# Overuse of benzodiazepines: still an issue?

**Key practice points:**

- Non-pharmacological methods, such as cognitive-behavioural approaches are the preferred first-line management of insomnia or anxiety
- If other treatment options have been unsuccessful, benzodiazepines or zopiclone may be considered for short-term use. A treatment plan should cover treatment duration, dose, outcome measures, adverse effects and review dates. This may be written as a contract to help the patient understand the expectations of their treatment and to provide a safeguard for the clinician to avoid escalation of prescribing.
- In elderly patients, lower doses of zopiclone or benzodiazepines should be prescribed, e.g. half the normal adult dose, and benzodiazepines with a long half-life, e.g. diazepam and nitrazepam, should be avoided
- For patients who have been using these medicines long-term, withdrawal should be discussed. A gradual taper improves the success rate of discontinuation and avoids or reduces adverse effects of withdrawal. Patients will require education and follow-up support during this time.

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Long-term use of benzodiazepines or zopiclone for insomnia or anxiety is discouraged as these medicines can cause a range of adverse effects, including:

- Vertigo
- Muscle weakness
- Effects on cognition
- Dependency
- Increased risk of falls
- Increased risk of motor vehicle accidents[1]
- Increased risk of dementia and possible increased risk of Alzheimer's disease[2, 3]

Despite these risks, and that zopiclone and benzodiazepines are not first-line treatments for anxiety or insomnia, patients in New Zealand are currently being prescribed large volumes of these medicines. Benzodiazepine and zopiclone use is particularly prevalent in older people: in 2014, one in ten people in New Zealand aged 65-74 years and one in five people aged 85 years and over were dispensed a benzodiazepine or zopiclone.[4]

## Prescribing points for benzodiazepines and zopiclone for insomnia or anxiety

Benzodiazepines are indicated for the treatment of insomnia and anxiety, and zopiclone for the treatment of insomnia; however, they are not first-line treatment options for either of these conditions. If patients begin taking a benzodiazepine or zopiclone they may perceive that the rapid symptom relief that is often gained when using these medicines outweighs any adverse effects and risks. Patients may subsequently be less willing to try other treatments, such as psychological interventions or selective serotonin reuptake inhibitors (SSRIs), but these are likely to be safer and more appropriate in the long-term than continued benzodiazepine or zopiclone use.

**For the treatment of insomnia:**

- Cognitive-behavioural approaches (e.g. discussing ways to improve quality and quantity of sleep - "sleep hygiene") have high levels of efficacy, are supported by a good evidence base and achieve better long-term outcomes than benzodiazepine or zopiclone use[5]
- Benzodiazepines are known to alter sleep architecture with less time spent in slow wave sleep and reduced overall sleep quality compared to the equivalent duration of sleep achieved by cognitive-behavioural approaches[6]

If other interventions have been unsuccessful and a benzodiazepine or zopiclone is being considered, clinicians and patients should be aware that:

- Zopiclone is indicated for the short-term management of insomnia, with the recommended dosing regimen of up to one tablet (7.5 mg) per night, for up to four weeks[7]
- Benzodiazepines should be prescribed at the lowest effective dose for a short duration; no more than four weeks, but preferably five to ten days
- A short-acting benzodiazepine should be chosen, as long-acting benzodiazepines cause greater next day drowsiness and associated adverse effects[5]

**For the treatment of anxiety**, benzodiazepines:

- Should not be routinely used except as a short-term measure during crises[8]
- Are not recommended for the treatment of stress following a traumatic event[9]
- Are only recommended for short-term use, e.g. two to four weeks

Other treatment options for anxiety include psychological support and counselling, SSRIs, tricyclic antidepressants and buspirone.

**In elderly patients:**

- Lower doses of benzodiazepines or zopiclone, e.g. half the normal adult dose, are likely to be necessary to minimise adverse effects, due to reduced renal clearance
- Benzodiazepines with a long half-life, e.g. diazepam and nitrazepam, should be avoided due to an increased risk of falls with next-day drowsiness

If benzodiazepines or zopiclone are prescribed**, consider a treatment plan which covers treatment duration, dose parameters, outcome measures, adverse effects and review dates.** This can be written as a contract if necessary, and helps the patient to understand the expectations of their treatment and provides a safeguard for the clinician to avoid escalation of prescribing. The treatment plan can state that regular reviews will take place and that no repeat prescriptions will be made without in-person contact.[10] Patients should be given information about adverse effects, and understand that benzodiazepines or zopiclone are for short-term use only and they should continue with non-pharmacological approaches for managing their insomnia or anxiety.

 For further information on the treatment of insomnia, see: **www.bpac.org.nz/BPJ/2008/June/insomnia.aspx**

 For further information on the treatment of generalised anxiety disorder in adults, see: **www.bpac.org.nz/BPJ/2009/December/anxiety.aspx**

 For further information on the treatment of anxiety disorders in young people, see: **www.bpac.org.nz/BPJ/2015/December/mental-health.aspx**

## Withdrawing treatment

Patients who have been using benzodiazepines or zopiclone long-term should be encouraged to stop. Strategies involve attempting to realign the patient's perceptions of risks and benefits, such as:

- Providing information about discontinuing benzodiazepines, e.g.:
  - 'Stopping benzodiazepines and Z-drugs', available from: **http://medical.cdn.patient.co.uk/pdf/4638.pdf**
  - 'Benzodiazepines (tranquillisers and sleeping pills)', available from: **www.reconnexion.org.au/secure/downloadfile.asp?fileid=1015143**
- Regular follow-up letters to patients informing or reminding them of the risks of benzodiazepine use and the benefits of withdrawal
- Fortnightly consultations during withdrawal
- Psychological support: counselling or referral to psychological support services **substantially improves rates of discontinuation** over and above patient education or follow-up approaches

**Withdrawal should be "slow but sure".** A gradual taper improves the success rate of discontinuation and avoids or reduces effects of withdrawal. Rapid withdrawal of benzodiazepines is associated with an increased risk of seizures, therefore patients should be warned not to stop their medicine abruptly. Patients who have been taking benzodiazepines or zopiclone at high doses (e.g. > 20 mg diazepam per day) or

for a long period of time (e.g. more than ten years) are best discussed with an addiction specialist before attempting withdrawal.

For further information, see: "Overuse of benzodiazepines: still an issue?", BPJ 66 (Feb, 2015).

**References:**


1. Brayfield A (ed). Martindale: the complete drug reference. London: Pharmaceutical Press. Available from: http://www.medicinescomplete.com (Accessed Dec, 2015).
2. Wu C-S, Ting T-T, Wang S-C, et al. Effect of benzodiazepine discontinuation on dementia risk. Am J Geriatr Psychiatry 2011;19:151–9. doi:10.1097/JGP.0b013e3181e049ca
3. Billioti de Gage S, Moride Y, Ducruet T, et al. Benzodiazepine use and risk of Alzheimer's disease: case-control study. BMJ 2014;349:g5205. doi:10.1136/bmj.g5205
4. Health Quality & Safety Commission (HQSC). Polypharmacy in older people. HQSC, 2015. Available from: http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/polypharmacy-in-older-people/ (Accessed Dec, 2015).
5. Morin CM, Benca R. Chronic insomnia. Lancet 2012;379:1129–41. doi:10.1016/S0140-6736(11)60750-2
6. Wagner J, Wagner ML. Non-benzodiazepines for the treatment of insomnia. Sleep Med Rev 2000;4:551–81. doi:10.1053/smrv.2000.0126
7. New Zealand Formulary (NZF). NZF v42. 2015. Available from: www.nzf.org.nz (Accessed Dec, 2015).
8. National Institute for Health Care Excellence (NICE). Anxiety disorders. London: NICE, 2014. Available from: https://www.nice.org.uk/guidance/qs53 (Accessed Dec, 2015).
9. World Health Organisation. WHO guidelines on conditions specifically related to stress. WHO, 2013. Available from: http://www.who.int/mental_health/emergencies/stress_guidelines/en/ (Accessed Dec, 2015).
10. The Royal Australian College of General Practitioners (RACGP). Prescribing drugs of dependence in general practice, Part B. Benzodiazepines. Melbourne: RACGP, 2015. Available from: http://www.racgp.org.au/your-practice/guidelines/drugs-of-dependence-b (Accessed Dec, 2015).


# Addressing mental health and wellbeing in young people

Two recent articles in the Best Practice Journal covered primary care approaches to young people with mental health issues. This is part of an ongoing series with more to come on this topic in 2016. So far, the articles have introduced current statistics relating to mental health and wellbeing in young people in New Zealand, guidance for identifying those who need assistance and non-pharmacological approaches to frequently encountered mental health problems in young people that can be carried out in primary care.

Key mental health statistics for young people in New Zealand include:[1–3]

- New Zealand has one of the highest rates of youth suicide in the OECD
- 10% of females and 5% of males aged 15 to 24 years report high levels of psychological distress
- In a sample of secondary school students covering 3% of the 2012 New Zealand secondary school roll, 21% of females and 10% of males had seriously thought about suicide in the last 12 months

**Risk factors for mental health issues in young people** include events early in life, such as childhood trauma, physical or sexual abuse, poverty and social deprivation.[4] In addition, young people of Māori or Pacific ethnicity and those who identify as LGBTI (lesbian, gay, bisexual, transgender or intersex) are at an increased risk of experiencing mental health issues.

**Opportunistic screening in primary care is a key strategy to detect young people in need of assistance.** A HEADS assessment (also referred to with multiple letters, e.g. HEEADDSSS) is a semi-structured interview covering aspects related to Home, Education and Employment, Eating and Exercise, Activities and peers, Drugs and Alcohol, Depression and suicide, Sexual health and the young person's Safety and Strengths.

Key points for clinicians to consider when conducting a HEADS assessment include:

- Explain the purpose of the assessment so a young person does not wonder why they are being asked questions unrelated to their visit
- Ensure that young people understand that information they provide is confidential
- Begin with topics that a young person is likely to find non-threatening