

Executive summary: Benzodiazepines sleeping through the problem

(Avoiding of) Initiation of benzodiazepines in primary health care. Perceptions of general practitioners, patients and nurses

by

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Benzodiazepines (BZD) are one of the most commonly taken psychotropic drugs in our society. The prescription of benzodiazepines is often a standard practice for incidents or complaints of anxiety and insomnia in primary care. Prolonged benzodiazepine use is a widespread phenomenon in medical practice even though there are numerous adverse effects and it is associated with dependence. The first prescription for a benzodiazepine can be the start of a long-term experience with benzodiazepines. Guidelines argue with the recommendation that the best way to avoid dependence is by careful prescription and – where possible – by avoiding initial prescription and using non-pharmacological approaches. Yet, contrary to the vast amount of publications on the chronic prescription of benzodiazepines in general, published research on the initiation of benzodiazepine prescription is scarce.

To understand the complexity of the phenomenon we investigated BZD usage from different angles. In this thesis a description of the perceptions of three different actors is given, namely the patient, the general practitioner and the nurse (in a nursing home setting) and how they might influence each other in initiating and maintaining benzodiazepine usage. This should lead to an understanding of how avoiding the use of benzodiazepines might be achieved. Findings on perceptions and attitudes of patients, GPs and nurses can lead to a better insight in the enabling or restraining barriers that can lead to a more rational use of benzodiazepines.

At the start of a benzodiazepine treatment the GP and the patient can be seen as a tandem that responds to each other's needs (findings from paper I and paper II). Both GPs and patients experienced satisfaction and dissatisfaction in relation to initiating a benzodiazepine treatment. They developed strategies to 'justify' the negative connotations surrounding the start of a BZD treatment. First time benzodiazepine users maximise the impact of their problems on daily life and the GP feels overwhelmed by these psychosocial issues.

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Patients also ask for help but place the responsibility of the solution with their general practitioner ('external locus of control'). The GP's sense of helplessness and his/her strong willingness to help the patient may trigger a first prescription. GPs should develop communication strategies to persuade patients that they take the problem seriously even though consultations do not always end with a prescription.

Doctors overrate the positive effect of starting a benzodiazepine treatment and underestimate the side effects. On the other hand, patients minimise their intake. So benzodiazepines are viewed as the 'lesser evil' by both patients and general practitioner as they have limited access to alternatives.

General practitioners in our study do not link dependence on BZD with first time users. GPs prescribe BZDs to help minimise complaints in the short term without paying much attention to risk of chronic usage (paper II). It becomes clear in paper I that initial users have already entered a pattern of psychological dependence. The danger exists that a lot of these 'first time users' will ask for a renewal of their prescription and if necessary put some pressure on their GP in order to receive that renewal which in turn will make it difficult for the GP to refuse a renewal.

Paper III indicates that some GPs are open to using a non-pharmacological approach but experience considerable constraints. One of the main barriers is that GPs have a lack of knowledge and do not feel confident in implementing these approaches and experience time constraints in an 'average' consultation. Choices of GPs are only made from a limited set of options with which they are familiar. A non-pharmacological approach can be either directly done by the GP him/herself or through the resources available within the community as for example social services and psychologists. GPs must take responsibility for creating a network with other professionals in primary care and effectively communicating with other professions. GPs can have a coordinating role in referral and at the same time take into account the needs of each individual patient.

The role of the GP is not always a curative one. Acknowledgement of patients' problems and feelings and to give insight in underlying cause of their symptoms is an important first step. Ideas, concerns and expectations of patients need to be clarified.

Only by fully understanding the whole problem can be decided which aspects can be tackled and how. Not all problems will have solutions or will require solutions, as a health care provider it is important to guide the patient into acceptance of certain situations.

A first essential step is that GPs have to be aware of and have knowledge of non-pharmacological approaches (see findings paper III) before they can actually apply this approach in their daily doctor-patient relationship.

As we can see in paper IV the use of benzodiazepines in nursing home settings is of particular concern, as nursing home residents receive considerably more benzodiazepines than the non-institutionalised elderly. The prescriber is still the general practitioner, but because of the GP's irregular and often short contacts with the residents, the nurse can play an important

role in whether or not a patient will receive a BZD or whether or not a patient will withdraw from a BZD treatment.

Nurses are often the 'go-between' amongst patient and general practitioner (findings paper IV). Their advice is thus of great importance in the process. They can have an important role in informing the patient on anxiety, stress and sleeping problems. Also, they can adjust the expectations, beliefs, concerns and sometimes behaviour of the patients. An important conclusion from our study is that once a benzodiazepine is prescribed by the GP, the consumption will easily be prolonged for an indefinite period. The risk exists that there is no further follow-up of the need for or the necessity of the medication once it has started and benzodiazepine usage becomes part of a routine procedure and is maintained by lack of evaluation. Another striking finding was that nurses' personal views sometimes were in discrepancy with their professional views. Some nurses were personally in favour of non-pharmacological approaches and would like to withdraw more patients from benzodiazepines, yet the professional views of the colleagues (nurses and doctors) and structural barriers were more dominant and were to be respected. However, there is a large potential role for nurses in using non-pharmacological approaches and in closely monitoring BZD usage and withdrawal. Education to provide more insight into the problems of insomnia and anxiety may positively influence their attitudes and behaviour.

Finally, all caregivers in nursing homes should be correctly informed about the relevance of this issue and confronted with their responsibilities.

The process of prescribing refers to all interventions and interactions between patients and providers. GPs' role as providing continuity of care, GPs' and nurses' communication skills and active listening instead of prescribing can assist patients in the process, referral to other health care or community providers. A better coordination at the system level would considerably improve integrated care. Multidisciplinary approaches need to be stimulated. Professionalisation increasingly involves creating networks and working together with a range of other professionals.

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