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Regular Review

Benzodiazepines in general practice: time for a decision

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The government's regulations restricting the range of benzodiazepines prescribable under the NHS have focused fresh concern on the use of these drugs in general practice. The intensity of the debate was reflected in a long correspondence in the *BMJ*¹⁻³ after a report of an alleged new syndrome attributed to benzodiazepine withdrawal⁴ and a leading article advocating cautious prescribing.⁵ At the same time, television's top consumer programme criticised doctors for overhasty and excessive prescribing of these drugs.⁶

How far could or should the prescribing of benzodiazepines in general practice be reduced? Here we examine three questions. Firstly, are there good reasons for trying to reduce the prescribing of benzodiazepines in general practice? Secondly, would such an attempt be harmful to patients? and, thirdly, would such an attempt be feasible in the working conditions of general practice?

Without doubt many doctors are worried about the scale on which benzodiazepines have been prescribed in general practice. Precise data cannot be cited since official statistics do not list benzodiazepines separately. Nevertheless, in England annual prescriptions for tranquillisers and sedatives (including benzodiazepines) in the NHS amounted to about 21 million in the late 1970s and about 18 million in the early 1980s.^{7,8} In these same two periods prescriptions for hypnotics (mostly benzodiazepines) ran steadily at about 14 million a year. These prescriptions were largely issued in general practice. A recent survey in five group practices showed that diazepam was the most frequently prescribed of all drugs.⁹ During one year sedative or hypnotic drugs were prescribed at least once to 16% of women and 7% of men registered in the five practices; in women aged over 45 the figure was about 25%.

These drugs are prescribed mainly to patients with minor affective disorders, which make up a large part of a general practitioner's case load and commonly present with symptoms of anxious or depressed mood or insomnia.¹⁰⁻¹² They are called minor disorders to distinguish them from the major mood disorders (depressive disorders, anxiety

neuroses, mania) seen in psychiatric practice. These minor disorders often seem to be associated with social problems¹³⁻¹⁵ and physical morbidity,¹⁶ and they usually improve within six to 12 months.^{11,13,17}

Arguments for and against

Three main arguments have been put forward to justify the use of benzodiazepines for such disorders. Firstly, they are said to be effective.¹⁸⁻²⁰ Secondly, benzodiazepines are said to be safer in standard doses than other drugs that might be used, safer in overdose than other drugs,²¹ and safer than alcohol, tobacco, or non-prescribed drugs which patients might take if benzodiazepines were withheld.²² Thirdly, benzodiazepines are relatively cheap: anxiolytic drugs account for only a small proportion of the total health bill in Britain and cost far less than the beer, wine, and spirits consumed by the population.²³

The critics of benzodiazepines dispute all three arguments. On efficacy much depends on our interpretation of the many published drug trials. Benzodiazepines are generally accepted to be superior to placebo in the treatment of patients suffering from anxiety neurosis,²⁴ though many studies may be criticised on methodological grounds.²⁵ Even when dealing with psychiatric patients, however, the beneficial effect of benzodiazepines has sometimes been found to be restricted to patients with high levels of anxiety; when given to patients with low anxiety levels benzodiazepines have been found to be no better than placebo.^{26,27} The evidence for the efficacy of benzodiazepines in general practice is unconvincing: many reports are methodologically inadequate, and the more rigorous studies have failed to show any advantage over placebo.²⁸ It might be argued that benzodiazepines are likely to be superior to placebo only in patients suffering from severe anxiety symptoms and that these patients are uncommon in general practice. Benzodiazepines are often used as hypnotics and they do seem more effective than placebo in

the treatment of insomnia, at least in the short term.²⁹ There are doubts, however, about their efficacy and the desirability of their use in chronic insomnia.^{30 31}

On safety the critics accept that benzodiazepines in standard doses are relatively safe but argue that they are not so harmless as originally thought. Physical dependence on benzodiazepines does occur, even with standard doses,^{4 32 33} though it is probably uncommon.³⁴ Other undesirable side effects include drowsiness, cognitive impairment,³⁵ and ataxia, leading to impairment of driving skills.^{36 37} People who have had serious road accidents are more likely than others to have been prescribed anxiolytic drugs in the three months before the accident.³⁸ In interpreting such findings, however, it is difficult to know whether the accident should be attributed to the drug, the emotional disorder, or other factors. Benzodiazepines may lead to release of aggression in people with a tendency to aggressive behaviour.³⁹ This so called paradoxical aggression in response to benzodiazepines has been shown experimentally in volunteers.^{40 41} The critics also accept that, in overdosage, benzodiazepines are safer than many other drugs, but they point to evidence that patients sometimes use benzodiazepines for self poisoning within 48 hours of the consultation at which the general practitioner prescribed them.^{42 43} Such an outcome would be avoided, they argue, if the consultation were used for counselling only and not for prescribing. One recent finding relevant to the discussion of the safety of benzodiazepines is the presence of brain scan abnormalities detected in a small sample of long term benzodiazepine users compared with controls, a finding which is striking but difficult to interpret.⁴⁴

On the third argument—relative cheapness—the critics point out that while psychotropic drugs account for only a small proportion of the total health bill they make up one tenth of the nation's drug bill. Moreover, no matter how cheap the benzodiazepines are, prescribing them at present levels is still a waste of money if there is little evidence of their effectiveness for most minor affective disorders seen in general practice.

Two further arguments

The critics advance two further arguments against benzodiazepines, one practical and one moral. The practical argument is that these drugs may undermine a person's capacity to draw on his or her own resources to cope with adversity⁴⁵—a difficult argument to evaluate scientifically. Benzodiazepines are said to reduce the capacity of rats to adjust food seeking behaviour to stress, but this incapacity is hardly akin to loss of human resourcefulness.⁴⁶ The moral argument is that anxiolytics may be the new opium of the people, since they suppress emotional symptoms while the underlying social and political causes remain unchanged.⁴⁷

On the second and third questions there are fewer arguments and less evidence. In a notable experiment in an East Anglian general practice barbiturate hypnotics were withheld from patients and the prescribing of all hypnotic medication was reduced by half with no apparent ill effects.⁴⁸ In the United States prescribing of anxiolytic drugs was reduced in one clinic by educational material and clinic interviews, and in an entire state by removing benzodiazepines from the medical pharmacopoeia, and in neither study were adverse consequences reported.^{49 50}

General practitioners are often said to lack the time to

provide non-drug treatment in place of benzodiazepines.⁵¹ Little or no research evidence has appeared on this point. We do know, however, that effective alternatives to drug treatment may be psychological or social treatment provided by other professionals working in general practice—for example, social workers and psychologists.⁵²⁻⁵⁴ In most cases the provision of these alternatives has been followed by a fall in the prescribing of anxiolytics.

A recent study has provided new evidence on all three of the questions posed above. The effects of withholding anxiolytic medication were examined in two group practices in Oxford.⁵⁵ The general practitioners identified over 90 patients in whom they diagnosed new episodes of minor affective disorder for which they would normally have prescribed anxiolytic medication. Standardised tests of mental state given by independent research workers confirmed that over 80% of the patients were suffering from a psychiatric disorder. The most frequent presenting symptoms were anxiety and somatic complaints. Half the patients were allocated randomly to treatment with anxiolytic medication chosen by the general practitioner and half to counselling given by the general practitioner, without medication. In the event the anxiolytic drugs chosen by the general practitioners were almost always benzodiazepines. The counselling was brief and non-specialised, consisting mainly of simple listening, explanation, advice, and reassurance. Before treatment the two patient groups were similar in all important ways. When standardised assessments were repeated after the start of treatment the proportions of patients with psychiatric disorder fell from 80% before treatment to about 40% at one month, and about 30% at seven months. The salient finding was that in the two treatment groups improvements were similar in amount and parallel in course. This finding pointed strongly to the conclusion that prescribing anxiolytic drugs was no more effective than brief counselling by the general practitioner in treating new episodes of minor affective disorder. Patients who still had a substantial psychiatric disorder at seven months were equally represented in the two treatment groups. They were distinguished from other patients by their greater severity of psychiatric disorder at the first consultation and at four week follow up.

Three other findings were particularly relevant to this review. There was no evidence that withholding anxiolytic medication increased consumption of other substances, such as alcohol, tobacco, or non-prescribed drugs. Nor did counselling make increased demands on the general practitioner's time, either at the first or at later consultations. And the patients receiving counselling appeared to be more satisfied with their treatment than did those receiving anxiolytic medication.

Conclusions

What conclusions may be drawn from earlier arguments and evidence and from this latest study? Firstly, a substantial reduction in the prescribing of benzodiazepines is desirable in general practice. Drug trials indicate that benzodiazepines are not particularly effective for the minor affective disorders commonly seen in general practice; benzodiazepines appear to be no more effective than brief counselling by the general practitioner; and benzodiazepines, though relatively safe, still carry enough hazards to cause concern.

Secondly, a reduction in benzodiazepine prescribing in general practice would be unlikely to be harmful to patients. Thirdly, such a reduction would be feasible in general

practice. Doctors would not experience greater demands on their time, and most patients would find the withholding of benzodiazepines acceptable and indeed preferable.

If general practitioners are to reduce the prescribing of benzodiazepines how should they manage patients presenting with new episodes of minor affective disorder? For patients with disorders of mild to moderate severity, the best treatment is likely to be brief counselling provided by the general practitioner or by another professional working in the practice. Such counselling need not be intensive or specially skilled. It should always include careful assessment of the causes of the patient's distress. Once these have been identified anxiety may often be reduced to tolerable levels by means of explanation, exploration of feelings, reassurance, and encouragement.

For patients with more severe anxiety treatment should be tried with counselling or benzodiazepines or both. If benzodiazepines are prescribed the aim should be to tide the patient over a crisis until psychological or social measures can be used. The drug should be prescribed over a short period to avoid the risk of dependence. The length of the safe period of time is uncertain, estimates varying from two weeks to 12

weeks.³⁰⁻³⁴ A reasonable working rule is that benzodiazepines should be prescribed for no more than three weeks and then withdrawn gradually. The patient should be given a clear explanation that prescribing will be time limited in order to avoid dependence and that the goal is to allay anxiety while its causes are being sought and dealt with.

With this treatment some patients with severe anxiety are likely to recover within a short time. Others are likely to remain unwell for at least six months, and the best treatment for them is not clear.⁵⁶ Possible alternatives are other forms of medication such as antidepressants, or another psychological treatment such as problem solving or anxiety management training, which could be provided by the general practitioner or other professionals. These are important issues for future research.

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