The College

Benzodiazepines and Dependence:

A College Statement

There is increasing concern, both among doctors and the lay public, on the potential for dependence of the benzodiazepine group of drugs. In order that the Royal College of Psychiatrists could publish a view on this contentious topic, a consensus meeting was arranged on 10 June 1987 by the Programmes and Meetings Committee (see list of participants). The following statement has now been approved by the College.

(1) **Actions of benzodiazepines**

(a) *Anxiety reducing effect*

Benzodiazepines should be primarily prescribed for the short-term relief of anxiety when it is:

(i) disabling
(ii) severe or
(iii) subjecting the individual to unacceptable distress.

In the above cases, benzodiazepines ideally should be prescribed for no more than one month.

Benzodiazepines may be prescribed where anxiety is complicated by other illnesses, but caution should be observed in prescribing them when the disorder is already chronic. The long-term use of any compound to deal with mild anxiety is not in general advised. The consequences of long-term usage are liable to far outweigh the symptomatic relief.

There is not sufficient evidence to support the use of benzodiazepines for obsessional states.

(b) *Sleep inducing effect*

The prescribing of benzodiazepines is suitable for some cases when insomnia is:

(i) disabling
(ii) severe or
(iii) subjecting the individual to extreme distress.

Benzodiazepines for sleep induction should ideally be given only intermittently either in in-patient or out-patient settings. As much care must be taken in the prescribing of benzodiazepines for insomnia as for anxiety.

There has been in the past an automatic assumption that benzodiazepines should be given for sleep disturbance. It is extremely important that doctors should look at the underlying causes for insomnia before deciding upon the use of drugs for symptomatic relief. If benzodiazepines are prescribed for insomnia, then this should be at a low dosage, not every night, and normally for a maximum period of one month.

(c) *Antispasmodic and anticonvulsive* and (d) *Physical symptoms accompanied by psychological distress*

The consensus meeting did not wish to comment on the above indications as it was felt that the use of benzodiazepines for these purposes was outside the remit of this particular meeting. The meeting, however, stressed that the same disadvantages (including dependence) may arise from the prescribing of benzodiazepines for these conditions.

(e) *Amnesia and other cognitive impairments*

Amnesia is frequently a real side effect of the use of benzodiazepines and not just a figment of the individual's imagination or a coincident symptom of emotional disorder.

It is often inadvisable to prescribe benzodiazepines to a patient in an acute crisis as the amnesic property of these compounds may not allow patients to make an optimum response to the situation which they are facing. In cases of loss or bereavement, the psychological adjustment to this trauma may be severely inhibited by benzodiazepines and any tendency to denial could be reinforced.

(f) *Disinhibition*

Studies which have looked at the disinhibiting effects of benzodiazepines prescribed for patients with personality disorders have shown that they may increase the incidence of suicidal behaviour i.e. thoughts of suicide may become actions. The use of benzodiazepines by this category of patient may facilitate aggressive behaviour not only towards the self but also towards others.

It is very important to recognise that benzodiazepines can exacerbate these problems of behaviour and extreme caution should therefore be used in prescribing such compounds in patients with severe personality disorders. The likelihood of dependence in individuals suffering from these disorders is also high.

(g) *Psychomotor impairment*

There is a danger that higher doses of benzodiazepines may

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cause psychomotor impairment which could affect such activities as driving and working with machinery. The longer acting compounds may accumulate and cause side-effects such as dysarthria, ataxia and diplopia.

Extreme vigilance must be taken to ensure that these compounds do not affect psychomotor skills, thus rendering the patient incapable of proper responses.

(h) *Non-psychiatric use*

It is recognised that the use of benzodiazepines has been (and is still) far too widespread and they are frequently prescribed for trivial and imprecise indications. This has arisen from the belief that benzodiazepines were safe compounds.

It is now acknowledged that the risks of benzodiazepines far outweigh the benefits in many cases and we would recommend that benzodiazepines should not be used in general for vague or mild disorders and should be prescribed for short-term relief only when the problem is:

(i) disabling
(ii) severe or
(iii) subjecting the individual to unacceptable distress and even then should ideally be prescribed for no more than one month.

(i) *Depression*

Depression is not a primary indication for benzodiazepines. However, if the depression is accompanied by anxiety then, in severe cases, benzodiazepines may be prescribed for short-term relief when the problem is:

(i) disabling
(ii) severe or
(iii) subjecting the individual to extreme distress

and should be prescribed for no more than one month.

The prescribing of benzodiazepines in cases of depression may have serious consequences and may precipitate suicide. Withdrawal from benzodiazepines in many cases may precipitate depression.

(j) *Excitement, agitation and severe psychotic disturbance*

In-patients expressing symptoms of excitement, agitation and severe psychotic disturbance should be prescribed benzodiazepines only on specialist advice and then for a very short time, in view of the disinhibiting action of these drugs. The prescribing of benzodiazepines for chronic psychosis is not normally recommended.

(2) **Dosage regimes**

Benzodiazepines should be prescribed in as low a dose as possible. Although it is difficult to produce a risk table, in general compounds of higher potency incur a greater level of dependence.

The arguments produced against long-term use of these compounds must be more widely recognised and patients should be encouraged to withdraw gradually from long-term use. Sudden withdrawal may be extremely distressing and possibly dangerous. High dose dependence is common, but it must also be accepted that dependence on benzodiazepines in therapeutic doses is also common. All pharmaceutical companies should produce formulations of their compounds at lower strengths which could be used also to help patients reduce from higher doses.

Even after the short-term use of benzodiazepines for therapeutic reasons, we would recommend a tapering-off regime (i.e. two weeks at reduced dosage) to minimise rebound. The longer the use of benzodiazepines the longer is the reduction period that would be indicated.

Recommendation: The dosage in the *British National Formulary* for benzodiazepines is not always applicable. For instance, the lowest dose of lorazepam given in the *British National Formulary* (1 mg) is stronger than the lowest dose given of the other benzodiazepines. It would therefore be very valuable to publish a table of equivalents.

Conclusion: Although the clinical judgement of the clinician is crucial as to the dose to be prescribed, we hope to inform our members more adequately in order for them to make the best decisions possible.

(3) **Dependence**

The intermittent use of, or the dependence on high doses of, benzodiazepines for non-medical purposes is qualitatively not such a great problem as with other psychotropic drugs such as amphetamines and barbiturates. There is evidence that benzodiazepines used on their own are relatively safe, but when used in conjunction with alcohol and antidepressants this is not the case.

Certain benzodiazepines are associated with dependence and some have more severe withdrawal reactions than others. It may be that the use of benzodiazepines of low potency can reduce the risk of long-term dependence.

(4) **Possible research topics**

The following research topics were suggested:

(a) the possible use of alternatives to benzodiazepines (especially as anxiolytics and hypnotics);
(b) the incidence of dependence and the differential effects of various drugs in this respect;
(c) strategies for getting patients off medication when dependent (not only physically but psychologically);
(d) collaborative studies with general practitioners on alternatives to pharmaceutical strategies, and an evaluation and study of the motivation needed by clinicians to adhere to the strategies.

PROF R. G. PRIEST
Chairman
Psychopharmacology Working Party

DR S. A. MONTGOMERY
Chairman
Programmes and Meetings Committee

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List of Participants

Name	Appointment
Dr G. Burton	Committee for the Safety of Medicines, DHSS
Dr S. Levine	Oldham & District General Hospital
Prof M. Lader	Institute of Psychiatry
Prof R. G. Priest	Registrar, Royal College of Psychiatrists
Dr T. Corn	The Wellcome Research Laboratories
Dr P. Tyrer	Mapperley Hospital
Prof H. L. Freeman	Editor, *British Journal of Psychiatry*
Dr S. A. Montgomery	Chairman, Programmes and Meetings Committee

Guidelines for regional advisers on consultant posts in hospital and community rehabilitation

The special problems of management posed by those suffering from chronic mental illness is linked to the need to develop facilities for care of patients outside hospital. With the move towards locally based psychiatric services it is vital that each district has a consultant whose responsibility lies in these fields. It is important to recall that much psychiatric illness becomes chronic.

These problems are the prime responsibility of the consultant in rehabilitation and community care. Such a post is an essential component of the District Service as described in the recent College report *Psychiatric Rehabilitation Updated*. (*Bulletin*, February 1987, **11**, 71).

Specifications for consultant posts in rehabilitation and community psychiatry should be tailored to suit local needs. Although there is a need for flexibility to reflect the particular organisation of services in any District, as a guideline there should be a minimum commitment of 0.2 FTE/100,000 total population. It is expected that the Regional Adviser will consult with the Specialty Regional Representative for Rehabilitation nominated by the Section for Social and Community Psychiatry.

(1) **The nature of the post**

(a) *Population to be served.* The population to be served should be clearly defined in terms of total (i) all ages and (ii) the number over 65. There should be a description of the catchment area in terms of geography and social structure and there should be comment on any sociodemographic or other features of the catchment population which create unusual service needs.

(b) *Organisation.* There should be a District Rehabilitation Committee or equivalent structure with representation from NHS, Local Authorities and relevant voluntary Sector agencies. This should be accepted by the statutory authorities as the prime source of advice for planning, developing and monitoring rehabilitation services. The consultant in rehabilitation should be the medical representative on this committee.

(c) *Facilities—general.* There should be a clear statement of the facilities in the hospital and in the community, both these will be the responsibility of the appointee and those, e.g. hostels, group homes, day centres, with which s/he will be expected to work but over which s/he will not have direct control. There must also be a clear statement of the development plans for the District and the role within these plans which the appointee is expected to fulfil.

(d) *In-patient facilities.* Most posts, though not all, will have in-patient beds. No post should involve work solely on long-stay hospital wards. If the post holder is responsible for long-stay wards, then it should be clearly stated that admission to these wards and discharge from them, is under the control of the rehabilitation consultant and that the beds are not available for admission to other consultants. In-patient beds must be supported by adequate occupational therapy and clinical psychology services.