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Interventions for benzodiazepine withdrawal: Perceptions of benzodiazepine counsellors

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Abstract

Governments have been urged to adopt real-time prescription monitoring in order to manage and reduce risks associated with the long-term use of sleep and anti-anxiety medications. Given this imperative, accessible psychological interventions for benzodiazepine (BZD) dependency and withdrawal are essential. The aim of this study was to understand how counsellors support clients assessed as suitable for community-based drug withdrawal services to reduce their BZD use. Six BZD counsellors and two service coordinators were interviewed. Counsellors collaborated with their clients and prescribing doctors to develop individualised taper schedules that were in line with recommended clinical guidelines. Psychoeducation underscored a range of evidence-based interventions, and a trauma-informed approach was considered essential in working with clients to reduce their use of BZDs. Continuity in care was affected by the degree of prescribing doctor support for the taper. Counsellors reported that workforce sustainability was enhanced by quality clinical supervision and professional development opportunities. The role of counsellors in providing accessible, community-based interventions for clients to reduce their use of BZDs was supported. Psychosocial support, combined with a medically supervised taper, has a strong evidence base and implications for client-centred interventions are discussed.

KEYWORDS

benzodiazepines, counselling, deprescribing, drug dependence, evidence-based practice, supervision

1 | INTRODUCTION

For several decades, the inappropriate medium- to long-term use of benzodiazepines (BZDs) has been recognised as a major health issue. Negative impacts of BZDs on health outcomes, cognitive functioning and general well-being have been well documented (Ashton, 2005; Baldwin et al., 2013; Barker et al., 2003; Lader, 2011). Underscoring the extent of the problem, BZDs are one of the most implicated prescription medications in traffic collisions, ambulance call outs and polydrug overdose deaths (Elvik, 2013; Liew et al., 2017; Rapoport et al., 2009). BZDs have also been found to facilitate male, alcohol-related violence (Forsyth et al., 2011).

Despite clinical guidelines recommending prescriptions of no longer than four weeks, significant numbers of individuals continue to regularly use BZDs on a long-term basis. BZD dependence is often normalised by users and rarely is cessation or reduction prioritised (Chandler et al., 2014). Withdrawal is typically a complex, prolonged process. Nevertheless, research shows minimal interventions such as a tailored GP letter or consultation (Darker et al., 2015) can assist patients to withdraw. However, GPs report difficulty addressing

the needs of patients with complex psychological issues and prescription drug misuse (Anthierens et al., 2007; Kapadia et al., 2007; Porath-Waller et al., 2015). There is now compelling evidence that psychosocial support contributes to the effectiveness of BZD withdrawal, and it has been found that combining a medically supervised taper with psychological counselling is superior to tapering alone (Parr et al., 2009; Reeve et al., 2017).

Influential early BZD research advocated that best practice withdrawal included an initial consolidation of BZDs to long-acting diazepam, a slow reduction in dose rates (tapering) overseen by a medical practitioner and psychological support (Ashton, 1984, 2005, 2013). During withdrawal, Australian and many international clinical guidelines recommend lowering BZD doses by no more than 10% every 1–2 weeks (Manning et al., 2018; Psychotropic Expert Group, 2013); however, debate on the optimum reduction rates, the control the client has over the process and the nature of psychosocial support continue (Darker et al., 2015; Gould et al., 2014; Lader & Kyriacou, 2016).

In an evaluation of a community-based Victorian BZD counselling and support service, Wurf et al. (2019) found that psychological counselling combined with a medically supervised BZD taper resulted in 88% of participants reducing or withdrawing BZDs. Participants were assessed as suitable for community treatment and did not have concurrent high-risk polydrug use or complex medical conditions requiring inpatient withdrawal. Significant reductions in pre- and post-intervention psychological distress were also found, and the effect size was large.

Amongst older clients, who have some of the highest rates of BZD use, psychological support together with tapering has also been shown to enhance the reduction and withdrawal of BZDs (Reeve et al., 2017). These findings are significant given the high prevalence of anxiety in aged care facilities, the high rates of BZD use and risks associated with increased falls (Davison et al., 2017).

Delivering evidence-based interventions is a requirement for registered Australian health professionals and is mandated for alcohol and other drug (AOD) services in many jurisdictions. Notwithstanding this, internationally, the AOD sector has faced multiple workforce challenges over the last two decades including debates about requisite staff qualifications/competencies, access to training, well-being of the workforce and staff retention (Duraisingam et al., 2009; Eby et al., 2010). Complicating these workforce challenges is the increasing recognition that many AOD clients have experienced significant lifetime trauma. Complex clinical presentations often have negative impacts on the treating health professionals' own well-being, staff retention rates and client outcomes (Best et al., 2016; Bride et al., 2009; Giordano et al., 2016; Poghosyan et al., 2010). In a recent literature review, Huggard et al. (2017) concluded that alcohol and drug clinicians are at risk of experiencing secondary traumatic stress and compassion fatigue. Turnover rates of AOD counsellors in the United States have been estimated to run to 33% annually, with 36% of the workforce leaving the profession entirely (Eby et al., 2010).

Determining how best to coordinate care between prescribing doctors and counsellors requires further research, especially considering access to, and the deprescribing of, benzodiazepines remains primarily through medical practitioners (Kapil et al., 2014; Nielsen et al., 2013). Nevertheless, in terms of workforce sustainability, staff development and training has been identified as integral to providing effective AOD services and continuity in care (Roche & Nicholas, 2017). In addition, positive well-being and job satisfaction amongst AOD staff have been associated with a supportive work environment, professional development opportunities and formal and informal supervision (Bride & Kintzle, 2011; Ewer et al., 2015). Bride and Kintzle (2011) recommended that responsible managers provide appropriate workplace support and ensure that counsellors have a mixed, diverse caseload that does not consist entirely of clients with complex trauma presentations.

Recently, some Australian state governments have moved to real-time prescription monitoring in order to assist doctors and pharmacists to safely prescribe and dispense prescription medicines that have a high risk of causing dependence, including BZDs. It is therefore anticipated that a growing number of people will need intervention services for BZD dependency and withdrawal. The purpose of this study was to develop an understanding of how counsellors can effectively support clients assessed as suitable for community-based withdrawal to reduce their BZD use. The current study aimed to address the following research questions:

1. How do counsellors contribute to effective, client-centred interventions to reduce BZD use?
2. How is continuity in care influenced by counsellors working with prescribing doctors to enact established tapering guidelines for BZD withdrawal?

Implications for practice

- Effective counselling for BZD withdrawal is underpinned by flexible service delivery, client-centred support and successful collaboration with prescribing doctors.
- Best practice withdrawal incorporates a medically supervised, gradual taper and extensive psychoeducation addressing the effects/side effects of medication.
- Clients taking long-term anti-anxiety medications have often experienced past trauma. Trauma-informed approaches, as well as cognitive behavioural therapy (CBT) and other evidence-based psychological interventions, assisted successful withdrawal.

Implication for policy

- Effective workload policies stress the importance of well-qualified and supported counsellors. To facilitate staff retention and well-being, routine, high-level clinical supervision is promoted. Caseload allocations that provide a more diverse client mix, including working with clients who have experienced less complex trauma, assist counsellor well-being.

3. What counselling qualifications and training provide an appropriate level of service to clients withdrawing from BZDs?
4. Does ongoing counsellor supervision and professional development play a role in sustaining the workforce?

2 | METHOD

2.1 | Design

This study was part of a broader mixed-methods quality assurance evaluation of a well-established, non-government support and counselling service for people with a BZD dependency. Clients were assessed as suitable for community care and did not require more intensive inpatient support due to complex health needs or high-risk polydrug use. The current qualitative study centred on the perceptions of counsellors, and managers who directly support individuals with a BZD dependence. The evaluation assessed the service across five quality dimensions of the Australian Health Performance Framework (AHPF, COAG, 2017). Research questions were developed and guided by the AHPF domains of effectiveness, continuity of care, appropriateness, accessibility, and efficiency and sustainability.

2.2 | Participants

Participants were eight key staff who all worked as BZD counsellors or in support/management roles. Of the eight participants, six staff were employed as BZD counsellors. Five of the BZD counsellors were Australian Health Practitioner Regulation Authority 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. A further two psychologists were undertaking programmes that led to endorsement in clinical and counselling psychology, respectively. All counsellors were employed on a part-time basis with the duration of employment ranging from 1.5 years to 25 years. Two service managers also participated in the study. All eight counsellors/managers in the service were interviewed (100% response rate). Seven participants identified as female and one as male.

2.3 | Materials

A semi-structured interview protocol consisting of a series of questions and further areas for prompting was developed using the recommendations from the New South Wales Government Evaluation Toolkit (NSW Government, 2021). The interview commenced with consents and introductions. Key questions included, 'Can you briefly tell me about your role?', 'Are there particular qualifications necessary to provide adequate counselling for clients?', 'How is the programme implemented?', 'What are the positive aspects of the service?' and 'What are the challenges?'. In addition, questions probed adherence with the established standards/evidence base, responsiveness to client needs, accessibility, as well as staff support, supervision, frustrations and the impact of the service upon clients.

2.4 | Procedure

Relevant university and organisational ethics approvals were obtained before the study commenced. Interviews with staff were conducted by the second author at the service site in Melbourne, Australia. The interviewer was a full-time graduate psychology student and did not know the participants. Six interviews were face to face, and two were conducted via telephone. Interviews lasted between 30 and 50 min and were audio-recorded with the written consent of participants. Audio recordings were transcribed verbatim with the assistance of Dragon Naturally Speaking software. Iterative reading of the data allowed for familiarisation with the content and the views of counsellors and managers. Transcripts were then coded using first cycle margin annotations noting prevalence and salience (Saldaña, 2021). An initial 64 descriptive codes were generated across transcripts that mirrored participants' responses. These codes were then collated into categories, and repeated patterns of meaning were identified using thematic analysis (Terry et al., 2017) and were organised under the four major research questions.

3 | RESULTS

3.1 | Research question 1: How do counsellors contribute to effective, client-centred interventions to reduce BZD use? (AHPF: Effectiveness and appropriateness)

Counsellors reported that they work in collaboration with clients to develop an individualised taper schedule in line with the Ashton Manual (Ashton, 2013) and the Psychotropic Guidelines (Psychotropic Expert Group, 2013) that recommend a gradual switch to a long-acting BZD and a 10% dose reduction every 1–2 weeks. Combined with the tailored BZD taper, a range of evidence-based psychological interventions underpinned by psychoeducation and teaching clients adaptive coping skills were used. Interventions included cognitive behavioural therapy, acceptance and commitment therapy, motivational interviewing, interpersonal, humanistic and brief psychodynamic approaches. Specific interventions that counsellors used for coping with anxiety, depression, symptoms of withdrawal, trauma and insomnia included activity scheduling, goal setting, mindfulness, meditation, progressive muscle relaxation and cognitive restructuring.

Counsellors stressed the importance of educating clients about the fight-flight-freeze response, the impact of benzodiazepine use on cognitive functioning, recognising common withdrawal symptoms and how withdrawal symptoms change over time. It was

noted that sometimes psychoeducation was the only intervention that was used because clients were previously unaware of the effects of BZDs and withdrawal. Psychoeducation was underpinned by a manualised package of resources, *The Benzodiazepine Toolkit* (Reconnexion, 2018), developed by the service. Goal setting to encourage physical exercise, a healthy diet, restricting the use of other substances and good sleep hygiene was linked with improvements in clients' overall well-being. Undertaking healthier lifestyle changes assisted clients to comply with the tapering schedule. Additionally, psychoeducation involved helping clients acquire skills around relapse prevention, such as managing future stress, self-regulation and reaching out to others.

A major theme highlighted by these findings was the need for flexibility in the delivery of services. All counsellors stressed the necessity of using a client-centred approach and that collaboration was essential for a successful reduction or discontinuation of BZDs. Counsellors incorporated clinical recommendations from the Ashton Manual and the Psychotropic Expert Group, but these guidelines were used as a starting point for a gradual tapered reduction that was client led. When asked about the positive aspects of the service, one counsellor responded:

> Certainly, at the very core of the organisation that culture of being very client-centred is just inherent (to the service) … we are mindful from the point that somebody engages with our service, whether that's online from sending an email, calling us, or walking in the front door, that how we respond to that person, it's really important that … they have a positive experience. That whenever they engage with us, they always feel welcomed, supported, and empowered … we are giving them information, you make the choices that are best for you, we don't want to tell you how you should be doing things …
>
> (Participant 4).

The client-centred focus of the service was emphasised by all participants. Counsellors explained that they were helping clients meet their goals, whatever those goals were. Goals could be cessation of the medication or a dose reduction. As one counsellor reflected:

> … because they're often so complex and lower functioning, life's really hard for these people. You know they're often estranged from family, few, if any, friends, financial difficulties, other drug and alcohol issues … they feel like life is hard and terrible… So understandably from their point of view the benzodiazepine's often a really low priority, they're like, "but this makes me feel good, why do you want me to get off it?"
>
> (Participant 7).

The struggle to reduce BZD use was recognised as a particularly challenging process and the severity of withdrawal symptoms added to the struggle. Participant six noted, 'As people are coming down from their tranquilisers, their memories start to resurface sometimes … their emotions start to come back … tranquilisers tend to blunt people's emotions'.

3.2 | Research question 2: Is continuity in care influenced by counsellors working with prescribing doctors to enact established tapering guidelines for BZD withdrawal?

The organisation's protocols for communicating with prescribing doctors required counsellors to write to a client's doctor (with the client's consent) outlining the taper that was collaboratively developed using the recommended guidelines. A wide range of experiences in coordinating the withdrawal with prescribing GPs and psychiatrists was reported. Experiences included relief and cooperation, the client's decision not to involve their doctor, doctor resistance or refusal to collaborate, and no response from the doctor. In the former cases, examples of strong engagement with the prescribing doctor were noted. Indeed, counsellors believed that a prescribing doctor's involvement was crucial for successful intervention; however, some prescribing doctors only had limited experience with using best practice guidelines for tapering. Potentially, due to this limited experience, counsellors indicated that most clients were self-referred, having researched benzodiazepine dependence online and contacted the service independently of their GP.

It was not uncommon for clients to report that their GP had refused to continue prescribing BZDs and that they had tried, or were about to try, going 'cold turkey'. This sentiment was captured by Participant six:

> We will advocate for clients usually, but if GPs are really difficult, they'll sometimes say, "Well I'm your GP and this is what I'm telling you, and I'm not prescribing extra". So, they'll actually tailor their scripts to a reduction programme… 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", … benzos have such a bad name … in the medical profession, that people don't want to take people on with, especially with higher levels of benzos. So that can be really tricky
>
> (Participant 6).

A concern was that if a taper moves too quickly, clients often compensated with alcohol, other drugs or relapsed and took higher doses of BZDs. In addition, clients often had limited adaptive coping mechanisms and had relied on the medication for long periods. Gradual tapers could take from 12 months to two years depending on the initial

dose, client motivation and the severity of withdrawal symptoms. This is detailed in the following excerpt:

> And the hard part … is that progress for those types of clients can seem like it's not happening, it can seem like it's at a standstill. …when we reflect on what's going on, we're building the relationship, we're developing engagement, we're getting them to attend more regularly. Their benzos might not be coming down, but we're preparing the ground for them to actually be able to do a reduction
>
> (Participant 2).

3.3 | Research question 3: What counselling qualifications and training provide an appropriate level of service to clients withdrawing from BZDs? (AHPF: Accessibility and efficiency)

Counsellors employed at the service held postgraduate psychology or social work qualifications beyond the minimum qualifications (a certificate IV in AOD) required by most government and funded AOD services in Australia. Managers noted that when hiring, they attempted to recruit applicants with additional training, especially those with a thorough knowledge of mental health disorders.

> 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 programme 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 someone who's got a cert IV in AOD to be in the middle of that sort of work
>
> (Participant 2).

However, many counsellors believed that a counselling-level qualification would be adequate for the role because comprehensive on-the-job training was provided. Training included understanding BZD doses, withdrawal symptoms, mental health disorders and collaborating with prescribing doctors. The latter role often involved educating the GP and, as one participant stated:

> … it's a really important service because it's such a specific population of people, and the staff that work there have that specialist knowledge around benzodiazepines. Whereas your general AOD workers may not have that, or it's not up-to-date and often GPs won't have that information either or the advice they give is to come off them fairly quickly. Or things like, "oh, just come off half a tablet every two weeks" or something, rather than working person-to-person at coming up with an individual plan. So, I think (the service) is a vital programme
>
> (Participant 2).

Negative past experiences with health professionals were common and clients reported they had been misinformed about their symptoms and the withdrawal process. Participant three noted:

> They've often come from having experiences with other health professionals that are invalidating and attribute everything that they're experiencing to mental health, as opposed to the medication withdrawal. So, it's very validating and they can often find that to be quite relieving, to understand what's going on … that's really helpful for clients. And just learning new coping strategies. Often they may have formed maladaptive coping strategies in the past, and the medication itself is a maladaptive coping strategy, so it's about developing new ones, and understanding that there may not be a quick fix, this may be something that they have to learn to sit with, some levels of distress, and also have some coping mechanisms to maybe turn down the volume on the distress but it may not numb the distress
>
> (Participant 3).

As well as specific benzodiazepine knowledge, counsellors highlighted that a trauma-informed approach to counselling was necessary for working with this population. Staff had received training on the principles of trauma-informed practice, working therapeutically with complex trauma clients and managing vicarious trauma (Knight, 2018).

Active attempts were made to increase accessibility for people with benzodiazepine dependency. Managers and counsellors alike commented that improving accessibility is prompted by the type of symptoms experienced by clients such as agoraphobia, anxiety, panic attacks or generally finding it hard to leave the house and keep appointments. Participant two stated:

> It really needs to be an acknowledgement of the fact that they are not coping and you need to take steps to make sure that the service is easy for them to access because if it isn't, it's so hard for them to get here, so hard for them to do the work. And the majority of the clients that we work with come from a trauma background. They are making themselves vulnerable to come here, they are taking a huge risk to reach out to any service. So that has to be kept in mind for everything that we do… I think some of the larger organisations perhaps, where you have to go through a sort of filtering process before you get to where you need to go, that is painful. I try to make some referrals

> on behalf of other clients to other services and I've been on the phone for hours trying to figure it out, and I think to myself "if I can't figure it out, how is my client, who is on all these substances, with a history of trauma, who struggles to get out of bed, actually going to do this themselves?"
>
> (Participant 2).

> clients autonomy, treating them as equal, and empowering them to achieve their goals,... that's really kind of modelled in the management style
>
> (Participant 3).

A synthesis of the factors identified for effective BZD counselling arising from the four research questions is presented in Figure 1.

3.4 | Research question 4: Does ongoing counsellor supervision and professional development play a role in sustaining the workforce? (AHPF: Sustainability)

A high level of formal and informal clinical supervision was regularly provided to all counsellors, and supervision was viewed as crucial for sustaining and retaining counsellors. Managers prioritised clinical and professional supervision. Intake was generally managed to ensure counsellors maintained a balanced caseload of complex and lower risk client groups.

Workplace cultural values were seen as positive, and these values were underscored by a non-hierarchical management structure. As one counsellor responded:

> ... [E]galitarian is the first word that comes to my mind. We all have a lot of autonomy ... We're kind of promoting the sort of values that we are trying to use when we work with clients as well... providing our

4 | DISCUSSION

Key themes in effective counselling for individuals with a BZD dependency were flexible service delivery, client-centred support, successful collaboration with prescribing doctors and well-qualified and supported counsellors. Participants associated these primary themes with more effective client outcomes. Similar to recommendations in Australian guidelines for BZD withdrawal and the Ashton Manual (Ashton, 2013; Manning et al., 2018), counsellors affirmed that BZD withdrawal was most appropriate when the reduction schedule was tailored to clients' goals and the clients maintained control and choice over the duration and pace of their taper. Previous research with clients with substance use has also highlighted the importance of client preferences during counselling (Edwards & Loeb, 2010).

Complementing the recognition of client-centred support by counsellors, Oldenhof et al. (2019, 2021) examined the role of both patient and GP influences in reducing BZD use. They stressed the importance of prescribers '*having the conversation*' with patients about

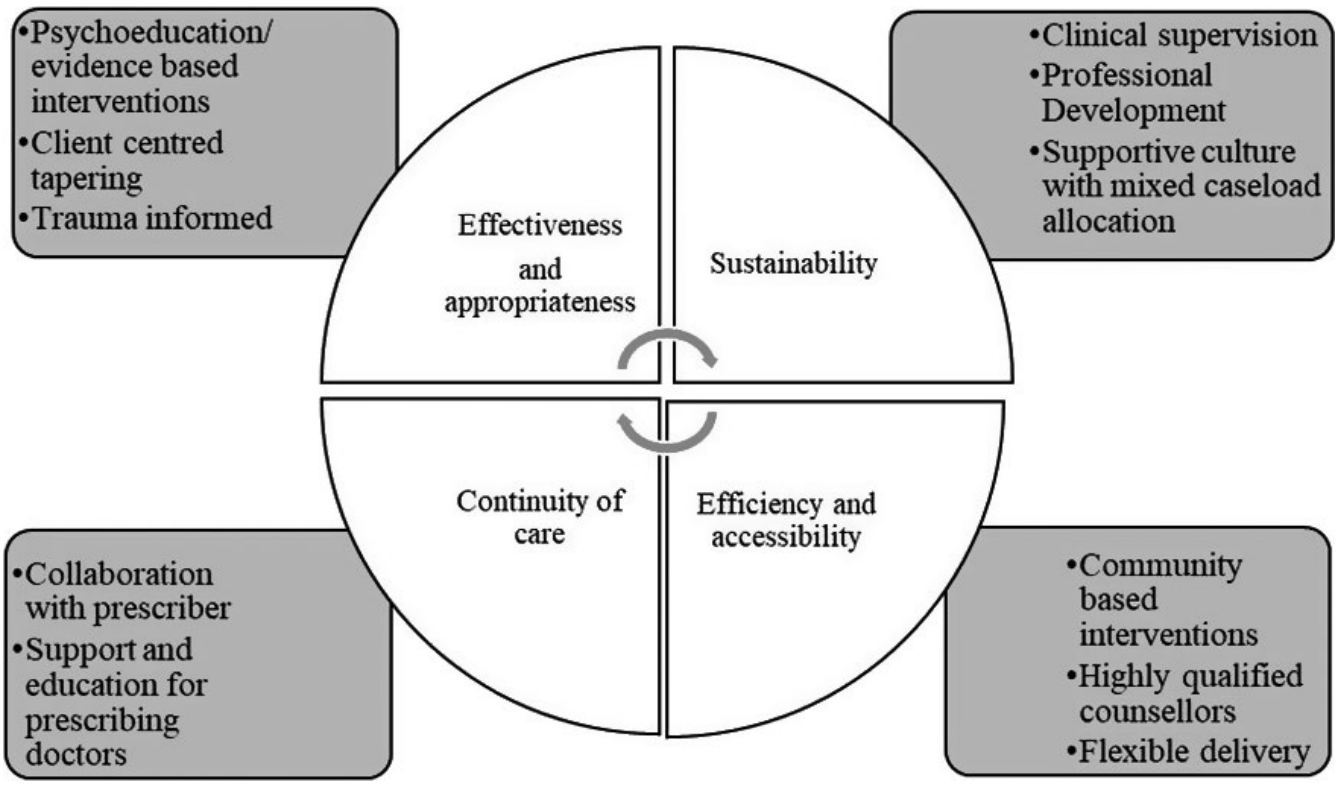

FIGURE 1 Model of effective counselling for reducing BZD use

medication risks and collaboratively reviewing the costs and benefits of medication. Thus, a decision balance sheet (a motivational interviewing technique), as well as specialist counselling referral, was incorporated into their model. Further, when patients trust their prescriber and are educated about medication side effects, even if they are in the pre-contemplative stage of change, reductions in BZD use have been obtained (Martin & Tannenbaum, 2017).

Counsellors stressed that approaches need to be sensitive to the fact that many clients had experienced past trauma (e.g. Dore et al., 2012) and reductions in drug use can lead to previous mental health issues resurfacing. As with previous research (Staiger et al., 2010), clients with comorbid disorders were recognised as experiencing additional barriers to intervention and providing accessible services for this group was identified as a priority.

Therapeutic approaches varied, but all were recommended evidence-based interventions (APS, 2018). Psychoeducation has been recognised as an essential component in withdrawal (Dou et al., 2019; Mugunthan et al., 2011) and underscored counsellors' interventions. Overall, counsellor flexibility was reported to increase the effectiveness of interventions and it allowed for highly collaborative goal setting and client choice.

Experiences of providing coordinated care between counsellors and prescribing doctors varied. At times, counsellors reported high levels of successful collaboration, while at other times attempts were unsuccessful. When collaboration was successful, counsellors reported better outcomes. Previous research suggests some GPs may be reluctant to discuss BZD withdrawal because of fear that it will harm the doctor–patient relationship (Anthierens et al., 2007; Martin et al., 2013). Prescribing doctors may also have limited information about the risks of inappropriate, long-term BZD use and be less optimistic about successful tapering or discontinuation, especially amongst older patients (Cook et al., 2007).

Unsuccessful attempts at collaboration with prescribers reinforce research suggesting that targeted education about the adverse health effects of long-term benzodiazepine use is necessary for GPs and that physicians need to advise patients of non-pharmacological options to manage sleep and anxiety problems (Magin et al., 2018; Parr et al., 2006). The fact that inappropriate long-term prescribing continues despite the guidelines and research discouraging it highlights the role of counsellors in supporting and advocating for individuals with benzodiazepine dependence. GPs providing education and managing gradual tapers with their patients can be effective, but the process is enhanced with psychological support (Darker et al., 2015). Withdrawal can also be lengthier and more involved than many GPs can manage given their schedules. Indeed, a recent survey revealed that two in three GP appointments in Australia are for mental health problems (The Royal Australian College of General Practitioners, 2018).

The findings regarding qualifications and training for AOD counsellors are in line with survey findings by Best et al. (2016) which showed that 73% of Australian AOD staff were qualified at degree or postgraduate level, reflecting a trend of employing staff with higher qualifications than the minimum certificate in AOD. Professional development in BZD withdrawal, mental health and trauma counselling was viewed as essential for working in an area that is underresearched and subject to misleading advice (Lader, 2011).

Additionally, because of the legitimacy that surrounds prescription drug dependence, counsellors' affiliations with the broader AOD sector were more limited. Whether this population is substantially different from other consumers of AOD interventions requires future research. The rising prevalence of the inappropriate use of prescription drugs and moves to real-time prescription monitoring further highlight the need for psychosocial support during withdrawal. However, motivational differences between patients who self-refer for counselling for BZD withdrawal, and those referred by their prescribing doctor, warrant further investigation.

High levels of clinical supervision were viewed favourably by counsellors and were linked with staff well-being and high retention rates. Despite conflicting findings (Watkins, 2020), the importance of formal and informal supervision in supporting staff and as a protective factor against secondary traumatic stress has been highlighted in the AOD and psychotherapy literature (Bride & Kintzle, 2011; Ewer et al., 2015; Johnson et al., 2020; Laschober et al., 2013). In addition, counsellor autonomy regarding intervention approaches and in selecting professional development opportunities has been shown to increase job satisfaction (Gallon et al., 2003; Knudsen et al., 2007). Importantly, Bride and Kintzle (2011) found that job satisfaction was able to mediate the effects of secondary traumatic stress on occupational commitment. Job satisfaction has also been associated with better work performance (Riketta, 2008).

One limitation of the study is the small sample size and the fact that counsellors were working for the same organisation. Although adequate for a qualitative study (Braun & Clarke, 2006), this may limit the generalisability of the findings. Secondly, the interviews were part of a broader evaluation of the service and participants may have been influenced by social desirability effects. Power structures, present in all social situations, may also affect the outcomes of qualitative research. Lastly, research in the AOD sector focuses primarily on populations misusing alcohol, amphetamines and opioids, and less attention has been paid to the effects of pharmaceutical drug misuse. Because of this, findings from broader AOD research may not be directly transferable to this population. Future research looking at various services for prescription drug support may provide further insight into the experience of working with this population and the fit with broader AOD services.

5 | CONCLUSION

This study provides insight into the effectiveness and challenges in providing psychological interventions for individuals with a BZD dependency. Participants highlighted how they advocate for their clients and collaborate with GPs/specialists to provide coordinated care. Although interventions were driven by clinical tapering guidelines, counsellors stressed that the process must be flexible and remain client-centred. Clinical supervision and professional

development were unequivocally acknowledged as major contributors to job satisfaction and a sustainable workforce. Recognised challenges were the lack of knowledge about BZD withdrawal amongst prescribers and the general public, accessibility to services and the impact of dealing with complex presentations and trauma. Overall, the findings highlight the need for a comprehensive understanding of BZD dependency and the effectiveness of well-supported counsellors in providing psychological support during a medically supervised taper.

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