of very nasty adverse effects (only related to this drug when used by the elderly). (25)

Women and Benzodiazepines

The other group of people to whom benzodiazepines are mainly prescribed is women. Figures vary, but approximately 66 - 75% of benzodiazepine prescriptions go to women. The image of the major benzodiazepine user as a young woman beset by a host of social

problems is now less widespread. Tranquillisers are used across all age groups.

However, many younger women may still be being prescribed benzodiazepines. The Women's National Commission report claim the ages 25-35 and 45-54 as peak years in tranquilliser prescribing, with married women being twice as likely to receive a prescription as single women or men. They also noted concern at very young users, prescribing policies to women in prison, and increased use amongst Asianwomen. However, statistics from TRANX of those people who contacted them for the first time in 1987 and gave information on their age and sex, showed women between 34 - 65 were the most frequent callers. Further research is necessary to discover why women are being prescribed benzodiazepines and what role is played by age, class, race or ethnic background and the reason for initial prescribing. Future health promotion initiatives which may help avoid prescriptions (ie relaxation and assertiveness training for women) and any withdrawal support initiatives will need this information to ensure that their services are reaching their target audience.

Nevertheless, women are prescribed benzodiazepines more often than are men. The reason for higher levels of prescribing to women remains unclear. The presence of children in the family is not necessarily a prerequisite. One study found that in the treatment of psychosocial disorders a person was more likely to be prescribed a psychotropic drug if they lived alone or just with a partner. The presence of a child in the household increased the likelihood of alternative treatment being given. However, this was based upon one general practice which may have had a particular practice philosophy (26). Possible alternative reasons include:

* higher GP consultation rates amongst women (not necessarily for themselves but on behalf of other family members which may then involve them discussing their own problems)

* women suffer from greater anxiety
(Particular factors may affect certain women, eg. (a) a dual role as carer and bread winner; (b) they are expected to be the main provider of emotional support within a family, often with little support from other adults; (c) or conversely, due to lack of a defined role outside of the home environment. During certain parts of the family cycle, ie departure of children from the home, the role the woman plays within the home may also be brought into question; (d) life crisis for which there is little emotional support, eg. bereavement, miscarriage, stillbirth, may affect women more frequently.)

* women are restricted in their choice of alternatives, either for the immediate reduction in anxiety (ie alcohol which is open to men for the relief of anxiety and stress, although this is changing and could produce fresh problems) or in the restructuring of their lives to avoid that which originally gave rise to anxiety (ie leaving an unsatisfactory marriage).

Debates on benzodiazepines rarely look to the root cause of anxiety and stress, nor seek to remove these causes. The Women's National Committee did address the causes of stress in their recent report and made recommendations on social and medical grounds to a cross section of government departments and professional organisations. Some of these were very broad ranging, such as advocating "career break" schemes for women employees. There is, of course, no certainty that tackling such factors would directly help benzodiazepine users. An increase in social support services may not result in an equivalent drop in benzodiazepine prescriptions. However such measures are clearly important and need to be considered in any wider consideration of reducing the amount of benzodiazepine use.

Ill-health

It would appear that ill-health is also a primary reason for benzodiazepines being prescribed. One study even found that physical health distinguished long-term users and other users of benzodiazepines more sharply than any other factor including emotional distress. Cardiovascular disorders and arthritis accounted for much of the ill-health. Many long-term users were also found to be suffering from depression. A follow-up study of 150 depressed women found that they were more likely to have received a tranquilliser than an antidepressant when they sought medical help. Rodrigo, King and Williams came to the conclusion in their study of the health of long-term benzodiazepine users that "the long term users we studied, although mostly women, were predominantly elderly and were experiencing appreciable ill health. It was not clear, however, that the nature of the ill health (depression and a range of physical illnesses) was such that chronic treatment with tranquillisers was necessarily the best form of management. These findings, if replicated, have important implications for the prevention and management of the long term use of tranquillisers". (27)

Research is needed to ascertain why tranquillisers are prescribed in connection with physical illness. Guidelines need to be given on the management of different conditions which could avoid the long term use of benzodiazepines.

Men and Benzodiazepines

Although not as many men are prescribed benzodiazepines, they still make up between 30% to 40% of those who are prescribed them. Men should not be shut out from support services because benzodiazepine dependence and use are seen as exclusively a female concern. The reasons why men use benzodiazepines, the source of their anxiety and sleeplessness should be explored to ensure that responses to it are relevant. (28)

Stopping Prescribing Becoming Long-term

Even if the reason for prescribing is appropriate, long-term prescribing which carries the risk of side-effects and dependency could be avoided. Benzodiazepines could be prescribed in smaller numbers at any one time, and a person's GP could insist that the patient saw him/her before another prescription was issued and offer counselling on each visit. A practice policy on repeat prescribing involving frequent monitoring and review, would reduce the likelihood of prescribing becoming long-term eand inappropriate. (One DHA survey concludes "The study provides evidence of a clear correlation between long term patients and the number of prescriptions normally made by practitioners and suggests that without a change in repeat prescriptions policy among a minority of GPs new dependent users are likley to be created unnecessarily (29).)

Benzodiazepines and Anxiety

Benzodiazepines ought to be used specifically for the treatment of short-term acute anxiety and insomnia, but even in these instances where prescribing is seen as appropriate, are there alternatives? If adequate alternatives do exist then along with the elimination of inappropriate prescribing, appropriate prescribing could also be reduced, ensuring that the likelihood of dependency occurring is restricted to the lowest level possible.

Counselling in general practice has been shown to be effective in reducing anxiety and avoiding benzodiazepine prescribing. Offering support in this instance is likely to be different from the support needed to help a dependent person come off benzodiazepines. A study which took place in Oxford concluded that there was little difference in outcome between two samples of anxious patients in two group practices. One sample received anxiolytic drugs (mainly benzodiazepines) the other received counselling which was "brief and unspecialised, consisting mainly of simple listening, explanation, advice, and reassurance". Counselling did not make greater demands on the GP's time. The patients involved appeared to be more satisfied with their treatment than those receiving anxiolytic drugs, and there was no increase in alcohol or tobacco consumption nor a rise in the use of non-prescribed drugs. (30)

Although the counselling given need only be "brief and unspecialised" not all GPs would be happy with this role, or keen to take it on. Teaching relaxation techniques may become necessary as well as counselling in the treatment of insomnia. In the long-term assertiveness training may be required for women to cope with anxiety. There is some evidence that counselling attracts more interest amongst younger GPs.

Yet GPs are not encouraged to employ counselling staff as an alternative to taking on the work themselves. GPs can claim reimbursement at 70% for nursing staff. It has always been presumed that they cannot do so for psychologists, counsellors

and psychiatrists. However, one practice obtained this reimbursement when they threatened to sue their FPC for being in breach of contract of the terms of the "Statement of Fees and Allowances" paragraph 52.5. The General Practice claimed that counselling could properly be included in the terms covering reimbursement for "nursing and treatment" as this covered any medical attention normally provided as part of general medical services which a practitioner could appropriately delegate (31). If the Government's recommendations that the categories of staff covered by the reimbursement system be enlarged, becomes law (see White Paper "Promoting Better Health"), this may cover counselling staff. At present very few counsellors are attached to general practice surgeries (32), although many clinical psychologists do offer regular sessions in GP practices. Those counsellors who do work via general practice, have different rates of pay, training and job description. Confidentiality between patient and GP or alternatively counsellor, needs to be clearly defined. Referral policies from GP to counsellor also need to be clarified.

Contact between GPs and psychologists is unfortunately limited, for example in terms of training. This is unfortunate as skill in the correct assessment of patients may avoid inappropriate benzodiazepine prescriptions, and psychological treatments might avert drug treatments. In fact it has been claimed that "A priority task of those psychiatrists working in the community should be to train other professionals, particularly GPs, in the skills of managing anxious patients without drugs."(33) Possibly psychologists could be seconded to practices. As a high percentage of GP consultations involve psychological factors, it is clear that GPs do require training in this field.

Finally, GPs are restricted from prescribing aids to relaxation, such as relaxation tapes. These have been officially accepted as an effective psychological treatment in the United States (34). The teaching of relaxation techniques has also been shown to be a valid way of avoiding benzodiazepine prescriptions and of reducing their usage through reducing anxiety symptoms.(35)

However, GPs could ensure that they are up-to-date with the self-help groups in their areas and counselling services via the district psychologist. An effective primary care team with social work, psychiatric nurse or health visitor assistance, could be of great benefit in the maintenance of this sort of information system and in helping self-support groups.

Support Services For Withdrawal

The amount of support needed varies from person to person. A study in Birmingham found that minimal intervention of two counselling sessions per week and reading material failed to help people reduce their tranquillisers more than marginally. A full 10-week counselling programme with further counselling after three months helped 42% of the 111 patients to give up

tranquillisers and 22% had reduced their dose by between 50 and 75%. This would seem to indicate that people can find withdrawal very difficult to achieve even after they have definitely decided to try and withdraw. The researchers estimated that approximately one third of long term benzodiazepine users will need substantial support on withdrawal. This would need to go beyond telephone counselling and self-help support groups, and would also include help with their underlying problems. (36)

Support on withdrawal can come from three sources - a patient's GP, a voluntary/self-help group, and statutory addiction agencies. GPs need to realise the serious nature of withdrawal symptoms and be aware of the degree of support needed by patients when they wish to come off the drug. In some cases a great deal of skill is needed in supporting withdrawal from tranquilliser addiction. Inadequate support may lead to the patient desisting from their attempt to withdraw. If GPs are not aware of the possibility of withdrawal-related anxiety, a repeat prescription may be issued in the mistaken belief that withdrawal-related anxiety represented a return of the original condition. A sleeping pill to counter the withdrawal symptom of sleeplessness may be prescribed without the patient being fully aware that the sleeping pill is also a benzodiazepine. Both these circumstances need to be guarded against. (In "Coming Off", Shirley Trickett advises those affected by insomnia during benzodiazepine withdrawal to check with their doctor that they are not being prescribed a benzodiazepine as a sedatiave.) A recent survey of general practices found that three quarters had a policy of weaning patients off drugs (37). However, the survey was sent to all general practices in the UK, of which only 1,600 replied, a response rate of 15%. No information could be given about non-responders. It is possible that those who responded were the most interested and most forward thinking about this subject.

District Health Authorities play a central role in providing support services too. The Women's National Committee surveyed health authorities asking if each District Drug Advisory Committee's remit included tranquillisers, and whether a co-ordinating group had been set up to tackle their abuse. Districts were requested to set up Drug Advisory Committees by the end of 1985. The original circular setting up these Committees did not specifically refer to benzodiazepines. However, answers to parliamentary questions have made it clear that the Government do see benzodiazepines as a legitimate concern of district drug dependency work (38). [188 drug misuse projects have received a total of £17.5 million in central pump-priming funding for local services for drug misusers since 1983. Of these, four were dedicated to benzodiazepine addiction and received £339,000. These four grants were made between 1983 and January 1985. In addition, the BBC were given approximately £70,000 in 1988 to run a help-line in conjunction with their series on benzodiazepines which began in November and continued until April 1989. Several other small grants have recently been made: to TRANX (UK) for 1988/89 of £10,000, £21,000 to pilot a

weekly telephone help-line in Bexley HA, and to MIND to research the services provided by the NHS, voluntary and self-help sectors for benezodiazepine users with the aim of producing a directory of services. An information leaflet for the public and professionals giving information on the drug, its use and alternative strategies is also to receive central funding. (39) (40)]

The Women's National Committee received 164 valid replies. 20% of Districts' Drug Advisory Comittees did not consider their remit to include tranquillisers. 53% of DHAs had not set up a co-ordinating group to tackle the abuse of tranquillisers (7% did not reply). Of the 40% of DHAs who did have a co-ordinating group, additional comments made it clear that often responses referred to self-help groups to whom the DHA had given financial support.

Ideally, support should be available within each DHA. This might be through addiction centres which offer support to people dependent on a variety of substances. Any such centre must be willing to take self-referrals as well as those made by doctors and other professionals. Drop-in facilities and telephone help-lines would also be necessary. The clinic in Birmingham has found that encouraging people to use the centre takes a lot of hard work and trust needs to be built up.

Voluntary groups have done much to set the pace in recognition of the size of the problem of benzodiazepine use, dependency and withdrawal problems. Organisations offer a variety of services including telephone help-lines, answers to written enquiries, information packs (several organisations mention people needing reassurance and facts as much as counselling on withdrawal), one-to-one consultations, referrals to groups in other parts of the country, audio tapes, group meetings where discussion covers diet, exercise, alternative ways to cope, relaxation techniques and some groups also produce newsletters. In 1987 TRANX (UK) received a total of 13,579 enquiries, of these 1,836 were new enquirers. Voluntary groups are also a useful source of information about benzodiazepine use, eg of the 60% of new enquirers who gave TRANX (UK) information on the type of benzodiazepines they were taking, 94% said Valium and 85% Ativan, showing that many people may be taking more than one benzodiazepine. Only 17% of TRANX's new enquirers were over 65 which tends to imply that elderly people are not using voluntary groups specifically concerned with benzodiazepines for help.

Although the Government has not supported benzodiazepine support groups in the same way that other drugs projects have been supported, there are nevertheless perhaps as many as 280 self-help type groups in England alone (41). Small projects like the one co-ordinated by Molly Jones first at Keighley Women's Centre and then through the Temple Row Centre in Keighley. The group offers individual group and telephone support, transport for disabled people, home visits for those who are agoraphobic or suffer panic attacks, relaxation techniques are taught and a rota

kept of women willing to speak on relevant issues such as miscarriage and the menopause. Molly Jones claims that many women have ill-health problems other than dependence on benzodiazepines. Unfortunately information on such groups remains sparse, the research being carried out by MIND hopes to redress this.

Patient choice on withdrawal

GPs have found that since benzodiazepines have been placed on the limited list (see appendix C for information on the limited list) some patients still wish to be prescribed their 'old' drug. Over half the 1,500 GPs in one study had written private prescriptions for one or more "blacklisted" benzodiazepines in the year after the limited list was introduced. Most of the 1,500 GPs had had trouble persuading people to use a substitute from the limited list (42).

Understandably, patients who have become dependent on benzodiazepine will wish to choose their moment to withdraw, if they feel that they can do so. People who are dependent on benzodiazepines will not be able to stop taking the drugs at the flick of an "increased publicity" switch; indeed it would be dangerous. A person who has become dependent on benzodiazepines will often be very shocked to find that they had become addicted to a drug prescribed by their doctor, ie a legal drug. One factor in establishing a benzodiazepine dependency may be the fact that in the short-term they work very well: the patient feels a great deal better, and without knowing about the possibility of dependency occurring, side-effects or withdrawal symptoms, goes back for more tablets and so on.

Ambivalence may be felt about withdrawing from benzodiazepines for the following reasons:

- loss of confidence incurred due to taking benzodiazepines, as taking a pill to 'cope' can lead to feelings of inadequacy.

- such action may lead to the recognition of some underlying problem in that person's life, or a re-evaluation of the person's lifestyle. This could include the recognition that some aspect of the person's life, such as a relationship with a partner, must be altered.

- difficulty in coping with withdrawal symptoms.

If a patient does not want to come off benzodiazepines even after appropriate help and support have been offered, then the doctor should not withdraw the patient suddenly nor alter their dose without their full agreement. If the patient does not want to withdraw then prescribing for dependence might seem appropriate.

DHA prescribing policies

So far this paper has mainly made reference to the responsibility of General Practices to prescribe appropriately and protect patients from the potentially harmful effects of benzodiazepines. Mention must also be made about the role DHAs play in contributing to overall prescribing levels. Hospital prescribing is believed to contribute to the creation of new users and potential addiction in the community. Hospital patients are often given benzodiazepines as a night sedation, irrespective of need. On leaving hospital the prescription is frequently continued along with other discharge medication. Repeat prescriptions are then offered by the GP.

Hospitals in the Colchester area have responded to this challenge. Benzodiazepine prescriptions are now severely curtailed by hospitals in the area and patients are provided with information about the drug if it is prescribed. There has been a dramatic fall of lorazepam prescribing by 50% and temazepam and nitrazepam are down by between 20 and 30%. It is hoped that this reduction will be reflected in GP prescribing. Information leaflets provided to in- and out-patients prescribed benzodiazepines by the hospital pharmacist may eventually become available via community pharmacists and GPs as well. As counselling and follow-up is recommended along with the leaflets if the information is to be really effective, such a move will require a great deal of collaboration between GPs and community pharmacists (43).

Hospitals also need to consider the degree of quiet on wards at night.

Legal action

Over the past few months legal action has been set in motion, seeking to prove negligence over benzodiazepine prescribing. Each case has to be proved separately. Different defendants are possibilities; the drug company; the Government for allowing the drug to be licensed; a hospital; or the person's GP. At present over 1,500 people have applied for legal aid in connection with this action. A steering group of solicitors is co-ordinating research and keeping local solicitors in touch with new moves. Anyone who wishes to seek legal advice on this subject would be well advised to contact the steering group either personally or through their own solicitor (Appendix D).

Conclusion

Benzodiazepines do have a legitimate role in the management of anxiety and insomnia. The legitimate boundaries of benzodiazepine use have been set out by the Committee on the Safety of Medicines in their bulletin no 21. Yet, this advice has not been followed universally. Benzodiazepines have themselves created a medical problem of which the NHS cannot

just wash its hands. Benzodiazepines have been used to answer a need for which they are inappropriate and for time spans which render the drug ineffective.

Benzodiazepine prescribing could be substantially reduced without affecting its legitimate use:
* If the underlying causes of anxiety and insomnia were dealt with particularly as they affect elderly people and women.
* If alternatives such as counselling became more widespread.
* If the severity of withdrawal symptoms were accepted and support forthcoming.
* If prescribing policies became more sensitiveand alternative treatments were offered.

These factors could contribute to a falling population of users and a reduction in the number of new users which in turn could reduce the likelihood of dependency.

Whether or not legal action in due course effectively alters prescribing policies, planned action is needed to limit the use of benzodiazepines by offering a positive alternative to doctors and patients. Strategies for coping with anxiety, insomnia, long-term ill-health, bereavement and possibly ageing and loneliness, in a non-medical manner (or a more appropriate medical one in the case of long-term ill-health) are necessary.

Recommendations

ACHCEW would like to make the following recommendations:

* further research should take place on the people who are prescribed benzodiazepines, and the reasons for the initial prescription. This should look particularly at age, sex, physical ill-health and hospital prescribing.

* there should be a debate on the medicalisation of social and personal problems particularly those of the growing elderly population and of women. The views of women and elderly people should play a major part in any debate.

* discussion should take place on the alternatives to drug prescribing and how these could be best provided by the NHS, this should include relaxation techniques, counselling and assertiveness training.

* there should be an increase in the availablity of counselling skills in general practice - including the secondment of psychologists to general practice.

* encouragement should be given to GPs to review benzodiazepine prescribing policies

* information should be distributed to GPs to alert them to the problems of withdrawal.

* patients should be given more information about the problems of dependency associated with benzodiazepines.

* each DHA should have a policy on benzodiazepine prescribing which includes formal help for those wishing to withdraw (possibly through addiction centres) and see that it is implemented.

* adequate support should be given to self-help support groups nationally and locally (including specific benzodiazepine support groups and well women's centres where social and psychological problems can be discussed, as well as medical aspects of women's health).

CHCs may wish to take the following action:

1) Assess whether the DHA has looked at benzodiazepine prescribing in hospitals, and looked at the implications of quiet night wards and the provision of patient information on benzodiazepines.

2) Ascertain whether the DHA has an addiction/drug advisory service and whether it includes benzodiazepines under its terms of reference. How this service is advertised to the public and local GPs should also be considered.

3) Discuss with FPCs and DHAs ways in which support services for the anxious or those suffering sleep disturbance may be provided to avoid unnecessary prescribing and reduce the risk of dependency occurring. These should include relaxation techniques, counselling and assertion training.

4) Support Health Education/Promotion programmes for the elderly in all aspects of their lives and those that enable women to be more assertive about their health needs.

5) Maintain a list of local sources of help including voluntary or self-help groups.

HF 1989

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APPENDIX A: Side-effects and Withdrawal Symptoms

Over-sedation can result in loss of control over movements (ataxia), difficulty with pronouncing words (dysathria), double vision (diplopia), muscle weakness, vertigo, poor memory and concentration, impaired psychomotor performance and mental confusion. Even drugs taken at night (which are designed to be cleared from the body more quickly and are called short-elimination drugs) can result in impaired mental and physical abilities the next day - often termed a 'hangover effect'. This is possibly a contributory factor in traffic accidents.

Benzodiazepines can cause a complete dulling of emotions, sometimes termed 'emotional anaesthesia', eg grief at a bereavement can be masked by drug use and is only experienced when the drug regime ends, possibly years later. Suppression of feeling does not eradicate its cause and it is likely at some point that both will have to be faced. Shirley Trickett in her book "Coming Off" gives the example of a woman who had been prescribed tranquillisers after the death of her husband, when she finally came off, thirteen years later, she was overwhelmed for several days by grief for her husband. A study of 111 people withdrawing from benzodiazepine in Birmingham found that one-fifth had been started on them after a bereavement.

In some cases of anti-social and aggressive behaviour, ranging from shoplifting to outbursts of rage, violence, sexual offences and baby-battering, long-term benzodiazepine use has been found to be a contributory factor. Benzodiazepines can also have adverse effects in pregnancy, causing neo-natal depresssion and withdrawal symptoms in the new born child. Long-term use of the drug may affect hormone function with varying results including breast enlargement in men and women, secretion of milk, premenstrual tension and menstrual irregularity. (See H.Ashton, Adverse Drug Reaction Bulletin June 1986 no 118 for full discussion of adverse effects of prolonged benzodiazepine use)

Withdrawal symptoms

Shirley Trickett's book gives the following complete list:

> "increased anxiety, increased depression, insomnia, panic attacks, suicidal feelings, agoraphobia, outbursts of rage, flu-like symptoms, hyperactivity, craving for tablets, headaches, dizziness, sweating, palpitations, slow pulse, tight chest, abdominal pain, nausea, nightmares, restlessness, increased sensitivity to light, noise, touch and smell, sore eyes, blurred vision, creeping sensation in the skin, loss of interest in sex, impotence, pain in jaw or face, sore tongue, metallic taste, pain in the shoulders and neck, sore heavy limbs, pins and needles, jelly legs, shaking. Fits have been reported but only where drugs have been stopped abruptly."

The following should be noted about withdrawal symptoms. It is not certain that everyone experiences withdrawal symptoms. If

withdrawal symptoms are experienced it is not likely that all those listed above will be experienced. Careful dosage reduction reduces the likelihood of withdrawal symptoms. Withdrawal schedules which cut down the number of tablets over several weeks until a person is drug-free are included in "Coming Off" by Shirley Trickett. Not ever clinic uses this method for withdrawal. If a person is considering stopping taking a drug they should always consult their doctor.

Withdrawal symptoms may be experienced following administration of therapeutic doses for fairly short periods of time. They may vary in duration from weeks to years, depending on the length of time that benzodiazepines were being taken, ie the longer the usage, the longer withdrawal symptoms may last. This is unlike the withdrawal symptoms for some hard drugs, ie heroin when the ex-user can feel considerably better after a few weeks.

Withdrawal symptoms may be severe. Anxiety may be worse during this period than at the time the drug was originally prescribed. Anxiety experienced on withdrawal is not a return to the pre-benzodiazepine anxiety state, but is due directly to the way in which the drug interacts with the body. People who have been given benzodiazepines for reasons other than anxiety have also experienced enhanced anxiety states on withdrawal. Many of the withdrawal symptoms are anxiety related, often expressed physically, ie difficulty in breathing and palpitations.

Appendix B - Dependency

The existence of particular personality traits may pre-dispose people to dependence. These are those with a borderline personality disorder characterised by "unstable and impulsive behaviour", who will "abuse benzodiazepines at high doses for short periods", but for whom dependence is only a problem if "consumption is prolonged". The other group comprises "the timid worrier", the "passive-dependent or anxious personality disorder", and it is argued by some that benzodiazepines are unlikely to have a beneficial effect on their anxiety as this is only symptomatic of an underlying mood disorder (Tyrer BMJ vol 298 pgs 102-104 1989). Others claim that the "timid worrier" benefits greatly from benzodiazepines in overcoming anxiety at least initially (possibly benzodiazepines are only effective where anxiety is high). This is due to a suspected pharmacological basis for anxiety which benzodiazepines counteract. However benzodiazepines also impair the inidividual's ability to learn alternative coping strategies for dealing with stress which is also suspected of having a pharmacological basis similar to that which causes anxiety (Ashton BMJ vol 298 pgs 103-104 1989). However, alternative strategies for coping with stress can be learnt.

The above hypothesis would seem to imply that, as benzodiazepine users form a group of people with a tendency towards dependency, benzodiazepine prescribing policies should be given even greater consideration and be strictly monitored, with every effort being

made to offer alternative help.

Yet the strength of personality and courage that is sometimes necessary to come off benzodiazepines is masked by these arguments. They do not address the amount a person may already be coping with in their lives, nor is an explanation given as to why a person may be able to come off benzodiazepines easily on the first occasion of long-term use and not on subsequent ones (Ashton 1984 BMJ vol 288 pgs 1135-1140). Finally, no reason is given as to why people who are assessed as having no prior psychiatric problems or who are given benzodiazepines for reasons other than anxiety may nevertheless experience difficulties on withdrawal (Adverse Drug Reaction Bulletin June 1986 no 118).

Appendix C - PACT and The limited list

PACT: Data collection on repeat prescribing may be done via a modification of PACT if doctors' representatives, the Department of Health and others agree on how this will be done. PACT (Prescribing Analyses and Cost) at present provides GPs with three levels of information: 1) a comparison of their practice's prescribing costs and frequency with the national average and the mean for the area covered by the relevant FPC (information is broken down into six major therapeutic groups); 2) quarterly figures for those doctors in practices with high prescribing costs; 3) a complete catalogue of items prescribed (this can only be provided on request) (11).

The Limited List: The limited list was introduced on 1st April 1985. Broadly speaking, it restricted the prescribing of brand named drugs amongst certain categories of medicines. One of these was benzodiazepines. A 'blacklist' of drugs no longer available on NHS prescription, although available on a private prescription, was drawn up and now forms section 18a of the Drug Tariff. Some generic benzodiazepines were also placed on the black list along with their brand-named equivalents. A few brand-named benzodiazepines were not affected although these seem to be those marketed for special applications such as injections. Benzodiazepines are now only available on an NHS prescription in their generic form. These are: Diazepam, Chlordiazepoxide, Lorazepam, Oxazepam, Nitrazepam, Loprazolam, Temazepam, Triazolam, and Lormetazepam. Pharmacists may stock whatever drugs they wish. However they are re-imbursed at a fixed price so that it is unlikely that they would stock drugs in any form but the generic form.

Appendix D: Self help groups/user groups and useful addresses

TRANX (UK) can be contacted at 25a Masons Avenue, Wealdstone, Harrow, Middlesex, HA3 5AH. Tel: 01-427 2065. 24hr answering machine number 01-427 2827.

COUNCIL FOR INVOLUNTARY TRANQUILISER ADDICTION can be reached at Cavendish Buildings, Brighton Road, Waterloo, Liverpool. Tel 051 949 0102

RELEASE can be contacted at 169 Commercial Street, London E1 6BW. Tel 01-377 5905. The 24 hour emergency help-line number is 01-603 8654. The operator will answer this number and refer the caller on to the duty volunteer. Callers seeking advice or counselling between 10am and 6pm Monday to Friday can phone the office number.

MIND can be contacted at 22 Harley Street, London W1N 2ED. Telephone number 01-637 0741.

TURNING POINT have four regional offices: Head Office and Southern Regional Office, Turning Point, 4th Floor, CAP House, 9-12 Long Lane, London EC1A 9HA. Northern Regional Office, Turning Point, 396a and 397 Corn Exchange Building, Hanging Ditch, Manchester M4 3HW. Trent Regional Office, Turning Point, Marlborough House, 1a Cranmer Street, Nottingham NG3 4GH. West Midlands Regional Office, Turning Point, 2nd Floor, 1 Copthall House, Station Square, Coventry CV1 2FZ.

DRUGS, ALCOHOL, WOMEN NATIONALLY (DAWN) can be contacted at Omnibus Workspace, 39-41 North Road, London N7 9DP or on telephone number 01-700 4653.

MOLLY JONES, Temple Row Centre, 23 Temple Row, Keighley, West Yorkshire, BD21 2AH. Tel Keighley 606700.

WITHDRAW Workshops, 515a Bristol Road, Birmingham, B29 6AU or contact by telephone number 021-471-3636. They are planning to run seminars during 1989 throughout the country to share their experience of aiding withdrawal. The seminars are for drug workers, psychologists, nurses, social workers, occupational therapists, physiotherapists, counsellors and health visitors which will cost £90. Anyone interested should contact the above address.

The LEGAL ACTION steering committee can be contacted via: Paul Balen, Freeth, Cartwright & Sketchley, Willoughby House, 20 Low Pavement, Nottingham NG7 DL.

A SUMMARY OF KEY POINTS

Problems with Benzodiazepines

Benzodiazepines are used to reduce anxiety and sleeplessness. The problems associated with this drug are:

* A possible reduction in therapeutic effect over time
* Potential unpleasant and dangerous side-effects
* People may become dependent on them and experience unpleasant symptoms on withdrawal

Changed Guidance

Guidance on the use of these drugs has markedly changed over the last decade in an attempt to minimize the above problems and secure a legitimate and appropriate role for their use.

Guidance now suggests that:

* Benzodiazepines used for anxiety should only be used in the short-term - 2 to 4 weeks.
* Anxiety must be severe, disabling or subjecting the individual to unacceptable distress. "Mild anxiety" is not suitable for treatment with these drugs.
* For insomnia, benzodiazepines should be prescribed only when it is severe, disabling or subjecting the individual to extreme distress.
* Specifically rejected is the sole use of benzodiazepines for depression and warnings are given about their use in cases of bereavement.

Who is being prescribed Benzodiazepines?

As many as three million people may be taking benzodiazepines for four months or longer.

* Many long term users may be elderly people for whom side-effects are more severe than for younger adults.
* Some 70% of benzodiazepines are prescribed to women
* Many long-term users may be being prescribed benzodiazepines for long-term physical ill-health

If alternatives are to be offered particular attention must be taken to ensure that they are acceptable to the above client groups.

Areas for Action

* Repeat prescriptions: keeping prescribing short-term is the key to avoiding unpleasant side-effects and the possibility of dependency and withdrawal symptoms. However, if this is to happen adequate alternatives need to be offered.

* Alternatives ways of managing anxiety and sleeplessness: this will require greater counselling skills at the primary care level and more knowledge of such things as relaxation techniques. Sensitive research needs to be carried out to assess the specific problems elderly people have with sleeplessness and appropriate strategies need to be devised to overcome rather than tolerate these problems.

* DHA policies on benzodiazepine use can be very effective in reducing the amount that this drug is prescribed in hospital. DHAs need to review regularly prescribing policies and the information they give to patients about this drug.

* Adequate withdrawal support services need to be provided through DHAs, GPs and voluntary organisations as long-term users may experience extreme problems on withdrawal. For example:
  - not all DHAs include benzodiazepines in the terms of reference of their District Drug Advisory Committees, although the Government sees this as a legitimate area of district drug advisory work.
  - adequate support needs to be given to voluntary groups working in this area.
  - GPs need to be fully conversant with withdrawal symptoms and their potential severity to support adequately people on withdrawal.