MONASH University

A MIXED METHODS EVALUATION OF THE RECONNEXION BENZODIAZEPINE SUPPORT AND COUNSELLING SERVICE

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reconneXion
Treating Panic, Anxiety, Depression and Tranquilliser Dependency
a service of each

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Executive Summary

Medium to long-term benzodiazepine use has been associated with a range of adverse health outcomes and high rates of dependence. Notwithstanding this, reducing the consumption of benzodiazepines is a complex process and individuals often require professional assistance for successful tapering and withdrawal. An evaluation of the services provided by Reconnexion, the only community-based benzodiazepine withdrawal support and counselling service in Australia, was undertaken to examine the effectiveness of the service and identify areas for improvement in meeting the needs of individuals withdrawing from benzodiazepines. The mixed-methods evaluation incorporated data from three key stakeholder groups. Firstly, client experiences of benzodiazepine dependence and withdrawal were investigated. Secondly the perceptions of counsellors and other key staff who are working directly with individuals experiencing benzodiazepine dependence were captured. Finally, the contributions of telephone volunteers supporting and providing information to people withdrawing from benzodiazepines were evaluated. Findings from client perceptions indicate that the Reconnexion service was highly effective in meeting their needs. Moreover, the findings highlighted:

- the necessity of a flexible client-centred approach to delivering evidence-based services
- the need for education and advocacy when collaborating with prescribing doctors
- the benefits of employing highly qualified counsellors, and
- the advantages of using a trauma-informed approach with this client population.

The study reinforces past research on the importance of supervision and professional development in supporting and sustaining the workforce. Finally, findings support the value of a telephone information and support helpline in providing social and emotional support to clients, and in maintaining client engagement with treatment.

Benzodiazepines

Benzodiazepines (BZDs) are a class of psychoactive drugs that slow down the activity of the central nervous system and are commonly prescribed for the treatment of anxiety disorders and sleep disturbances (Australian Drug Foundation, ADF, 2018). In Australia, BZDs are classified as drugs of dependence, meaning that they are a controlled substance that require a medical prescription to be legally purchased from a pharmacy. Benzodiazepines are intended for short-term use and should only be used uninterruptedly for a maximum of two to four weeks. When used as recommended, beneficial effects of consuming BZDs include anxiety reduction, control of epileptic seizures, relief from muscle spasms, assistance with sleep onset and temporary relief from insomnia (Baldwin et al., 2013).

The long-term use of BZDs (i.e., over four weeks) often leads to dependence and adverse side effects. For instance, long-term users can experience memory impairments, emotional blunting (the inability to experience pleasure or pain) and pseudodementia. Paradoxical stimulant effects can also occur, leading users to experience increased anxiety. Long-term use of BZDs may cause or exacerbate depressive symptoms, and occasionally, the drugs may precipitate suicidal tendencies (Ashton, 2013). Continued use of BZDs has also been associated with over-sedation, causing the user to experience drowsiness, poor concentration, psychomotor impairment, lack of coordination, muscle weakness, dizziness and mental confusion (ADF, 2018; Ashton, 2013). Despite studies finding that elderly populations are at an even greater risk of experiencing life threatening outcomes as a result of BZD overuse, older adults make up a large proportion of long-term users (Neutel, Skurtveit, & Berg, 2012).

Signs indicative of a person being dependent on BZDs include requiring the drug to be able to function in daily life, increased tolerance, an escalation of dosage, continued use of the drug despite awareness of negative effects, and experiencing a withdrawal syndrome (Ashton, 2005). The most common symptoms associated with benzodiazepine withdrawal include anxiety, autonomic dysfunction, agitation, seizures, hallucinations, and panic attacks (Ashton, 2013). Withdrawal from BZDs is recommended for medium to long term users, nevertheless because of the withdrawal symptoms outlined above, a slow taper utilising lower doses of the medication over a period of time is generally advised (Ashton, 2005; Baldwin et al., 2013; Lader, 2011).

Why Reconnexion exists

Despite the known adverse effects of long-term BZD use, individuals have been prescribed them for months or even years (Ashton, 2005). Approximately seven million prescriptions for BZDs are filled in Australia each year under the Pharmaceutical Benefits Scheme (Ware & Thorson, 2016). Withdrawing from long-term BZD use is a complex and lengthy process. The most widely accepted approach to withdrawal is known as the 'Ashton tapering method', of which the two fundamental components are slow tapering of the dose and psychological support for the user (Ashton, 2013; Lader, Tylee, & Donoghue, 2009). Clinical guidelines advise tapering dosages down 10% every 1-2 weeks (Frei et al., 2012; Psychotropic Expert Group, 2013). The tapering schedule must be tailored to each person, considering the unique needs and characteristics of the individual. This includes, but is not limited to, personality factors, personal ability to adapt, lifestyle, environmental stresses, reasons for taking BZDs, social support, and current dosage. The overall withdrawal process may take weeks, months or possibly years (Ashton, 2013; Lader et al., 2009). Evidence-based psychological support includes cognitive behavioural therapy, motivational interviewing and supportive counselling, which may include strategies such as letters from general medical practitioners advising a reduction or complete cessation of BZD use (Darker, Sweeney, Barry, Farrell, & Donnelly-Swift, 2015).

Reconnexion, a Victorian state-wide service of EACH funded by the Department of Health and Human Services (DHHS), is the only benzodiazepine specialist service in Australia. It is a community-based, non-government organization which provides benzodiazepine dependency treatment according to the Ashton tapering method in an outpatient setting. Services provided by Reconnexion include benzodiazepine dependency counselling, a volunteer support phone line, and secondary consultations with prescribing doctors. In addition, Reconnexion delivers workshops and education for prescribers and the broader Victorian community.

The evaluation

An evaluation of the services provided by Reconnexion was necessary to ascertain its effectiveness and to identify areas for improvement in meeting the needs of individuals withdrawing from BZDs. The purpose of this evaluation was to assess and report on the performance of Reconnexion across the range of quality standards outlined in the Australian Health Performance Framework (AHPF, The National Health Information and Performance Principal Committee, 2017). This framework is useful in assessing the performance of services across a range of dimensions including client needs, system infrastructure, and staff wellbeing. The evaluation framework encourages accountability from organisations to continually improve the quality of care that consumers receive. The knowledge gained from the evaluation aids in identifying areas where outcomes have not been achieved or where change is necessary.

Research questions were developed and guided by the AHPF domains of *effectiveness*, *continuity of care*, *appropriateness*, *accessibility,* and *efficiency and sustainability*. Three studies were conducted for this evaluation. Study 1 presents an analysis of the extent to which Reconnexion benzodiazepine withdrawal services meet the needs of individuals reducing their benzodiazepine consumption. Study 2 provides perceptions of system performance directly from paid workers implementing services. Study 3 investigates the contribution volunteers make to improving client outcomes and discusses the impact that a volunteer support line has on achieving these health program standards.

The findings may be used to aid development, quality assurance, and improvements in providing withdrawal counselling services to individuals experiencing benzodiazepine dependence.

Method

A sequential, explanatory mixed methods design (Creswell & Creswell, 2017) was employed for the evaluation.

Three discrete groups of key stakeholders were surveyed to capture:

1. client experiences of benzodiazepine dependence and withdrawal (Study 1)
2. the perceptions of counsellors and other key staff who are working directly with individuals experiencing benzodiazepine dependence (Study 2), and
3. the contribution of telephone volunteers supporting and providing information to people withdrawing from BZDs (Study 3).

Ethics approval was sought and granted through the Monash University Human Research Ethics Committee (MUHREC) in April 2018. In each of the three studies qualitative data were analysed using Saldana's (2013) data coding method followed by Braun and Clarke's (2006) approach to thematic analysis.

Study 1 – Client self-completion measures and interviews

Design

In phase one of the client study, quantitative data were collected using the Victorian Alcohol and Other Drug (AOD) Self-Completion Form (DHHS, 2018). This was followed by semi-structured interviews with a smaller number of participants in phase two. Phase two qualitative data were used to explain and elaborate on the findings obtained from the quantitative data.

Participants

Phase one quantitative data were available for 24 clients (female = 10, male = 14) who had sought individual counselling for BZD withdrawal and support. Participating clients were aged between 27 and 83 years and had attended an average of eight counselling sessions. Of these 24 participants, six participants who had attended the service between May and July 2018 during the phase-two recruitment, agreed to a follow-up individual interview. Five of these participants were female and one was male.

Materials

The Victorian Alcohol and Other Drugs Self-Completion Form (DHHS, 2018) was used to measure the effectiveness and appropriateness dimensions of the AHPF. Specifically, benzodiazepine consumption over the preceding 28 days was measured by the Drug Use Disorders Identification Test (DUDIT) which forms part of the self-completion form. A DUDIT sample item is: "In the past four weeks (28 days) have you used any of the following substances? If yes, record number of days and how much you used in the past four weeks."

The self-completion form also contained the Kessler 10 (K10, (Kessler et al., 2002), a psychometric tool used to measure self-reported levels of psychological distress. The K10 asks participants ten questions, for example, "During the past 30 days how often did you feel tired for no good reason?". Participants then rate themselves on a 5-point-Likert scale ranging from 1 = *none of the time* to 5 = *all of the time*. Good validity and reliability have been found for the K10 across different cultural and sociodemographic subsamples.

Two client reported experience measures were also included in the study. The first asked clients to rate the degree to which they felt respected by their counsellor and the second rated the level of confidence clients had in the service. Phase two qualitative data were captured using a semi-structured interview protocol (see Appendix A).

Procedure

An invitation to participate, an explanatory statement, and consent forms were provided to all current and recent clients of Reconnexion during the months May-July 2018. Participants agreed to the use of data from their self-completion form at the time of intake and at the time of service completion (phase 1). Participants could also consent to receiving a follow-up phone call to arrange to be included in a confidential individual interview with a research team member from Monash University (i.e., phase 2).

Interviews took place at the Reconnexion office or in the participant's home in August-September 2018 and were audio-recorded and transcribed. Quantitative data were analysed using SPSS version 25 and G Power was used to calculate effect sizes.

Study 2 – Staff interviews

Participants

Participants in study two were eight (female = 7, male = 1) staff members who were employed in counselling, supervision, program support and management roles. Of the six counsellors, three were registered psychologists, two were provisionally registered psychologists and one was a mental health social worker. Two of the psychologists held an endorsement, one in counselling psychology, and one in health psychology, and two were working towards endorsement. All counsellors were employed on a part-time basis and the duration of employment ranged from 1.5 years to 25 years.

Materials

The interview protocol was adapted from the NSW Government Evaluation Toolkit (New South Wales Government, 2018) and consisted of open-ended questions that encouraged exploration. The staff questions aligned with the relevant evaluation questions including: the program's effectiveness and its match with the established evidence-base, counsellor qualifications necessary to provide counselling services to clients, responsiveness to client needs, accessibility, positive aspects and challenges, and staff supervision and professional development (Appendix B).

Procedure

The interviews were conducted between July and August 2018 with staff at their main service site in Melbourne. Six interviews were face-to-face, two were via telephone. Interviews lasted between 30 and 50 minutes and were audio-recorded with the written consent of participants. Audio recordings were then transcribed verbatim, identifying information was removed and all names were replaced. Counsellors and staff were invited to share their professional experiences regarding service delivery and were given the opportunity to add information that they perceived as relevant or important.

Study 3 – Volunteer focus groups

Participants

Participants were 12 volunteers (females = 10, males = 2), aged between 22 to 40 years old. Eleven of the volunteers who participated in the focus groups held a degree and one participant was in the process of finishing undergraduate studies. Six of the volunteers were currently studying a fourth-year honours, graduate diploma or higher degree in psychology.

Materials

The focus group protocol contained a structed set of questions which started with an opening phase, introductory phase, transition phase, key questions and ending questions (Krueger & Casey, 2009). The protocol can be found in Appendix C.

Procedure

All active volunteers were invited to participate in the study and informed of what their involvement in the research would entail. An explanatory statement was distributed to each participant before gaining consent and commencing each focus group. Five separate focus groups were held in July 2018. Focus groups were audio recorded and transcribed using a combination of Dragon Naturally Speaking software and manual transcription.

Findings

Study 1 – Client outcomes

Effectiveness

Quantitative data relating to the extent of benzodiazepine use over the preceding 28 days indicated that, overall, there was a general reduction in benzodiazepine use by the 24 participants (Figure 1). Eighty-eight percent of participants reported either reduced use or withdrawal from BZDs following individual BZD counselling from Reconnexion. In addition to BZD use, participants were also asked about their use of alcohol and other substances. Over the past 28 days, 46% of participants had also reduced their use of alcohol and other substances.

"I FEEL SAFE AND PROTECTED WITH (COUNSELLOR), I TELL HER EVERYTHING"

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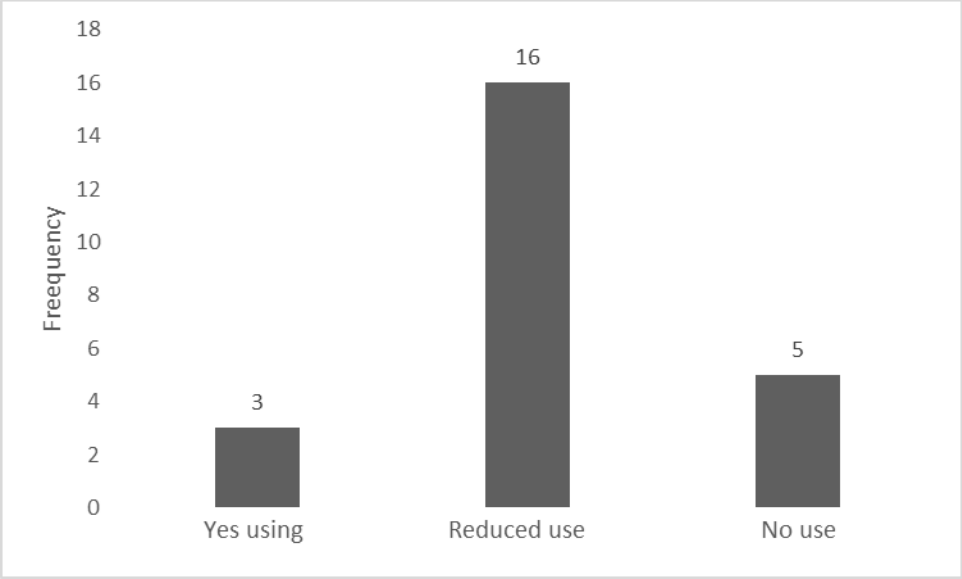

Figure 1. Use of benzodiazepines over the past 28 days.

A paired samples *t*-test was used to compare levels of psychological distress experienced by 21 clients, pre and post-counselling. Comparison of pre-counselling K10 scores (M = 27.61, SD = 10.15) with their post-counselling K10 scores (M = 21.28, SD = 8.39) revealed a statistically significant reduction in scores following the counselling intervention (t = 3.87, df = 20, p = .001, d = 0.83). The effect size (d = 0.83) is classified as large using Cohen's (1988) convention for interpreting effect sizes. These results show significant reductions in clients' self-reported psychological distress following targeted counselling for benzodiazepine withdrawal.

Client interviews

The reported experiences of participants with the Reconnexion program were generally very positive and corroborate the effectiveness of psycho-social support during withdrawal. Comments referred, specifically, to the overall effectiveness of the benzodiazepine withdrawal interventions. A main theme which emerged related to the perception that the service effectively met service-user needs. Also, very saliently, there were myriad observations regarding the professional therapeutic relationship between the participants and their respective counsellors. Clients comments included

- *"Improved my quality of life…"*
- *"My perceptions are very good…really pleasant place to be, empowering place. They know what they're doing…knowledge and personal skills to bring to people in their everyday lives"*
- *"…functioning the way I am because of Reconnexion"*
- *"It was the relationship with (counsellor) that helped me"*
- *"I've confidence in their skills"*
- *"My counsellor does goal-setting, monitors progress on reduction program, very empathetic and supportive, reminds me of the commitment I have made, understands me. Very supportive, no judgement, (I am) confident in the counsellors."*
- *"I received the results I wanted…can't speak highly enough of them…"*

"IF (COUNSELLOR) COULD GET PSYCHIATRISTS INVOLVED, THINGS WOULD BE GOOD, AND, (OTHER) SERVICE PROVIDERS (ARE NOT) VERY KNOWLEDGEABLE" (CLIENT)

"I RECEIVED THE RESULTS I WANTED…CAN'T SPEAK HIGHLY ENOUGH OF THEM." (CLIENT)

Safety

Participants' comments regarding the overall safe ambience of Reconnexion were positive. Clients appreciated that the office environment was warm and welcoming, and the administration staff were consistently kind and were always offering a cup of tea or coffee. Comments referred to the *"friendly, family feeling atmosphere…"* at Reconnexion and to the *"…feeling of safety there"*. One participant expressed: *"I feel safe and protected with (counsellor), I tell her everything"*.

Accessibility

"NOT ALL BZD USERS ARE UNEMPLOYED… (BUSINESS HOURS) SHOULD CHANGE IF SERIOUS ABOUT PROVIDING AN (ACCESSIBLE) SERVICE…" (CLIENT)

Reconnexion was considered to be geographically accessible due to the availability of free parking and public transport in the area. Moreover, participants evaluated the service as financially accessible, with two participants noting the service was available free-of-charge to those who could not afford to pay[1]. Participants generally agreed that the service's business hours were acceptable, but could be improved. One participant noted that *"not all benzodiazepine users are unemployed… (business hours) should change if serious about providing an (accessible) service…"*. To support this

[1] Due to changes in funding since data were collected for this report, the benzodiazepine withdrawal service is now free of charge for all clients.

idea of flexibility, all participants who were interviewed strongly supported a Reconnexion 24/7 helpline being developed. Participants' statements in support of this idea included *"If I need help (after hours), I (would) go to hospital ED. But, yes 24/7 helpline service would be extremely helpful…"* and "[It would be of] *benefit if Reconnexion had a 24/7 helpline…Doesn't restrict to business hours… Different to LifeLine…Specific expertise in specific area".*

Appropriateness

Quantitative data from two client-report experience measures were used to evaluate the appropriateness of the service. These ratings captured clients' confidence in the counsellor's knowledge and the extent to which clients felt respected. Eighty-seven percent of clients either agreed or strongly agreed with the statement "You felt confident in your counsellor's knowledge and skills" (Figure 2).

> *"MY COUNSELLOR DOES GOAL-SETTING, MONITORS PROGRESS ON REDUCTION PROGRAM, VERY EMPATHETIC AND SUPPORTIVE, REMINDS ME OF THE COMMITMENT I HAVE MADE, UNDERSTANDS ME. VERY SUPPORTIVE, NO JUDGEMENT, (I AM) CONFIDENT IN THE COUNSELLORS." (CLIENT)*

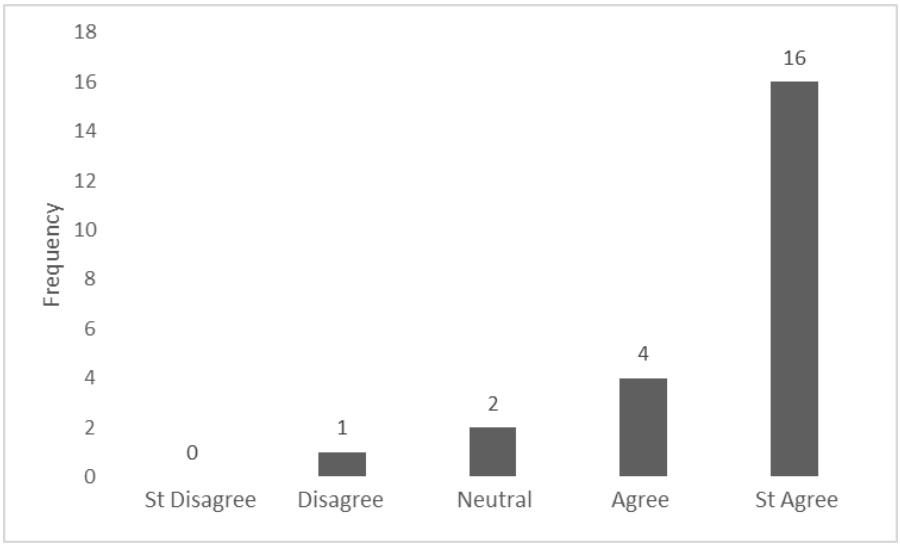

Figure 2. Confidence in counsellors' knowledge and skills

Almost all participants (95.8%) reported feeling respected by Reconnexion staff (Figure 3).

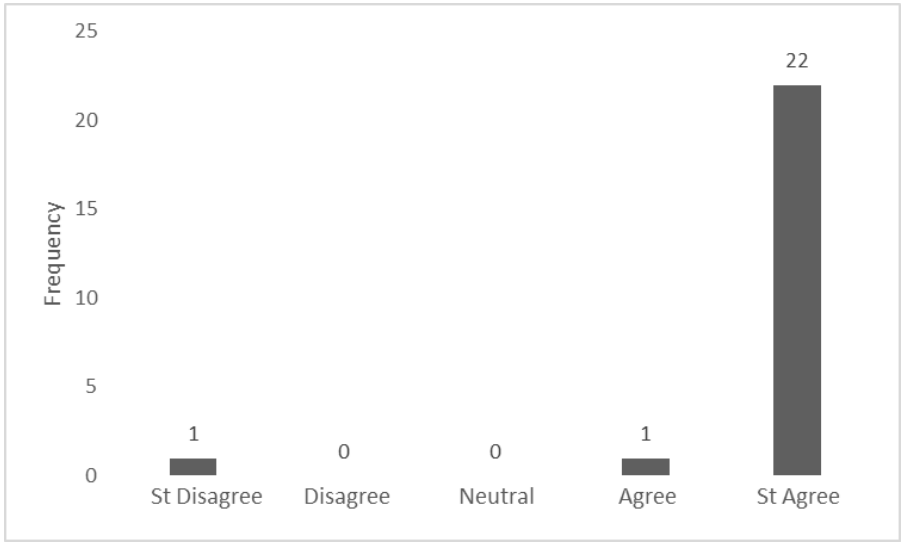

Figure 3. Felt respected by the counsellor.

Client interviews

"USE OF THE ASHTON METHOD WAS HELPFUL, USEFUL FRAMEWORK TO HELP ME… STEPPED TAPERING PROGRAM" (CLIENT)

There was considerable feedback regarding the appropriateness of the Reconnexion community-based service delivery model as distinct from AOD residential rehabilitation/inpatient services. Overall, community-based approaches were perceived as better suited to client's needs. As one participant noted the *"community model keeps you in the community with your supports around you".* Notwithstanding, this there was clearly a place for residential programs, with one participant stating that *"initially, at start of treatment, inpatient care may be useful…If there was an integrated residential rehabilitation and inpatient system, that would be good."*

In general, participants found that the use of a controlled taper was appropriate. As one participant noted the *"Ashton method was* [a] *useful framework to help me…"* and that the program allowed for client control during the withdrawal. "[I] *could express myself, felt supported all through withdrawal process".* Nonetheless, the substitution of longer acting benzodiazepines (e.g., Diazepam) in the taper process was perceived by some clients as problematic e.g., *"I objected to taking Valium", "… they squeeze people into a treatment model".* This sentiment underscores the importance of psychoeducation during the withdrawal process and the need for clients to have some awareness of basic drug metabolism and the different half-life of long and short acting BZDs.

"(I) COULD EXPRESS MYSELF, FELT SUPPORTED ALL THROUGH WITHDRAWAL PROCESS" (CLIENT)

Continuity of Care

In study one, continuity of care was assessed by investigating the broader level of cooperation and coordination between services offered by Reconnexion staff and services offered by other health professionals/organisations such as general medical practitioners, psychiatrists, and public mental health services including Crisis Assessment and Treatment Teams. Clients reported inconsistent experiences in this domain. When the various services cooperated, clients valued the high level of coordinated care. When care was not coordinated this often led to client frustration and was perceived to have a detrimental effect on the withdrawal process. Participants comments included:

- *"lack of cooperation and integration between parties for the benefit of client outcomes and clinical goals"*
- *"services could be good if they were more integrated…"*
- *"need psychiatrist(s) who will work in conjunction with Reconnexion"*
- *"if* [counsellor] *could get psychiatrists involved, things would be good, …* [other] *service providers* [are not] *very knowledgeable"*

Study 2 – Interviews with service delivery staff

Effectiveness and Appropriateness

> *"BY THE TIME THEY[CLIENTS] GET HERE, THEY ARE JUST SO ANGRY AND THEY FEEL SO ABANDONED AND MISTREATED SO JUST TO HAVE A SYSTEM HERE TO TELL THEM THAT WHAT THEY'RE EXPERINCING IS REAL AND NOT IMAGINED, IT CHANGES EVERYTHING FOR THEM I THINK AND THEY REALLY APPRECIATE THE SERVICE FOR THAT (VOLUNTEER)*

Reconnexion employs a program support specialist to monitor the delivery of evidence-based services and to keep abreast of new research findings. All counsellors emphasised the necessity of collaboration with clients and the need for a client-centred approach to successful reduce or discontinue BZDs. While tapering guidelines based on the Ashton Manual (Ashton, 2002, 2013) and the Psychotropic Guidelines (Psychotropic Expert Group, 2013), both advising 10% reduction in dosage every 1-2 weeks, are used as a starting point for gradual tapered reductions, clients remain at the centre of the reduction schedule. The rate of reduction was led by clients and was tailored to their specific needs. The client-centred focus of the program was emphasised by all staff, with one counsellor stating that:

"Certainly, at the very core of the organisation that culture of being very client-centred is just inherent".

Therapeutic approaches varied between different counsellors, but all counsellors offered evidence-based interventions including cognitive behavioural therapy, acceptance and commitment therapy, motivational interviewing, interpersonal, humanistic and psychodynamic approaches. This allows counsellors to use techniques that suit their client, enhancing their ability to treat different people and varying presentations. Psychoeducation was seen to be a major element of counselling. In addition to educating clients about the fight-and-flight response and the effects of BZDs on the neural pathways, psychoeducation involved helping clients acquire skills that can be used to cope with anxiety, depression, symptoms of withdrawal and trauma, as well as skills around relapse prevention, such as managing future stress, self-regulation, and reaching out to others.

"OUR HANDS ARE TIED A BIT BECAUSE WE'RE NOT PRESCRIBERS. SO, UNLESS OUR CLIENTS WANT TO BITE THE BULLET AND FIND A DIFFERENT PRACTITIONER TO PRESCRIBE FOR THEM WHILE THEY WITHDRAW - AND MOST DON'T, BECAUSE GPS DON'T LIKE SOMEBODY ROCKING UP AND SAYING, 'I JUST WANT YOU TO SEE ME THROUGH A WITHDRAWAL'... SO THAT CAN BE REALLY TRICKY" (COUNSELLOR)

Continuity of Care

Similar to the clients who participated in Study 1, the data from staff interviews demonstrated varied experiences with general medical practitioners and psychiatrists (i.e., prescribing doctors) in relation to the coordination of the tapered withdrawal. To effectively enact a gradual tapered reduction from BZDs, counsellors needed to collaborate with the prescribing doctors. Thus, at times, counsellors had to advocate for further BZD prescribing in order for clients to complete a successful taper. Given this paradoxical position, some counsellors suggested access to an onsite general practitioner may lead to improvements in the coordination and continuity of care that is delivered. It was also suggested that ready access to an onsite general medical practitioner may lift the profile of Reconnexion, increase the status of the service, and promote closer collaboration with the broader medical profession.

Counsellors felt the service's community-based delivery model suited most clients and that clients did not generally see themselves as needing the level of oversight provided by an AOD residential treatment facility. Community-based treatment enabled clients to continue to work full-time whilst completing an agreed taper plan.

Accessibility and Efficiency

All counsellors employed at the service were highly qualified and held postgraduate psychology or social work qualifications. These qualifications were well beyond the Victorian Department of Health and Human Services minimum required Certificate IV in Alcohol and other Drugs. A manager noted that the benefit of hiring counsellors with higher qualifications is their more thorough understanding of mental health. As well as specific benzodiazepine knowledge, counsellors all highlighted that a trauma informed approach to counselling was necessary for working with this population. To that end, staff have received training on the principles of trauma-informed practice, working therapeutically with complex trauma clients and managing vicarious trauma.

> *"YOU CERTAINLY NEED SOMEONE WHO IS MORE THAN JUST DOING THE MECHANICS OF A DRUG WITHDRAWAL BECAUSE WE KNOW THAT AS SOON AS THE CLIENT STARTS IN THE PROGRAM AND STARTS WORKING ON THEIR BENZO REDUCTION IT'S HIGHLY LIKELY THAT THE INITIAL SYMPTOMS THAT THEY WERE INITIALLY PRESCRIBED BENZOS FOR RE-EMERGE, OR MAYBE WORSEN, SO THE COUNSELLORS ARE ACTUALLY WORKING WITH A WHOLE LOT OF LIFE THINGS FOR THAT CLIENT AND NOT JUST THE BENZO THING. YOU COULDN'T JUST HAVE SOMEBODY WHO'S GOT A CERT 1V IN AOD TO BE IN THE MIDDLE OF THAT SORT OF WORK." (STAFF MEMBER)*

Sustainability

Staff expressed overwhelmingly positive experiences from working at the service. Supervision and professional development were reported to be a major priority of the organisation and a high level of supervision was provided. Staff stated that they had both formal and informal regular supervision and that training and supervision was also provided to all volunteers who worked on the telephone support line.

Study 3 – Volunteer focus groups

This study was centred upon the *accessibility* and *sustainability* sections of the AHPF.

Accessibility

> *"SOMETIMES JUST ENCOURAGING THEM, REASSURING THEM, GIVING THEM OR RETELLING THEM THE SAME INFORMATION THEY ALREADY KNOW, SOMETIMES THAT'S ALL THEY'RE CALLING FOR." (VOLUNTEER)*

Findings from the focus groups conducted with the volunteers highlighted how the operation of the support line dramatically increased the availability and accessibility of specialised help for benzodiazepine dependency. The telephone helpline also facilitated the initial step into treatment and increased access to clients unable, unwilling, or too apprehensive to visit the service in person. Moreover, the focus group findings suggest that the success of treatment is not just dependent upon the client's relationship with their benzodiazepine counsellor. Success was also influenced by the support outside of their appointment times that was provided by the volunteers operating the telephone line. One concern of volunteers was that the accessibility to face-to-face counselling was limited for individuals residing outside of the south-eastern suburbs of Melbourne.

Sustainability and Efficiency

Volunteers felt that uncharged phone calls for using the support line was cost-efficient for clients, regardless of where they were located. This was mentioned multiple times throughout the focus groups in reference to the service's sustainability. As one volunteer stated, *"we get a lot of calls from interstate and occasionally overseas"*.

> *"WE GET A LOT OF CALLS FROM INTERSTATE AND OCCASIONALLY OVERSEAS" (VOLUNTEER)*

Volunteers recognised their important role in providing social and emotional support to individuals experiencing benzodiazepine dependency, which is salient in comments like *"by the time they [clients] get here, they are just so angry and they feel so abandoned and mistreated so just to have a system here to tell them that what they're experiencing is real and not imagined, it changes everything for them I think and they really appreciate the service for that"* and

"sometimes just encouraging them, reassuring them, giving them or retelling them the same information they already know, sometimes that's all they're calling for".

> *"THE FACT THAT YOU CAN'T ALWAYS GET A HOLD OF YOUR DOCTOR OR COUNSELLOR, SO WE'RE HERE 9-5 MONDAY TO FRIDAY, SO IF SOMEONE WANTS TO CALL IN, WE ARE HERE." (VOLUNTEER) "*

Moreover, the hiring of volunteers was seen to contribute to the long-standing sustainability of the service because of the low-cost base of providing the telephone helpline. While extrinsic factors such as obtaining a professional reference motivated volunteers to seek work at Reconnexion, it was the intrinsic motivators, such as giving back to the community, that propelled volunteers to continue their work for the service. Nonetheless, every volunteer expressed worries and doubts over whether they would be able to continue volunteering in the long-term, mainly due to the requirement that they dedicate a full day a week to the job.

Discussion

This study offers insights into how Reconnexion, a benzodiazepine specialist support service, can best offer quality care by considering the voices of service users and the people delivering those services. Findings support the use of a community-based, slow taper method combined with psycho-social support delivered by counsellors and telephone volunteers to assist individuals to reduce and/or discontinue their benzodiazepine use. Moreover, findings support that, while directed by evidence-based withdrawal guidelines, the process must be flexible, with a client-centred approach necessary for successful benzodiazepine discontinuation. This is in line with the literature stating that benzodiazepine withdrawal is most successful when the reduction schedule is tailored to the individual, and the client is in control of the pace (Ashton, 2005).

Therapeutic approaches varied depending on the individual counsellor; however, interventions were all evidence-based therapies recommended by the Australian Psychological Society (2018). Interventions included cognitive behavioural therapy, acceptance and commitment therapy, motivational interviewing, interpersonal, humanistic, and psychodynamic approaches. Psychoeducation was a cornerstone of the counselling process and this is consistent with the findings of systematic reviews of BZD discontinuation (Dou, Rebane, & Bardal, 2018; Mugunthan, McGuire, & Glasziou, 2011).

In line with previous research, the findings also highlight the roles volunteers play in providing appraisal, informational, instrumental and emotional support to clients (Faulkner & Davies, 2005). This social and emotional support offered by the helpline facilitated better engagement with treatment and played a major role in the positive outcomes reported by clients.

Difficulties coordinating care with other health providers can negatively impact the withdrawal process, and unsuccessful attempts at collaboration with prescribers highlights that prescribers' knowledge surrounding guidelines for longer term benzodiazepine use and withdrawal may be limited. This reinforces research suggesting that targeted education about BZDs for prescribers is necessary. It is well recognised that there is a greater need for doctors to advise patients of the potential adverse effects of regular benzodiazepine use (Magin et al., 2018; Parr, Kavanagh, Young, & McCafferty, 2006) and to inform patients of non-pharmacological psycho-social support options to assist withdrawal.

The fact that inappropriate long-term prescribing continues despite the guidelines and research linking long term BZD use with adverse health outcomes underscores the need for services that support and advocate for individuals with BZD dependence. Staff emphasised how the specialised nature of this work requires highly qualified counsellors to advocate for their clients, and to further educate prescribers to ensure well-coordinated care is provided. Overall, findings from the current study highlight how a well-supported, highly trained workforce using evidence-based psycho-social interventions can aid in the effective reduction of BZDs for clients with complex presentations.

Limitations

The small sample size used in the current evaluation limits the extent to which the findings can be generalised. In addition, it was not possible to include a comparison or control group. Selection biases may have operated in the recruitment of clients who participated and the process of evaluation may prompt staff and volunteers to present their workplace in a desirable light, leading to an overstatement of positive outcomes. Possible effects of the power structures present in all social situations can also affect the outcomes of qualitative research (Stenius et al., 2017). In addition, post-intervention data were collected within three months of clients receiving services and longer-term outcomes were not investigated. Although self-reported medication use and outcome measures

were not validated against other, independent measures of drug use, moderate to high correlations have been obtained between self-reported medication data and independent electronic monitoring devices (Monnette, Zhang, Shao, & Shi, 2018). In addition, self-report data (e.g., Patient Reported Outcome Measures, PROMS) are frequently used in evaluating health outcomes.

Recommendations

- In its current form the Reconnexion BZD withdrawal and support service was found to be highly effective with 88% of clients who participated in the evaluation reporting either reduced use or withdrawal from BZDs following individual BZD counselling. Participants' psychological distress was also significantly reduced and the effect size of the intervention was large. Secure funding will be essential if the service is to continue to be delivered in an accessible manner.
- Feedback from participating clients, staff, and volunteers indicated the service was safe, appropriate, and accessible. Efficiency and within service continuity of care was enhanced by the use of a telephone support line operated by well-trained volunteers.
- Providing BZD withdrawal interventions that are well coordinated with other health professionals and organisations was an area of challenge. The option of an onsite prescriber GP may assist in strengthening the continuity of care that is provided across different professionals/organisations and in the streamlining of the tapering process.
- Continuing education and training to expand the knowledge base of prescribers and health workers will help ensure continuity of care and that the service continues to be provided in an efficient manner.
- Expansion of working hours and online delivery of counselling to accommodate clients who need to access services outside of the standard Monday-Friday, 9am-5pm or who are more isolated may assist accessibility.
- Community education to raise awareness about the adverse effects of sustained use of BZDs beyond the recommended guidelines will continue to be an important preventative strategy.
- Expansion of the hours of operation of the telephone support line may be possible with increased flexibility for telephone support work hours.

- The implementation of specialised benzodiazepine withdrawal counselling services in high risk rural and regional areas may also increase accessibility to the service.

References

Ashton, H. (2002). *The Revised Ashton Manual*. Retrieved from https://www.benzo.org.uk

Ashton, H. (2005). The diagnosis and management of benzodiazepine dependence. *Current Opinion in Psychiatry, 18*(3), 249-255. doi:10.1016/j.yco.2004.09.001

Ashton, H. (2013). *Benzodiazepines: How they work and how to withdraw*. Retrieved from https://www.benzo.org.uk/manual/

Australian Drug Foundation. (2018). *Benzodiazepines*. Retrieved from ttps://adf.org.au/drugfacts/benzodiazepine/

Australian Psychological Society. (2018). *Evidence-based psychological interventions in the treatment of mental disorders: A review of the literature (4th Ed.)*. Retrieved from https://www.psychology.org.au/About-Us/What-we-do/advocacy/Position-PapersDiscussion-Papers-and-Reviews/psychological-interventions-mental-disorders

Baldwin, D. S., Aitchison, K., Bateson, A., Curran, H. V., Davies, S., Leonard, B., Nutt, D. J., Stephens, D. N.,& Wilson, S. (2013). Benzodiazepines: Risks and benefits. A reconsideration. *Journal of Psychopharmacology, 27* (11), 967–971.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp0630a

Cohen J. (1988). *Statistical Power Analysis for the Behavioral Sciences.* New York, NY: Routledge Academic

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage.

Darker, C. D., Sweeney, B. P., Barry, J. M., Farrell, M. F., Donnelly-Swift. E. (2015). *Psychosocial interventions for benzodiazepine harmful use, abuse or dependence.* New York, NY: John Wiley & Sons, Ltd.

Department of Health and Human Services. (2018). *Victorian AOD self-completion form – fillable version.* Retrieved from https://www2.health.vic.gov.au/about/publications/FormsAndTemplates/victorian-aod-self-completion-form

Dou, C., Rebane, J., & Bardal, S. (2018). Interventions to improve benzodiazepine tapering success in the elderly: A systematic review. *Aging and Mental Health*, 1-6. doi:10.1080/13607863.2017.1423030

Faulkner, N., & Davies, S. (2005). Social support in the healthcare setting: the role of volunteers. *Health & Social Care in the Community, 13*(1), 38-45. doi: 10.1111/j.13652524.2005.00526.x

Frei, M., Berends, L., Kenny, P., Swan A., Jenner, L., Hunter, B., & Mugavin, J. (2012). Alcohol and other drug withdrawal: Practice guidelines, 2nd ed. Fitzroy, Victoria: Turning Point Alcohol and Drug Centre.

Kessler, R.C., Andrews, G., Colpe, et al (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine, 32*, 959-976.

Krueger, R. A., & Casey, J. (2009). *Successful focus groups: practical guidelines for research*. Thousand Oaks, CA: Sage.

Lader, M. (2011). Benzodiazepines revisited: Will we ever learn? Addiction, 106(12), 20862109. doi:10.1111/j.1360-0443.2011.03563.x

Lader, M., Tylee, A., & Donoghue, J. (2009). Withdrawing benzodiazepines in primary care. *CNS Drugs, 23*, 19–34.

The National Health Information and Performance Principal Committee. (2017). *The Australian health performance framework 2017.* Retrieved from https://www.coaghealthcouncil.gov.au/Publications/Reports.

Magin, P., Tapley, A., Dunlop, A. J., Davey, A., van Driel, M., Holliday, E., . . . Holliday, S. (2018). Changes in Australian early-career general practitioners' benzodiazepine prescribing: A longitudinal analysis. *Journal of General Internal Medicine, 33*(10), 16761684. doi:10.1007/s11606-018-4577-5

Monnette, A., Zhang, Y., Shao, H., & Shi, L. (2018). Concordance of adherence measurement using self-reported adherence questionnaires and medication monitoring devices: an updated review. *Pharmacoeconomics*, *36*(1), 17-27.

Mugunthan, K., McGuire, T., & Glasziou, P. (2011). Minimal interventions to decrease long term use of benzodiazepines in primary care: A systematic review and meta-analysis. *British Journal of General Practice, 61*(590), e573-578. doi:10.3399/bjgp11X593857

Neutel, C. I., Skurtveit, S., & Berg, C. (2012). What is the point of guidelines? Benzodiazepine and z-hypnotic use by an elderly population. *Sleep Medicine, 13*(7), 893-897. doi:10.1016/j.sleep.2011.12.014

New South Wales Government. (2018). *Evaluation Toolkit*. Retrieved from https://www.dpc.nsw.gov.au/tools-and-resources/evaluation-toolkit/.

Parr, J. M., Kavanagh, D. J., Cahill, L., Mitchell, G., & Young, R. (2009). Effectiveness of current treatment approaches for benzodiazepine discontinuation: A meta-analysis. *Addiction, 104*(1), 13-24. doi:10.1111/j.1360-0443.2008.02364.x

Psychotropic Expert Group. (2013). *Therapeutic guidelines: Psychotropic (Version 7)*. West Melbourne, Vic: Therapeutic Guidelines Limited.

Saldaña, J. (2013). *The coding manual for qualitative researchers*. London, U.K.: Sage.

Stenius, K., Mäkelä, K., Miovský, M., & Gabrhelík, R. (2017). How to write publishable qualitative research. In T. F. Babor, K. Stenius, R. Pates, M. Miovský, J. O'Reilly, & P. Candon (Eds.), *Publishing Addiction Science: A Guide for the Perplexed* (pp. 155-172). London, U.K.: Ubiquity Press.

Ware, B., & Thorson, R. (2016). Do benzodiazepines have a role in the management of pain? *Pain Management Today, 3*(1), 18-21.

Appendix A Interview Protocol for Clients

(Opening)

1. Firstly, a big thank you for attending today's interview. We appreciate hearing about your experiences with tranquillisers and your feedback about Reconnexion.
2. To start I'll introduce myself, then I'm happy to answer any questions you may have.

(Key Questions)

3. Can you tell me about your experiences with tranquillisers (benzos)?
4. What services have you received to help manage or reduce your tranquilliser use? Probe
    - Any GP or other medical or health services
    - Any use of complementary/alternative medicine
    - Use of internet/other sources of information
    - Any other services
5. How did you find Reconnexion?
6. How has Reconnexion helped you? Probe:
    - Effects on overall functioning, well-being, health, behaviour, social functioning
    - Community-based delivery model and administrative matters (accessibility and safety)
    - Support from volunteers
    - Support from counsellors. Where the desired counselling outcomes achieved?
7. What challenges did you have with withdrawing from tranquillisers?
8. What challenges have you had with services? Probe:
    - Any negative effects on overall functioning, well-being, health, behaviour, social functioning
    - Any problems with community-based delivery model Vs a more structured/controlled withdrawal facility.
    - Accessibility and safety of Reconnexion service.
    - Any problems with administration or organisation of the Reconnexion service
    - Volunteers at Reconnexion
    - Counsellors at Reconnexion

(Ending Open Questions and the Self Completion Form)

9. How do you think the Reconnexion service could be improved?
10. Are there any final comments you would like to add before I ask you to complete the *Victorian AOD Self Completion Form*?
11. Ask the client to fill in the *Victorian AOD Self Completion Form* and/or assist them to fill out the Form, encouraging them to answer all relevant sections.
12. Thank you and issue a Myer gift voucher.

Appendix B Interview Protocol for Staff and Service Consultants

(Adapted from the from the NSW Government Evaluation Toolkit)

(Opening)

1. First, thank you for attending today's interview. Reconnexion appreciates the invaluable contributions that you make to service delivery.
2. To start I'll introduce myself, then I'll ask you to briefly tell me about your role at Reconnexion. (Introduce yourself)

(Key Questions)

3. Can you briefly tell me about your role at Reconnexion?
4. What prompted you to work with Reconnexion?
5. Given your role, are there particular qualifications or registrations that you feel are necessary to provide adequate counselling services for clients?
6. How effectively is the program implemented?
    - How is it aligned with standards/evidence-based practice?
7. How responsive is the service to client needs?
    - Are the desired outcomes/counselling goals achieved?
    - Does the service meet client needs?
    - Are clients satisfied?
8. Is the service accessible to clients?
9. Does Reconnection have the capacity to sustain its workforce?
10. What are the positive aspects of the service? Probe:
    - Effects on clients (overall functioning, wellbeing, health, behaviour, social functioning)
    - Community-based delivery model and administrative matters
    - Supports for staff/staff safety
    - Personal benefits/satisfaction
11. What is particularly challenging? Probe:
    - Effects on clients (overall functioning, wellbeing, health, behaviour, social functioning)
    - Community-based delivery model Vs a more structured/controlled AOD withdrawal facility and administrative matters
    - Frustrations for staff
    - Personal stressors related to the work and safety
12. How would you describe the impact of the service upon clients? Does a reduction in benzodiazepine use occur over the short, medium and long term? How is it maintained?
13. What impact has your involvement with Reconnexion had upon you?

(Ending Questions)

14. If you were to advise a similar AOD service on how to run their program, what would be key points?
15. Are there any final comments you would like to add?

Appendix C Focus Group Questions for Volunteers

(Adapted from Krueger & Casey, 2009, p. 41)

(Opening)

1. First, thank you for attending – volunteers are an essential resource and Reconnexion appreciates the invaluable contributions that you make to service delivery.
2. Before we start I'd like to answer any questions you have about today's group and to cover three rules that will operate during the session. These rules are:
    a. We need to respect each other and use respectful behaviour in the group. I'll endeavour to give everyone an equal opportunity and time to have their say
    b. Privacy. We need to respect the privacy of other participants, and
    c. Confidentiality. We commit to the confidentiality of the focus group discussion. Is everyone OK to continue with these rules?
3. To start I'll introduce myself, then I'll ask you to please introduce yourself. Can you tell us your name and for how long you have been volunteering at Reconnexion?

(Introductory phase)

4. How did you first learn about the service?

(Transition)

5. Thinking back to when you first heard about Reconnexion, what did you think the service offered?
6. What did you understand your role as a volunteer would be?

(Key Questions)

7. What is particularly helpful about the service? Probe:
    - Effects on clients (overall functioning, wellbeing, health, behaviour, social functioning)
    - Community-based delivery model and administrative matters
    - Supports for volunteers
    - Personal benefits - satisfaction
    - Other
8. Are there any challenges with volunteering at Reconnexion? Probe:
    - Effects on clients (overall functioning, wellbeing, health, behaviour, social functioning)
    - Community-based delivery model Vs a more structured/controlled AOD withdrawal facility and administrative matters
    - Frustrations for volunteers
    - Personal stressors related to the work
    - Other
9. How would you describe the impact of the service on clients?
10. What impact has your involvement with Reconnexion had upon you?
11. Is the service client-focused? Are services accessible for clients? Examples
12. Is there a range of ways to help clients? Is follow-up available?
13. Can you comment on how safely the service is delivered (for you and the clients)?

(Ending Questions)

14. If you were to give advice to an Alcohol Other Drug (AOD) service on how to run their program, what advice would you give?
15. Are there any final comments you would like to add?