Benzodiazepine prescribing

Lessons from interprofessional dialogue

BACKGROUND
The prescribing of benzodiazepines in the general practice setting raises many issues for general practitioners. In the latter part of 2005, GP members of The Royal Australian College of General Practitioners Victoria Faculty Drug and Alcohol Sub-Committee and GP-Psychiatry Liaison Sub-Committee met with representatives of the Royal Australian and New Zealand College of Psychiatrists and the Pharmacy Guild to discuss these challenges from their different perspectives.

OBJECTIVE
This article aims to raise some issues about benzodiazepine prescribing that arose as part of an interprofessional dialogue between GPs, psychiatrists and pharmacists. This dialogue was an informal opportunity to debate current practice and learn from the perspective of others.

DISCUSSION
While a small group discussion has limitations in addressing all the issues pertaining to quality prescribing of benzodiazepines, it does provide a forum for useful debate and has the potential to enhance our effectiveness in the quality use of medicines, in the area of benzodiazepine prescribing.

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In the 2004–2005 National Health Survey, close to one in 5 adults (19%) reported they had taken some type of medication for their mental health and wellbeing in the previous 2 weeks. While the list includes vitamins, minerals and herbal supplements, 23% of this group reported using sleeping tablets and 10% had used medication for anxiety or nerves.[1] Of the benzodiazepines listed, the top three were oxazepam (2.6%), diazepam (5.6%), and temazepam (9.8%). Anxiolytics, hypnotics and sedative prescriptions make up approximately 4–5% of the total prescriptions written by Australian general practitioners.[2] There are some useful resources to help GPs to review the use and/or withdrawal of benzodiazepines by their patients[3–5] but how can we be sure we are targeting the right patients when we decide to intervene? Are we able to distinguish the patients who really benefit from these medications (however small this number may be) from those who are not really benefiting or suffering harm? An interprofessional meeting of GPs, drug and alcohol doctors, psychiatrists and pharmacists raised some of the practical issues associated with this dilemma. The case based discussion was very useful in clarifying some issues, which are presented in this article.

The psychiatrist's perspective

Benzodiazepines are commonly used in the management of severe anxiety disorders because they are effective, work quickly, are well tolerated and can be used on an 'as required' basis in some circumstances.[6] In cases of severe anxiety, such as chronic treatment resistant panic disorder, benzodiazepines do have a role alongside antidepressant medication and cognitive behaviour therapy.[7] They also have a role in the short term during the initiation of selective serotonin reuptake inhibitors (SSRIs) in some patients, as some patients will cease SSRIs if initial anxiety is not controlled.

The psychiatrist in the group reported his frustration at hearing patients complain about their dealings with GPs and pharmacists in relation to prescriptions for benzodiazepines, including problems such as being interrogated by the pharmacist in a public place, feeling criticised for taking benzodiazepines by the pharmacist or GP, or being refused a script from the GP, despite the psychiatrist previously communicating a management plan in writing to the GP.

The pharmacist's perspective

It is useful to understand the extent of the pharmacist's responsibilities when dispensing 'drugs of dependence',

defined as all S8 poisons plus those S4 poisons that are subject to misuse and trafficking, including benzodiazepines.[8]

The pharmacist also has specific obligations regarding reporting if called upon to dispense Schedule 4 or 8 poisons in greater quantities or more frequently than appears reasonably necessary.[9] The pharmacist must only dispense if the prescription is hand written with dosage and frequency stated (even when prescription is computer generated).[10]

Finally the pharmacist must counsel the client in a way that ensures privacy but also enables the pharmacist to ensure the legitimacy of the prescription, such that the pharmacist can promptly contact all prescribers and pharmacists if they become aware of multiple prescribers or supply pharmacists. Accurate contact details on the prescription greatly facilitate this process.

The GP's perspective

The GPs participating in this dialogue had a special interest in primary mental health care and/or drug and alcohol work. It is advised that GPs refer to existing RACGP guidelines on benzodiazepine prescribing for an evidence based overview and a brief outline of the management principles for the problem benzodiazepine user.[11]

Key messages from GPs experienced in long term benzodiazepine prescribing or prescribing to benzodiazepine dependent patients include:

- establish the patient's identity and decide if an appropriate clinical need exists
- remember dependence is neither a valid reason to continue prescribing, nor is it sufficient reason, on its own, to refuse to prescribe. An adequate assessment of all long term users and first time patients requesting benzodiazepines is crucial, to rule out physical dependence, history of withdrawal fitting, and suicidality. Seeking specialist advice or supplying a small quantity of diazepam are ethically and clinically appropriate short term responses
- active consent and cooperation from the patient is required before attempting to reduce, gradually withdraw or terminate a dependent patient's use of benzodiazepines. In the case of a patient who does not consent it is important to ensure that there are dispensing restrictions in place to prevent escalation of dosage
- a blanket refusal to prescribe benzodiazepines without adequate assessment can be as problematic as prescribing benzodiazepines.

When taking into account the different professional encounters of psychiatrists, pharmacists, GPs and doctors working in drug and alcohol medicine, it is useful to listen to the experiences of others and be mindful of this when dealing with patients who may regularly interact with other health professionals.

One of the key messages gained from this interprofessional dialogue was that practitioners might be dealing with benzodiazepine prescribing for quite different populations. The populations discussed at our meeting included patients who present to a psychiatrist for the management of depression and anxiety, walk in patients at a general practice demanding benzodiazepines, known drug users who may use a range of prescribed and nonprescribed drugs, and patients with anxiety and depression problems who choose not to accept a referral for any psychotherapy (which may be more adequate in the long term), or are looking for alternative ways to manage their difficulties.

The patient's perspective

Consumers have been asked about their interactions with health professionals while using or ceasing benzodiazepines. They perceived the information provided by GPs as limited and commented that medications were often too easily prescribed, sometimes without seeing the GP and never with discussion of cessation. Similarly they described receiving inadequate information (if any at all) from pharmacists.[12] Hopefully this situation has improved with the requirement to provide Consumer Medication Information (CMI) and the encouragement of interaction between health professionals.

In addition to providing patients with information about the risks and benefits of benzodiazepines, this interprofessional dialogue reminds us to communicate better within the multidisciplinary team. Some suggestions for action include that:

- we encourage patients to attend the same pharmacist for regular benzodiazepine scripts, or at least forewarn them about the responsibilities of the pharmacist when dispensing benzodiazepines
- we call each other on the phone to clarify the management plan when we have any concerns
- psychiatrists and GPs work harder to improve communication by letter, phone and fax to avoid stigmatising those patients who have legitimate treatment needs
- we ensure we do not undermine the professional advice of our colleagues.

These simple steps to enhance communication at a local level may be a key to ensuring the best medication outcomes for the diverse group of benzodiazepine users we each encounter in clinical practice.

Conflict of interest: none declared.

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