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General practitioners' opinions of a stepped-care benzodiazepine discontinuation programme

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Introduction

Effective interventions are available for general practitioners (GPs) to reduce unwarranted long-term benzodiazepine use (1–3). A majority of GPs report the intention to critically discuss discontinuation of long-term benzodiazepine use with their patients but neglect to effectuate this intention (4). Therefore, GPs' experiences with the feasibility of these interventions are crucial for successful implementation.

Methods

A postal survey was conducted exploring the opinions and experiences of 56 GPs (working in 30 general practices) with the feasibility of a stepwise benzodiazepine reduction programme (the Benzo-redux programme) (5,6). The questionnaire (available on request) was sent 2 months after the end of the second and last intervention. It consisted of 23 statements that had to be rated on a five-point Likert scale (afterwards recoded on a three-point scale: agree, neutral, disagree), six dichotomous yes/no questions with room for explanation, and four open questions.

The programme was carried out between August 1998 and December 2001 (Figure 1). First, we identified all patients that had used benzodiazepines for over 3 months ($n=2964$), who were subsequently checked by their GPs for inclusion and exclusion criteria. As the first intervention, we sent a personal discontinuation letter ($n=2004$). Three months later, subjects were invited by letter (and telephone in case of no response) for an evaluation

consultation. During this evaluation consultation, GPs motivated non-quitters to participate in the second intervention by using conversational advice derived from the stages-of-change concept (7). Of the non-quitters, only 180 patients took part in this second intervention consisting of a three-group randomized trial comparing tapering off supervised by the GPs, with and without five additional sessions of group psychotherapy, with a usual-care control group. In both active treatment groups, patients visited their GPs six times to reduce their benzodiazepine dosage by 25% per week after being transferred to an equivalent dosage of diazepam. Abstinence was achieved by one-quarter of the patients after the discontinuation letter and by two-thirds after tapering off. During the 15–21-month follow-up, half of all quitters remained completely abstinent (5,6,8,9).

Results

We received responses from 55 of the 56 general practitioners (98%). According to normal-sized Dutch practice (2350 patients), we identified an average of 59 long-term benzodiazepine users, of whom 40 received the discontinuation letter. GPs needed less than 5 min per patient to check exclusion criteria and 15 min for an evaluation consultation. The GPs reported that, in general, patients reacted positively about the discontinuation letter; 30 GPs (58%) had at least one patient who gave a strikingly positive reaction, mostly appreciation of the care of the GPs. On the other hand, one-third of the GPs (36%) experienced at least one strikingly

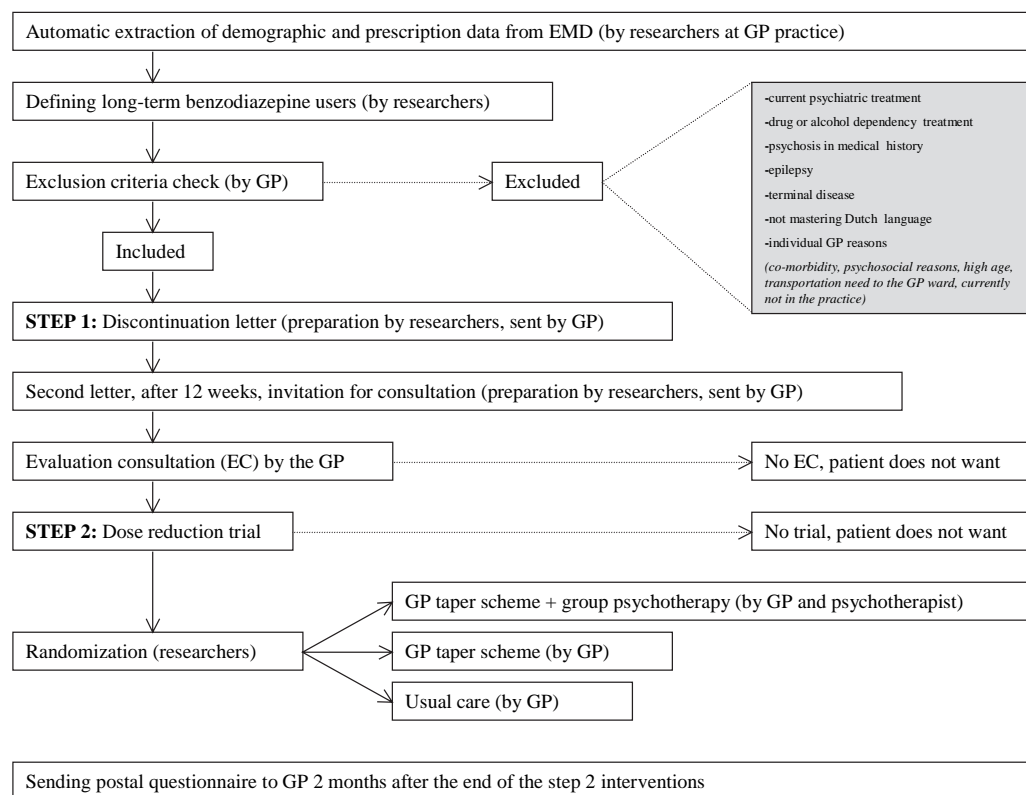


Figure 1. Operational flow chart of the Benzoredux programme.

negative reaction from a patient; their anger in most cases could be interpreted as concern about the willingness of their GP to continue their usage.

For each GP, we divided the sending of letters into two parts with a 4-week interval; 39 GPs (71%) were able to organize the evaluation consultations efficiently within their daily practice, while six GPs (11%) could not. The conversational advice to motivate non-quitters for the second intervention was well received by the GPs: 36 (67%) used them, and 32 (59%) thought their consultations improved by using them. Furthermore, 46 (83%) GPs indicated the importance of sufficient conversational advice for GPs in using this motivational strategy.

Most GPs (84%) considered the duration and number of reduction steps of the tapering-off scheme just right. Some recommendations were given to use it more individually, especially for low-dose users, e.g., no transfer to diazepam, fewer dosage-reduction steps, or only consultation by telephone. Moreover, 44 GPs (81%) would recommend colleagues to taper patients themselves, of which 39 (75%) would recommend our scheme. Satisfaction with the tapering-off scheme was also reflected by the fact that two out of three GPs used the tapering-off scheme for patients outside the trial (6). Interestingly, 32 GPs (78%) would encourage patients to take part in group psychotherapy sessions to support tapering

off, although they also reported that these patients were not easier to supervise, and our trial results also did not support superiority over tapering off alone.

Discussion

A stepwise benzodiazepine reduction programme was well received by GPs. Most GPs (82%) experienced no increase in medical consumption. Possibilities for individual tailoring may enhance satisfaction of GPs participating in benzodiazepine reduction programmes. The support and backup given by the researchers, e.g., identifying long-term users, preparing discontinuation letters, and defining the taper schemes, may have increased the enthusiasm of GPs. It may be worthwhile to offer this support to GPs when our programme is implemented in clinical practice.

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