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Editor's choice

View from the trenches

Dear Mother

I hope this letter finds you well. There is so much to tell you and so little time, because tomorrow morning is Monday and we're being sent back into No Man's Land. So few of the Old Pals remain for this 'final' mission. Most of them have left or are at least planning to leave. As for the big push, it's a worry because Field Marshall Stevens's FYFV doesn't seem to have been the walkover we were promised in Blighty a couple of summers ago. There have been soundbite explosions but they don't seem to have made much impact on the trenches.

I was reminded of all the hullabaloo around the great plan yesterday when I visited an end-of-life patient. As she lay tearful, distressed, and frightened I held her hand and realised that I was the only team member left to do it — so many colleagues better placed have been deployed to do other things.¹ It seems humanity no longer has a value here. Sustained Trimming and Privatisation plans promise much good and who is this squaddie to suggest otherwise? Let's hope virtual care is as good as they say it will be. It's probably shellshock but it seems like there's precious little *scientia* and even less *caritas* in these schemes. Has our fight really been worth it?

Signing off now Mother, if we don't make it, do remember us not as we have become but rather as we were, and promised to be.

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Prescribed drug dependence services for long-term BZD use: treating the problem while ignoring its causes

Davies and colleagues highlight the issue of inappropriate long-term benzodiazepine and Z-drug (BZD) prescribing¹ but their conclusions and recommendations are flawed.

First, they suggest that prescribing should be reduced by ensuring adherence to existing guidelines for prescribing and withdrawal, or developing new guidelines where needed.

Guidelines have failed to reduce benzodiazepine and Z-drug prescribing: clinicians do not adhere to recommendations to use hypnotics and anxiolytics short term and only after trying psychological therapies.² The reasons for this are multifaceted and complex. Second, they advocate more research into the harms associated with long-term BZD use. Many studies have investigated harms from long-term benzodiazepine use, including risks of cognitive impairment, falls, hip fractures, and road traffic collisions. Finally, the authors recommend mandatory national drug withdrawal services and a helpline and website for prescribed drug dependence. These recommendations are arguably the most concerning because they lack evidence to support them. There is already evidence for benzodiazepine withdrawal, ideally combining discontinuation with psychological therapy for the underlying disorder.³ Setting up new services without considering the likely workforce and resource needs, effectiveness, costs, or unintended consequences ignores the evidence that points to multifaceted rather than simplistic solutions to address the complex problem of BZD prescribing.

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Authors' response

Prof. Siriwardena is mistaken to state unequivocally that guidelines have failed to reduce BZD prescribing. Since their introduction in 2004,¹ benzodiazepine prescribing fell from 3.5% to 2.5% of patients between 2000 and 2015.² We agree that too many clinicians fail to follow guidelines but we do not accept we are wrong to insist on guidance adherence because the reasons for non-adherence are 'multifaceted and complex'. We do not agree there is enough research on the harms of long-term BZD use. Patient reports indicate harms that have not been captured in the existing evidence base.

We are criticised for recommending national withdrawal services because '[we ignore] the evidence that points to multifaceted rather than simplistic solutions' for long-term BZD prescribing. We fail to see how recommending national services can be considered simplistic given there is nothing to stop such services from taking a multifaceted approach. Indeed, there is now medical consensus for national withdrawal provision.

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