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) prescribing 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. 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. 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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REFERENCES

Authors’ response

Prof. Siriwardena is mistaken to state unequivocally that guidelines have failed to reduce BZD prescribing. Since their introduction in 2004, benzodiazepine prescribing fell from 3.5% to 2.5% of patients between 2000 and 2015. 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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REFERENCES