Time efficient interventions by general practitioners curb benzodiazepine consumption among long-term users

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WHAT IS ALREADY KNOWN ON THE TOPIC?

Benzodiazepines increase the risk of cognitive impairment, falls and motor vehicle accidents, so their long-term use is not recommended. Many patients are receptive to a trial of withdrawal, and general practitioners (GPs) can be effective catalysts for de-prescription. Evidence is lacking on the most efficient strategy to use in general practice.

WHAT DOES THIS PAPER ADD?

▸ This paper provides level 1 evidence that a 20 min discussion by GPs about the risks of benzodiazepines, alongside provision of a self-applied, written, stepped-dose, tapering protocol results in discontinuation rates of 45% at 1-year in primary care patients without severe comorbidity. This approach is as effective and more time efficient than the same educational intervention plus close monitoring of patients every 2 weeks.

▸ Irritability, insomnia, anxiety and tremor may occur transiently during the tapering process.

▸ Withdrawal symptoms resolve by 1 year and are no different in frequency to patients who do not receive a discontinuation intervention.

LIMITATIONS

▸ GPs were not blinded to the topic of the study and helped recruit patients, possibly explaining the relatively high rates of benzodiazepine discontinuation in the control group (15%), and inclusion of participants more open to withdrawal.

▸ Patients with severe psychiatric comorbidity or receiving current psychiatric treatment were excluded, meaning the results cannot be extrapolated to patients with significant mental illness.

▸ The GPs in this study were motivated and interested in proposing benzodiazepine discontinuation to their patients and may not be representative of all GPs.

WHAT NEXT IN RESEARCH?

▸ A trial is needed that tests the combination of evidence-based de-prescribing interventions targeted directly to consumers, along with GP support and implementation of cognitive-behavioural therapy, on discontinuation of benzodiazepine medicines in patients who are reluctant to attempt withdrawal or who do not succeed initially.

▸ Investigations should be conducted on the effect of quality improvement initiatives and benzodiazepine performance indicators to increase uptake of the educational intervention by GPs.

▸ Evidence is required to determine whether implementation of benzodiazepine de-prescribing interventions reduces mortality and emergency department visits due to sedative-hypnotic medicines.

COULD THESE RESULTS CHANGE YOUR PRACTICE AND WHY?

Yes. Discussions about benzodiazepine discontinuation with chronic users were previously thought to be excessively time-consuming and of little value. Knowing that one-in-two patients will successfully taper after a 20 min conversation and distribution of a tapering protocol—without the need for close follow-up—is a strong motivator for introducing this routine into my practice. These results provide a way to personally contribute to the reduction of potentially harmful treatments as advocated by the Choosing Wisely campaign for physicians (http://www.choosingwisely.org/).

Competing interests None.

REFERENCES


OUTCOMES

Benzodiazepine discontinuation at 12 months Discontinuation rates were higher in both intervention groups compared to the 15% (26/173) reported for controls (SIF relative risk (RR)=45.0%; SW=45.2%). Both interventions tripled the RR for benzodiazepine discontinuation (SIF RR=3, 95% CI 2.04 to 4.40; SW 3.01, 95% CI 2.03 to 4.46). There was no significant difference in effect between the two interventions (RR=1.00, 95% CI 0.78 to 1.28). Compared to usual care, the number needed to treat with either intervention to achieve remission in one person within a year was 4 (95% CI 3 to 5).

Influence of benzodiazepine dose In each group, discontinuation rates were higher in people taking less than 10 mg diazepam compared to those taking a higher dose.

Influence of anxiety severity For SIF discontinuation rates were the same regardless of anxiety severity. In SW and control groups discontinuation rates were higher for people with less severe anxiety.


Patients/participants Five hundred and thirty-two adults (median 64 years, 72% female) who had been taking benzodiazepines for at least 6 months. Main indications for benzodiazepine use were insomnia (68%) and anxiety (65%), or a mixture of both. Median treatment length was 60 months (range 6–480).

Setting GP practices in Spain; June 2010–March 2012.

Intervention Structured education, gradual dose tapering and follow-up visits every fortnight (structured intervention with follow-up visits (SIF); 26 GPs, n=191), or structured education followed by written instructions for dose tapering (structured intervention with written instructions (SIW); 24 GPs, n=168). Structured education included information on benzodiazepine dependence, abstinence and withdrawal symptoms, long-term risks, reassurance about reducing, and self-help information for insomnia. The two interventions differed only in method of follow-up.

Comparison Usual primary care management of long-term benzodiazepine discontinuation (25 GPs, n=173).

Patient follow-up 92.3% at 12 months.

Allocation Concealed, cluster randomisation by GP practice.

Blinding Single blind (assessors).
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