HELPING PEOPLE OFF BENZODIAZEPINES

AN EVALUATION OF
A PILOT INITIATIVE RUN BY
THE PRESCRIBED MEDICATION SUPPORT SERVICE
IN CONWY.

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Background

The Prescribed Medication Support Service of the North East Wales NHS Trust offers support to adults of any age (18 years and above) including the elderly who are prescribed any medication that is potentially dependency forming, such as, minor tranquillisers, anti-depressants, and painkillers. Support is also given to people who are dependent on over-the-counter preparations. Priority is given to pregnant women to minimise any potential harm to the unborn child.

Initial issues that can potentially lead to medication dependence

- Bereavement
- Stress
- Life events
- Depression / anxiety

Effects of long-term use/ dependence on medication

- Side-effects that require additional medical investigation and treatment.
- Increased risk of falls in the elderly.
- Increased risk of road traffic accidents.
- Risk of fatal overdose.

Benefits of withdrawal

- Physical and mental health gains.
- Increased self-esteem and confidence.
- Increased rates of return to work or education.

Abrupt cessation of prescribed medications can lead to severe and prolonged withdrawal symptoms (Ashton, 2002) and as such, a gradual reduction of medication is encouraged by the Service. A stepped care approach is adopted in which the level of intervention is increased in line with the needs of the client (Russel & Lader, 1993) and the Service works to the NICE guidelines for anxiety, depression and the prevention of falls in the elderly (NICE, 2004a; NICE, 2004b; NICE, 2004c). A body of research evidence indicates that the reducing regimes used by the Service such as individualised withdrawal programmes are effective methods for reducing medication use (Gorgels et al., 2005; Oude Voshaar, Couvée, van Balkom, Mulder, & Zitman, 2006). Furthermore, patients who also receive talking

therapies such as cognitive-behaviour therapy are found to benefit more than those who receive the reducing regime alone (Oude Voshaar et al., 2006). This suggests that the reducing regimes and counselling provided by the Prescribed Medication Support Service are effective methods of minimising the problems and side-effects associated with long-term medication use.

Until recently the service was offered across three Local Health Board areas, that of Wrexham Maelor, Flintshire, and Denbighshire. This covers a population of 370,000 who are looked after by 64 GP Practices. Research indicates that long-term use of sleeping tablets and minor tranquillisers alone (medications known as benzodiazepines) among the general population is between 0.6% and 3.9% (Baker, Tait, & Fraser, 1994). These figures suggest a potential client base of between 2,220 and 14,430 people although the total figure will be higher when other prescribed medications are taken into account. Typically clients are referred to the Service through their GP, Mental Health Team, Drugs and Alcohol Team or via self-referral, although a number of GP Practices specifically request help to reduce their prescribing levels. In these instances potential clients are identified and offered support before they reach a crisis point.

The team employed to manage this task consists of a Service Manager, Support Worker, and Administrator, all of whom work part-time, and 20 volunteer counsellors. The counsellors support the work of the clinical team by providing regular therapeutic sessions, often on a weekly basis, depending upon the needs of the client.

Recently the Conwy Local Health Board agreed to fund a pilot initiative in which the Prescribed Medication Support Service extended its operation into Conwy for an initial period of 12 months (2006-07). This report documents the details and outcomes of this project.

The Conwy Pilot Project (2006-07)

The development of a Prescribed Medication Support Service in Conwy was initiated and funded by Conwy Local Health Board to tackle levels of

benzodiazepine prescribing within the area that were higher than the National Targets otherwise known as SaFF (Service and Financial Framework) targets. These targets focus on national priorities with the aim to improve the quality and cost effectiveness of prescribing in primary care. In particular, this target encourages GPs to follow the advice of the Committee on the Safety of Medicines (1988) and the British National Formulary (2005) that benzodiazepine medicines should only be used for short periods of between two to four weeks (see Appendix 1 for full details of advice regarding benzodiazepine prescription). Thus, the main incentives for carrying out the project were to address inequalities in health care provision across the area and to increase the Quality of Life of long-term users of benzodiazepines. A further benefit of reducing the overall number of benzodiazepine prescriptions is the reduced likelihood that these medications are ever traded as illicit drugs.

Conwy has a population of around 110,000 who are looked after by 19 GP Practices. Based on the estimates from research findings this suggests that between 660 and 4274 people in Conwy may be long-term users of benzodiazepines, although this figure may well be higher given the pockets of high levels of prescribing within the area. The effects on local people are very difficult to measure and quantify because benzodiazepine use is a largely hidden problem, however, at its extreme, documentation shows that 68 people were admitted to local hospitals with benzodiazepine poisoning during the course of the pilot project year.

Funding for the project was provided to cover the employment of a Support Worker (RGN and Psychotherapist) for 20 hours per week and the expenses of a team of volunteer counsellors. The project ran from the end of May 2006 for an initial 12-month period. Although a number of clients were referred directly for help, the Service did not set out to operate on a referral basis. Instead the pilot project sought to reduce the level of prescribing by working closely with the five GP Practices that had the highest levels of benzodiazepine prescribing.

Within these five GP Practices the Support Worker had three distinct roles; firstly to promote good prescribing practices through the education of health professionals about the current guidelines (see Appendix 1), and secondly to give direct clinical support to long-term users of

benzodiazepines who wanted to withdraw from their medication. The third role consisted of preventative work in which GPs could refer patients to the Support Worker prior to issuing an initial benzodiazepine prescription. The Support Worker then provided education and information for the specific problem. Leaflets produced by Conwy LHB were provided to give advice on sleeping tablets, slips, trips and falls, and getting a good nights sleep. Further publications such as 'Sleep problems: A Self-Help Guide' and 'Understanding and Coping with Stress and Anxiety: A Self-Help Guide' produced by Newcastle, North Tyneside and Northumberland Mental Health NHS Trust (1999 & 2000) were also available.

The following protocol describes the process undertaken for helping people to reduce their medication.

Protocol for Benzodiazepine Reduction

1. The Support Worker worked alongside Pharmacists to identify long-term users of benzodiazepines (patients who have ordered more than 6 prescriptions in the previous 12 months) by using computer searches at GP Practices.

2. Exclusion criteria were used to identify people not suitable to be included in the project (see Appendix 2 for a full list of the exclusion criteria) and the final lists were agreed with the GP.

3. Intervention level 1 (brief intervention): The people on the final list were sent an educational letter explaining the benefits of medication reduction and how to start the reduction process (see Appendix 3 for a copy of the letter).

4. Intervention level 2 (follow-up letter): If there was no contact from a client or evidence that they were reducing their medication a follow-up letter was sent six weeks later (see Appendix 4 for a copy of the letter).

5. Intervention level 3 (minimal intervention): Additional input in the form of a single consultation to provide advice and support at the GP Practice, at home, or on the telephone was classed as a minimal intervention.

6. Intervention level 4 (structured withdrawal): For people who experienced more difficulty with the withdrawal process a more detailed support package was offered. Firstly an initial assessment of both physical and mental health was conducted and where appropriate follow-up referrals were made to the GP or Mental Health Teams for further investigation. Then a personal reducing regime was designed and regular follow-up meetings with the Support Worker were scheduled at six-week intervals. Additional options available included auricular acupuncture sessions (which are often useful to reduce stress, ease withdrawal cravings and aid sleep) and counselling sessions. Counselling was available on a one-to-one basis for weekly sessions and is beneficial for addressing psychological issues connected with withdrawal or the initial problem that lead to the use of the medication.

Throughout the course of the project monthly clinics run by the Service Manager were also held for people dependent upon painkillers.

Findings

GP Levels of Prescribing

The level of benzodiazepine prescribing of all five GP Practices taking part in the project, as measured by the Daily Divided Dose per 1000 patient units, declined by 651.47 between June 2006 and June 2007. This equates to an average reduction of 130.29 per GP Practice compared to an average reduction of 46.10 for the 14 GP Practices not taking part in the project over the same time period. The difference in the outcome between the GP Practices included and not included in the project was not statistically significant according to analysis using a Mann-Whitney test, $U = 24.00$, *ns*. However, this is likely to be influenced by the use of such small sample sizes.

Levels of client intervention

Details of the number of clients receiving each level of intervention at each GP Practice are presented in Table 1. Within the structured withdrawal intervention five voluntary counsellors provided 34 hours of one-to-one sessions with clients and gave an additional 110 hours of their time to the Service.

Table 1. The number of people receiving each level of intervention during the Prescribed Medication Support Service pilot project in Conwy (2006-07).

GP Practice	Brief intervention	Follow-up letter	Minimal intervention	Structured withdrawal	Total
Kinmel Bay	49	9	25	8	91
West Shore	32	27	5	5	69
Gyffin	24	9	8	10	51
Craig y Don	18	24	8	1	51
Tyn y Coed	15	0	1	0	16
Case Load	0	0	0	26	26
Total	**138**	**69**	**47**	**50**	**304**

Out of the 304 clients receiving an intervention 99 reduced their benzodiazepine medication and 37 stopped completely during the pilot project (see Chart 1 below). Of the other 168 no reduction was reported for the following reasons:

- The client chose not to / was unable to reduce
- the client stopped or reduced then restarted again
- the client left the GP Practice
- the client died
- prevention advice was given
- no information on outcome was available

Chart 1: The overall percentage of clients who stopped, reduced or did not report a reduction in their benzodiazepine use during the pilot project

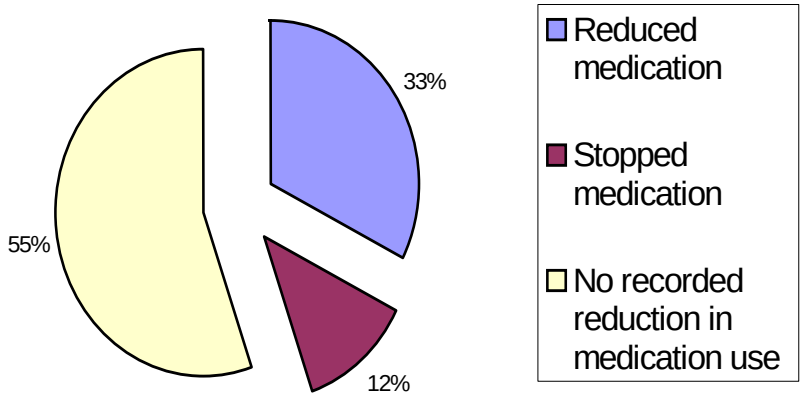


Chart two shows the percentage of clients from each GP Practice and the caseload who stopped or reduced their benzodiazepine medication during the pilot project. It shows a reasonably even pattern for the GP Practices with the exception of Tyn y Coed which had a lower positive response, and the caseload which had a higher positive response than the GP Practices. A full breakdown of the number and percentage of clients from each GP Practice responding positively to each type of intervention can be found in Appendix 5.

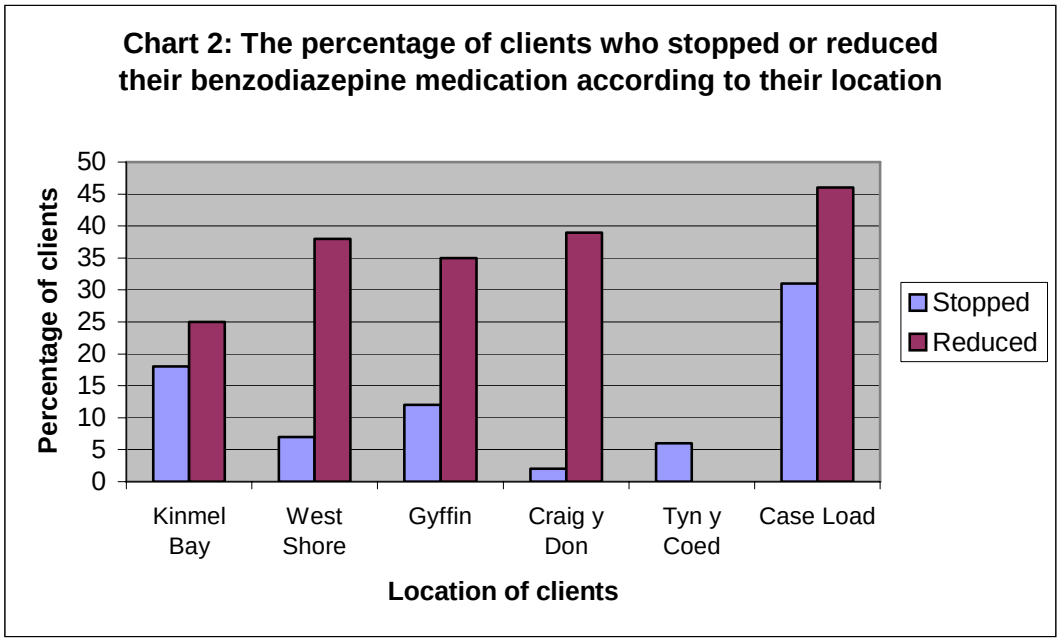
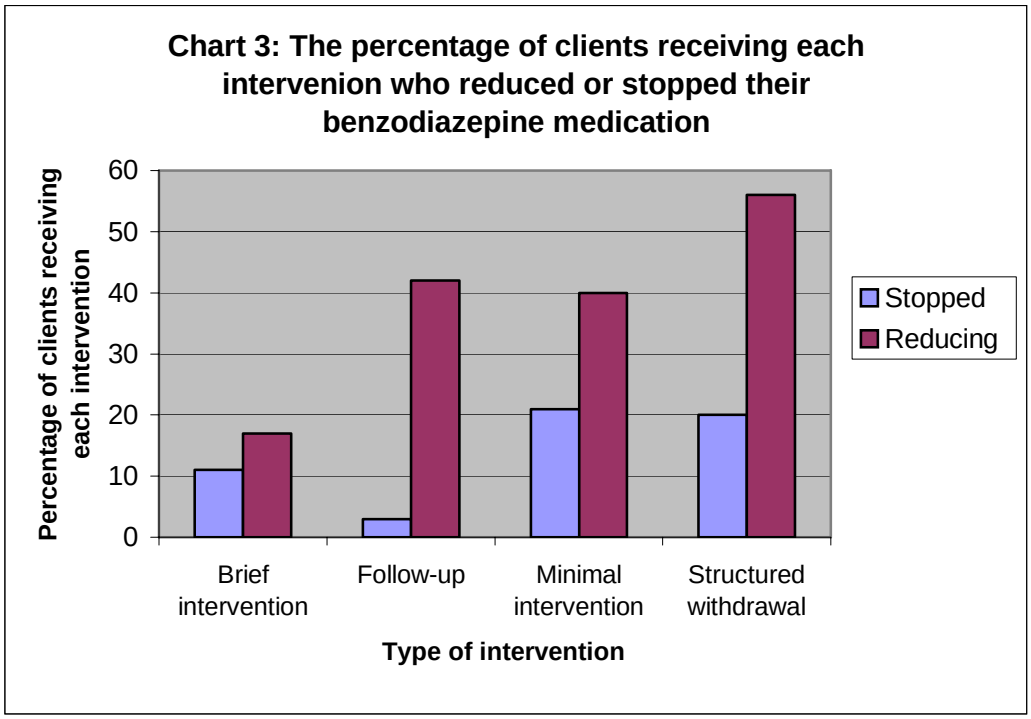


Chart three (below) shows the effectiveness of each level of intervention in terms of the percentage of clients who reduced and stopped their benzodiazepine medication during the course of the project. The percentage of clients who responded positively to the interventions increased in line with the intensity of the intervention.



The Client Experience

Two clients who used the Service during the pilot project kindly agreed to talk about their experiences. They were both long-term users of benzodiazepines and had been purposely selected to be asked to take part because of their insight and experience. One client was male and the other female. They took part in a semi-structured interview over the telephone that began with open-ended questions about how they heard about the service, which intervention programme they used, access to the service and suggestions to improve the service. They were also asked how long they had taken benzodiazepines, the original reason for starting, their current level of benzodiazepine use and how life is different now. They both consented to quotes from their interviews being published but identifying information has been removed to ensure anonymity.

The Service – One client found the Service by word of mouth as they were actively looking for help, whereas the other was told about the Service at their GP Practice. Both underwent a structured withdrawal programme and one used acupuncture which they found "very useful" and the other attended regular counselling sessions which they described as "tremendously helpful". Both clients reported finding access to the Service easy with appointments made to suit their own requirements. There was also agreement that the way to improve the Service would be to increase its availability so more people would have the opportunity for support. One client commented that they would like more specialists in the area and a greater awareness of the Service from GPs and other health professionals.

Personal stories – One client had been taking benzodiazepines for three to four years and the other for a long time, the height of their use was ten years ago. The reasons given for starting the medication were anxiety and a combination of bereavement, depression and life events including divorce. Both clients were virtually free of the medication with one client describing their use as "very occasional". When asked how their life was now different they responded:

> Client 1: At first the medication was very helpful but towards the end of my medication use I couldn't function and risked losing everything… family and work. I became depressed when on Benzodiazepines. I was unusual in that I managed to keep on working [while taking Benzodiazepines] and my job keeps me going.
>
> I have no complaints [about the Service]. I can't speak highly enough about it.
>
> Client 2: Medication masked the problem, it [the problem] didn't go away. I took 18 months off work. I was sleeping all the time, couldn't drive, was withdrawn and thinking very negatively. I would cry at the drop of a hat. At its worst life wasn't worth living. Now…I'm back at work, have positive ideas, cope better with life events, and sleep better. I'm not so uptight. I'm bubbly and upbeat.

> The Service is wonderful, can't praise it enough. Gill is helpful, understanding …..and gave me ideas for coping. It's not just a job to her, she really cares.

Conclusions

The effectiveness of the pilot project can be measured in a number of objective ways such as the level of GP prescribing and the numbers or percentages of people reducing or stopping their use of benzodiazepines.

There are a number of difficulties when trying to compare the levels of GP prescribing by the GP Practices included in this project and those who were not included. Firstly, the small sample sizes that are involved. Secondly, the different starting points for working with each GP Practice, and thirdly an inability to control for information reaching the comparison group, through for example, locum GPs working across various GP Practices. Nevertheless, over the duration of the project the average reduction in benzodiazepine prescribing by the five GP Practices taking part was nearly three times greater than the average reduction in prescribing of the GP Practices not taking part in the project suggesting that the project made a valuable clinical difference.

The levels of positive response (reduction and stopping benzodiazepine use) to the brief intervention are in line with those of published British research studies (Cormack, Sweeney, Hughes-Jones, & Foot, 1994; Morgan, Wright, & Chrystyn, 2002), suggesting that the practical difficulties of working in a clinical setting rather than in a controlled research setting were overcome. Furthermore, the increased effectiveness of the more intense interventions is also in line with the research findings (Oude Voshaar et al., 2006), indicating that the skills the specialised staff provide have greater effectiveness than generic educational tools. In the current study 24% of people requested further advice through a minimal intervention and 16% were helped using a structured withdrawal programme. Therefore in the future it may be possible for pharmacists or nurses to set-up a brief intervention and follow-up programme but it is essential that specialist staff

are in place to provide additional resources to help those who find the withdrawal process more difficult.

The clients who spoke about the Service rated their experiences very highly. Suggested areas for improvement concerned raising the profile of the Service among GPs, health professionals and the general public alike to help increase client access to the Service. It appears that a significant barrier to withdrawal from prescribed medication is that people don't know that specialist help is available.

Recommendations

- The new substance misuse strategy of the Welsh Assembly Government (2008) 'Working Together to Reduce Harm' calls for the reduction of inappropriately prescribed benzodiazepines. The success of the pilot project in reducing the levels of benzodiazepine prescribing therefore indicates that it would be beneficial to widen the Service across the whole of the Conwy area to continue the promotion of equality in benzodiazepine prescribing and health care provision.

- In the first instance the continued working with GP Practices with high levels of benzodiazepine prescribing is recommended to continue the education of health professionals until a culture of short-term prescribing of benzodiazepines becomes more established. This will enable relationships to be developed with the GP Practices and establish partnership working between the different health professionals involved.

- Increased access to specialist staff for prevention advice is recommended to provide GPs with a viable alternative to prescribing benzodiazepines. This will also help to reduce the future demands on the GP Practice by helping people to avoid taking benzodiazepines in the first place.

- Furthermore, the creation of regular minimal intervention clinics across the area would raise the profile of the Service with both health

professionals and clients alike and would also allow staff to spend more time in direct clinical work and reduce travel between appointments.

- The further strengthening of links with the voluntary sector, for example, with the Carers Outreach Service is an important area for development both to raise the profile of the Service and also to provide information and support to people affected by the long-term use of medication.

- In the future pharmacists or nurses may perform the administration of the brief intervention and follow-up but it is important to have specialist staff in place to provide minimal interventions and structured withdrawal programmes for the proportion of people who find withdrawal more difficult. In addition to individual counselling sessions therapeutic benefits could also be attained through the development of group sessions which foster peer support.

- A key element for implementing the above recommendations is the provision of sufficient specialist staff. The pilot project was conducted with one person working 20 hours a week so in order to widen the Service and increase the access to specialist staff for intervention clinics and prevention advice it is recommended that the part-time position is developed into a full-time post. The costs of doing this for a Band 6 Support Worker would be an additional £13,500 per annum. In addition, the support of a paid counsellor at Band 5 for 10 hours a week is recommended to increase the capacity for therapeutic work and reduce waiting times for this element of the Service. This would cost £6,600 per annum.

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Appendix 1

Guidelines for the prescription of benzodiazepines

CSM ADVICE ON BENZODIAZEPINES (1988)

1. Benzodiazepines are indicated for the short-term relief (2-4 weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic or psychotic illness.
2. The use of benzodiazepines to treat short-term 'mild' anxiety is inappropriate and unsuitable.
3. Benzodiazepines should be used to treat insomnia only when it is severe, disabling, or subjecting the individual to extreme distress.

NICE Guidance (2004): Insomnia – newer hypnotic drugs (No. 77)

NICE has made the following recommendations about the use of zaleplon, zolpidem and zopiclone to treat insomnia.

- When, after due consideration of the use of non-pharmacological measures, hypnotic drug therapy is considered appropriate for the management of severe insomnia interfering with normal daily life, it is recommended that hypnotics should be prescribed for short periods of time only, in strict accordance with their licensed indications.
- It is recommended that, because of the lack of compelling evidence to distinguish between zaleplon, zolpidem, zopiclone or the shorter acting benzodiazepine hypnotics, the drug with the lowest purchase cost (taking into account daily required dose and product price per dose) should be prescribed.
- It is recommended that switching from one of these hypnotics to another should only occur if a patient experiences adverse effects considered to be directly related to a specific agent.
- Patients who have not responded to one of these hypnotic drugs should not be prescribed any of the others.

Appendix 2

Exclusion Criteria

Exclusion criteria for identifying people not suitable to be included in the project

1. Methadone/alcohol withdrawal
2. Terminal illness
3. Chronic depression
4. Patients currently experiencing crisis
5. At risk of suicide
6. History of psychosis (or other major psychiatric disorder) or concurrent psychiatric problems
7. Under care of psychiatric services who are not suitable for reduction
8. Organic brain disease
9. Prescribed benzodiazepines as an anti-convulsant or muscle relaxant
10. On-going anxiety symptoms
11. Care home/MDS patients
12. Age greater than 70 years (the age restriction was dropped during the year after successful outcomes with adults approaching this age. A person's 'readiness for change' was found to be a more important predictor of positive outcome than their biological age)

Appendix 3

Letter sent out as brief intervention

Practice Header

~[Todays Date]

~[Name]
~[Patient Address (List)]

Dear ~[Title] ~[Surname]

We are writing to you because we note from your records that you have been taking sedatives or minor tranquillisers for some time now. Your doctor, is concerned about this kind of medication when it is taken over a long time, as the body can get used to these tablets so that they no longer work properly. Also, long-term use of this medicine can cause anxiety, day time drowsiness, reduce memory and increase the likelihood of accidents or falls.

What we would like to do is to reduce the amount of tablets you are taking with the possibility of stopping them at a future date. We do not want you to stop taking them suddenly as this could cause some unpleasant effects.

Our aim is to make you less dependent on these tablets. We would like you to consider reducing your medication. To encourage you to do this we are slightly reducing the amount of sedative tablets on your prescription. To try to reduce the number of tablets that you take and to make this supply last the full month we suggest

* try to reduce slowly every two to four weeks until you wean yourself off the drug.

* contact the surgery to meet the Prescribed Medication Support Worker with the option of receiving an individualised reduction programme.

If you would like further help or advice please contact the Practice.

Yours sincerely,

Gill Fitzpatrick & Rory Wilkinson
Prescribed Medication Support Worker/ Prescribing Support Pharmacist
We are both available most Tuesdays.

Appendix 4

Follow-up letter

Practice Header

~[Todays Date]

~[Name]
~[Patient Address (List)]

Dear ~[Title] ~[Surname]

We recently wrote to you regarding your sedative medication and we suggested that you consider trying to reduce this medication. The reasons for suggesting you reduce your medication are that this type of medication when taken over a long time can cause drug-induced anxiety, day time drowsiness, muscle weakness and impaired balance which can increase the likelihood of serious falls (leading to an increased risk of hip fracture). Long term use may also cause problems with your memory and judgement.
We suggest that you tried taking less each day (e.g. half a tablet instead of a full tablet) and then continue to reduce slowly every two to three weeks until you have gradually weaned yourself off the drug or contacting the surgery to meet Gill Fitzpatrick (the Prescribed Medication Support Worker) to discuss an appropriate reducing programme for you.

As we have not heard from you we would like to know whether you felt able to reduce your medication, if you have tried and had difficulties or if you are currently reducing. Please can you complete the form below and return to the Practice.

Many thanks.

Yours sincerely,

Gill Fitzpatrick & Gill Boothman
Prescribed Medication Support Worker/ Prescribing Support Pharmacist

To: Gill Fitzpatrick, Prescribed Medication Support Worker at [Name] Practice

From:……

O I am currently reducing my medication
O I would consider reducing my medication but need further support
O I would like to discuss my medication
O I would like Gill Fitzpatrick to contact me
O I do not want to reduce my medication

Gill Fitzpatrick can be contacted at [Name] Practice on Tuesday mornings (by telephone or appointment) or on 0782 441 6865.

Appendix 5
Positive response rates to each intervention per GP Practice

Table 2: Positive response rates to the brief intervention per GP Practice

Practice	Number of clients	Stopped	Reducing
Kinmel Bay	49	9 (18%)	7 (14%)
West Shore	32	3 (9%)	7 (22%)
Gyffin	24	3 (13%)	4 (17%)
Craig yDon	18	0 (0%)	5 (28%)
Tyn y Coed	15	0 (0%)	0 (0%)
Total	138	15 (11%)	23 (17%)

Table 3: Positive response rates to the follow-up letter per GP Practice

Practice	Number of clients	Stopped	Reducing
Kinmel Bay	9	0 (0%)	4 (44%)
West Shore	27	1 (4%)	14 (52%)
Gyffin	9	0 (0%)	2 (22%)
Craig yDon	24	1 (4%)	9 (38%)
Tyn y Coed	0	0 (0%)	0 (0%)
Total	69	2 (3%)	29 (42%)

Table 4: Positive response rates to the minimal intervention per GP Practice

Practice	Number of clients	Stopped	Reducing
Kinmel Bay	25	6 (25%)	7 (29%)
West Shore	5	1 (20%)	3 (60%)
Gyffin	8	2 (25%)	4 (50%)
Craig yDon	8	0 (0%)	5 (63%)
Tyn y Coed	1	1 (100%)	0 (0%)
Total	47	10 (21%)	19 (40%)

Table 5: Positive response rates to the structured withdrawal per GP Practice

Practice	Number of clients	Stopped	Reducing
Kinmel Bay	8	1 (13%)	5 (63%)
West Shore	5	0 (0%)	2 (40%)
Gyffin	10	1 (10%)	8 (80%)
Craig yDon	1	0 (0%)	1 (100%)
Tyn y Coed	0	0 (0%)	0 (0%)
Case load	26	8 (31%)	12 (46%)
Total	50	10 (20%)	28 (56%)