

Community-based counselling for benzodiazepine withdrawal: A mixed-methods study of client outcomes

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Abstract

Despite adverse health outcomes being associated with long-term tranquilliser use, health professionals face numerous barriers in reducing reliance on benzodiazepines. This study investigated the effectiveness of focused counselling in facilitating benzodiazepine withdrawal. In phase one of a two-phase mixed-methods evaluation, preintervention and postintervention quantitative data for 24 participants were analysed. Measures included the Australian Treatment Outcome Profile, Kessler 10, and two client outcome ratings. In phase two, follow-up individual interviews were conducted with six participants. Following counselling, 88% of participants reported either reduced use or withdrawal from benzodiazepines. Significant reductions in psychological distress were obtained in Kessler 10 scores, and the calculated effect size ($d = 0.84$) was large. Medically supervised tapering was well received when combined with focused counselling. We found strong support for the tapering process and for the appropriateness of counselling. Withdrawal was facilitated when services were well coordinated and the client's sense of control was maintained.

KEYWORDS

benzodiazepines, client experiences, counselling, deprescribing, evidence-based practice, mental health

1 | INTRODUCTION

Benzodiazepines (BZDs) are a class of psychoactive drugs that are prescribed for the treatment of anxiety disorders and sleep disturbance (Lader & Kyriacou, 2016). Also known as 'minor tranquillisers' or sedatives, BZDs are now commonly prescribed in various treatment settings around the world, including in Australia (Alcohol and Drug Foundation, 2021; Jessell et al., 2020; Mehdi, 2012). While it is recommended that BZDs be used only for short-term purposes (2–4 weeks), the reality is that many individuals use these drugs for

months or even years (Buykx et al., 2012). Consequently, BZDs have become one of the most over-prescribed classes of drugs.

The widespread use of BZDs, including amongst the elderly, within adolescent subgroups, for the treatment of mental health disorders, and as part of polydrug use has been well documented (Fletcher et al., 2020; Lin et al., 2017). Unwanted side effects associated with prolonged BZD use may include drowsiness, psychomotor impairment, lack of coordination, muscle weakness, dizziness and mental confusion (Ashton, 2013). BZDs can also cause cognitive impairments including difficulties with concentration, attention and

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the acquisition of new information (Crowe & Stranks, 2018). Side effects have been reported to interfere with completing daily activities, and from a patient perspective, side effects may even outweigh the benefits of taking the medication (Reeve et al., 2013). Importantly, problems with dependence are well recognised and have been documented for several decades (Outram et al., 2006; Skodra, 1992).

More disturbing are the adverse health outcomes that have been linked with the overuse of BZDs. The Coroners Court of Victoria, for example, found that during 2009–2015 BZDs were frequently implicated in drug overdose deaths (Monheit et al., 2016). Epidemiological studies have further indicated that overdose mortality typically involved polydrug use where BZDs were combined with opioids or other psychoactive drugs (Jones et al., 2012; Zoorob, 2018). Altered subjective drug responses and impaired cognitive performance have been demonstrated with high-dose BZD/opioid use, and because of this, caution has been recommended when prescribing BZDs with opioid users (Lintzeris et al., 2007).

Nevertheless, BZDs are commonly used by patients who have been prescribed opioids for chronic pain (Manning et al., 2018; Nielsen et al., 2015). In the United States, overdose deaths involving BZDs have increased eightfold since 2002 and BZDs are involved in one third of fatalities involving opioid overdoses (Jessell et al., 2020). Similarly, BZD misuse has been reported to co-occur with severe alcohol use. For example, 30% of a recent US sample of adults receiving treatment for severe alcohol use disorder were found to also misuse BZDs (McHugh et al., 2020). An analysis of ambulance call outs in Melbourne highlighted that BZDs are the most implicated drugs in pharmaceutical drug-related attendances (Lloyd & McElwee, 2011). Long-standing evidence has also implicated BZDs in traffic collisions (Rudisill et al., 2016). Kelly et al. (2004) found that after alcohol and cannabis, BZDs were the most common class of drugs found in tests of Australian drivers. Furthermore, road crash risks are found to increase significantly when polydrug use, especially opioid and BZD combinations, has been detected (Leung, 2011).

To facilitate withdrawal from BZDs, a range of strategies including pharmacological, psychological and combined interventions have been investigated. Sudden withdrawal, especially from higher doses and after prolonged use, has been associated with seizures, psychosis and panic reactions (Ashton, 2013). Therefore, a widely accepted approach to withdrawal is 'Ashton tapering'. The intervention incorporates a switch to longer acting BZDs (e.g. diazepam) followed by a slow taper of the dose. Despite variations in taper schedules, suggested reductions of around 10% or less every 1–2 weeks are common (Lader & Kyriacou, 2016).

In addition to tapering, psychological support is recommended (Ashton, 2005, 2013; Lader, 2011; Manning et al., 2018). Limited research suggests integrating psychological treatment/counselling with a slow taper has been found to be superior to tapering alone (Parr et al., 2009). Amongst older clients (≥ 65 years), there is also very good evidence that tapering interventions that include psychological support and education are associated with higher success

Implications for Practice

- Clients reported significant reductions in psychological distress and benzodiazepine use following focused counselling to reduce/cease their BZD use. The effect size was large.
- Counselling was seen as appropriate and safe. Despite barriers to deprescribing, flexible client-centred tapering was well tolerated, and clients reported high levels of confidence in, and respect for, BZD counsellors.
- Clients valued a sense of control over the taper, access to high-quality information about BZD side effects/withdrawal and general psychoeducation about non-pharmacological alternatives to reduce anxiety.

Implication for Policy

- Clients frequently ask counsellors about the use of prescribed psychoactive medications and their side effects.
- Current initiatives to reduce BZD use have focused on prescription monitoring. Our findings highlight a need for accessible, educational and evidence-based counselling to support at-risk BZD users during a medically supervised taper.

rates (Gould et al., 2014; Martin et al., 2013; Reeve et al., 2017). Moreover, the requirement to address the social and affective needs of older persons as part of the withdrawal process has been widely acknowledged.

Providing information and educational strategies, such as tailored letters from medical practitioners recommending a reduction or cessation of BZDs, have been effective in reducing some BZD use (Darker et al., 2015). Further, the role of general practitioners in the withdrawal process, even for patients in the pre-contemplative stage of change, has long-standing support from patients (Holden et al., 1996), especially when they trust their prescriber (Oldenhof et al., 2021). Nevertheless, multiple barriers to deprescribing by medical professionals have been identified including a low self-efficacy for managing the process, limited awareness of potentially inappropriate medication regimes, inertia and entrenched contextual barriers to reducing/ceasing medications (Anderson et al., 2014).

Generally, surveyed healthcare professionals feel they lack adequate support for preventing and addressing prescription drug misuse. One Canadian study, for example, has reported that 74.2% of respondents indicated they did not have adequate support to prevent and address the misuse of prescription drugs (Porath-Waller et al., 2015). While counsellors have also acknowledged the need for evidence-based information about substance use and support for client-based empowerment (Blair et al., 2021), many do not feel adequately trained to work with clients who have substance use disorders (Martin et al., 2016). Counsellors are well placed to provide

evidence-based interventions to assist clients during withdrawal from overused psychoactive substances and are frequently asked about the impact of psychiatric drugs on therapy (Blair et al., 2021; Dorais et al., 2020). Evidence-based psychological support for BZD withdrawal includes cognitive behavioural therapy, motivational interviewing and supportive counselling (Darker et al., 2015; Dutra et al., 2008; Parr et al., 2009; Reeve et al., 2017).

Given this widespread hesitancy to address prescription drug misuse, and that few studies have examined the specific contribution of counselling to BZD withdrawal, the current study was designed to investigate client outcomes following focused BZD counselling. Evaluation questions were developed with reference to output quality dimensions from the Australian Health Performance Framework (AHPF, COAG Health Council, 2017). The AHPF supports the system-wide evaluation of health services with the objective of improving health outcomes. Multiple determinants of health, including health behaviours, an individual's biomedical status, environmental circumstances and socioeconomic factors, are acknowledged within the AHPF conceptual framework.

Specific questions investigated in the current study, and the AHPF quality dimension they address, were as follows:

1. Is focused counselling, combined with a medically supervised taper, effective in reducing BZD use and psychological distress? (effectiveness)
2. Do clients perceive BZD counselling as safe and accessible? (safety and accessibility)
3. During a medically supervised BZD withdrawal, how confident and satisfied are clients with receiving focused counselling? (appropriateness)
4. Do counsellors work with prescribing doctors to deliver coordinated interventions? (continuity of care)

2 | METHOD

2.1 | Design

A sequential explanatory mixed-methods research design (Creswell & Creswell, 2017) was adopted to investigate the experiences of clients who had sought focused counselling to reduce their BZD use. In phase one, quantitative data from the Victorian Alcohol and Other Drug Self-Completion Form (DoH, 2021) were analysed to answer research questions 1 and 3. In addition, two client-reported outcome ratings were also administered. Leibert et al. (2020) have argued that mixed-methods outcome research uses a variety of quantitative measures, given the challenges in capturing change during counselling. Moreover, single group designs using paired data help control for individual differences in outcomes. In phase two, semi-structured, individual interviews were conducted with a small number of participants to better contextualise the quantitative responses in questions 1 and 3 and to address research questions 2 and 4.

2.2 | Participants

Phase one participants were recruited from former clients of a specialist BZD counselling service during a routine, 3-month post-discharge follow-up. The service was located in Melbourne, Australia. Clients were assessed by the service as suitable for community care, and their presentation did not include high-risk polydrug use or complex medical conditions requiring inpatient hospital care.

All clients who were due for routine follow-up during the 3-month evaluation period were invited to participate. Twenty-four clients aged between 25 and 83 years consented, and their pre- and postintervention questionnaire responses constituted the phase one quantitative data. Of the 24 participants, 14 were males and 10 were females. The mean number of counselling sessions attended was nine. Available summary demographic and BZD data for each participant are provided in Table 1.

Following receipt of the participant information sheet, six (five females and one male) of the 24 participants also consented to undertake an in-depth individual interview. Before undertaking the interview, participants were encouraged to discuss their nomination with either the University research team or their counsellor. The resulting interview data constituted the phase two qualitative research. Phase two interviewees received a \$30.00 department store voucher for their participation.

2.3 | Measures

The *Victorian Alcohol and Other Drug (AOD) Self-Completion Form* (DoH, 2021) was used to collect quantitative data during phase one. The Self-Completion Form incorporates several well-validated drug and health screening questionnaires.

To evaluate the effectiveness of counselling, items from the *Australian Treatment Outcome Profile* (ATOP; Ryan et al., 2014) were used to compare participants' pre- and postintervention BZD use. The ATOP is a brief, one-page measure of substance use and health over the preceding 28 days that has been adapted from the UK Treatment Outcomes Profile (TOP; Marsden et al., 2008). The ATOP surveys both illicit and prescription drug use.

Items from the ATOP are scored using frequency questions (e.g. number of days over the past 4 weeks), quantity questions, yes/no questions and self-ratings. Sample items include 'How often did you use benzodiazepines (prescribed and illicit) over the past four weeks?' and 'Did you use benzodiazepines at any time?' Psychometric properties of the ATOP have been widely investigated and good to excellent (0.74–0.82) interrater reliability coefficients for benzodiazepine use have been found (Deacon et al., 2021; Ryan et al., 2014). Concurrent validity with a range of 'gold standard' measures ($r = 0.51$ – 0.72) and good to very good sensitivity and specificity scores for diverse samples, including individuals participating in community treatment, have been established (Lintzeris et al., 2020).

Additionally, the *Kessler 10* (K10; Kessler et al., 2002) was used to assess participants' pre- and postintervention levels of

TABLE 1 Participant demographic data

Participant number	Gender	Age	Sessions attended	Presenting BZD	BZD use 3-month post-discharge	Current dose	Other drug use/comorbidities
1	M	72	5	Alprazolam	Nil	Nil	Nil
2	M	60	2	Diazepam	Diazepam	15–30mg	Prescribed and unprescribed BZDs
3	F	45	10	Diazepam	Diazepam	1.5 mg	Tobacco
4	M	39		Stilnox	Stilnox		Alcohol, binge drinking
5	M	25	17	Diazepam (post-relapse with hospital admission)	Diazepam	Nil	Alcohol, methamphetamine, prescribed BZD, prescribed opioid, codeine, tobacco
6	M	34	25	Clonazepam	Nil	Nil	Alcohol, tobacco
7	F	42	10	Alprazolam	Nil	Nil	Nil
8	M	50	1	Clonazepam	Nil	Nil	Cannabis, tobacco
9	M	32	1	Temazepam	Nil	Nil	
10	F	55	10	Diazepam (post-relapse with hospital admission)	Diazepam	16 mg	Non-prescribed BZD, opioids and cannabis
11	F	72	2	Diazepam	Diazepam	15 mg	Alcohol, tobacco
12	F	54	1	Clonazepam	Clonazepam	0.6 mg (12 mg Diazepam equivalent)	Alcohol, prescribed zopiclone, pain management
13	M	57	6	Diazepam	Diazepam	10 mg	Non-prescribed opioids, tobacco
14	M	65	15	Alprazolam	Diazepam	20mg	Tobacco
15	M	47	1	Alprazolam	Clonazepam	1.5 mg (30mg Diazepam equivalent)	Tobacco
16	M	47	39	Diazepam	Diazepam	8 mg	Melatonin prescribed
17	M	42	2	Alprazolam	Alprazolam	2 mg (10 mg Diazepam equivalent)	Injecting heroin every 3–4 days
18	M	38	1		Diazepam	30mg	Non-prescribed BZD, Panadeine Forte
19	F	83	13	Serepax	Nil	Nil	
20	F	66	20	Diazepam	Nil	Nil	
21	M	69	8	Zopiclone	Zopiclone	1.75mg	
22	F	37	15	Diazepam	Nil	Nil	
23	F	47	5	Alprazolam	Nil	Nil	
24	F	45	15	Imovane	Diazepam	1.5 mg	

psychological distress. The K10 comprises 10 items, which are rated on a 5-point Likert scale ranging from 1—*None of the time* to 5—*All of the time*. Examples of items include 'During the past 30 days how often did you feel worthless?' Excellent reliability ($\alpha = 0.93$) has been reported for the K10, and it has strong content and predictive validity (Andrews & Slade, 2001; Kessler et al., 2002, 2003).

A further two client-reported outcome ratings were used to capture the confidence clients had in the intervention and the extent to which they felt respected. The items were 'I have confidence in the counsellor's knowledge and skills' and 'I felt respected by the counsellor'. Each item was rated from 1—*Strongly disagree* to 5—*Strongly Agree*.

Phase two semi-structured interviews commenced with an introduction and general questions about the client's experience with BZDs. Clients were then asked about how they found the service, the benefits of the service and challenges they faced with the delivery and access to the service. Interviews were concluded by asking clients for their suggestions about how the service could be improved.

2.4 | Procedure

Approval from the Monash University Human Research Ethics Committee (Project No. 12196) and service approvals were obtained before the evaluation commenced. De-identified data were accessed following client consent. Participants completed the Victorian AOD Self-Completion Form at both intake and at the 3-month follow-up.

Tapering was individualised in line with the Ashton Manual (Ashton, 2013) and Australian guidelines for BZD withdrawal (Manning et al., 2018). In phase two, in-depth interviews were conducted by the second author as part of a postgraduate, professional psychology research project. The interviewer was unknown to the clients.

2.5 | Intervention

Taper schedules were developed by counsellors in collaboration with the prescribing doctor and included conversion to a single, long-acting BZD followed by a tapered dose reduction of around 10% every 1–2 weeks. Schedules were regularly reviewed and negotiated with the treating medical practitioner and client, as outlined in the services of *Benzodiazepine Toolkit* (Reconnexion, 2018).

A collaborative, shared-care approach to deprescribing was used and followed the *Having the Conversation* model that was developed for prescribing doctors by the service (Oldenhof et al., 2019). The model incorporates three initial steps for prescribers: starting the conversation, reviewing the costs and benefits of medication, and education and intervention. At any time during this process, referral for psychological counselling/support can be initiated. Counselling

sessions were available on a government subsidised, fee-for-service basis with fee exemptions for vulnerable groups.

Psychoeducation and teaching clients coping skills underpinned all counselling interventions. The *Benzodiazepine Toolkit* (Reconnexion, 2018) provided a comprehensive guide that counsellors used to explain how BZDs work, dependency, treatments, withdrawal symptoms and deprescribing. Comorbid anxiety, depression and trauma were addressed through evidence-based interventions including cognitive behavioural therapy, acceptance and commitment therapy, interpersonal therapy and brief psychodynamic therapy. Specific intervention components that counsellors used for coping with anxiety, depression, symptoms of withdrawal and trauma included activity scheduling, goal setting, mindfulness/meditation, progressive muscle relaxation and cognitive restructuring.

The counselling intervention was conducted by trained counsellors employed by the service (Wurf & Swing, 2022). Two of the counsellors were endorsed, registered psychologists, one in counselling psychology and one in health psychology. A further two counsellors 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 to 25 years.

2.6 | Data examination and analysis

To compare preintervention and postintervention levels of psychological distress, a paired samples *t* test was used. Preliminary data were examined using recommendations from Hair et al. (2018). Missing data were less than 10% and, hence, were not included in the analysis. Pre- and postintervention K10 scores were available for 21 of the 24 participants. Outlier checks did not detect distinctive scores, and the assumptions of the paired *t* test were met. Skewness (0.47) and kurtosis (0.32) were well within acceptable limits (Hair et al., 2018). When visually inspected, difference scores from the pre- and post-K10 results were normally distributed. This was supported by the results of the Shapiro-Wilk test ($W = 0.96$, $df = 21$, $p = 0.71$), which indicated no significant difference from a normal distribution. The effect size was calculated using Cohen's *d*, and established conventions were used for interpreting the effect size (Cohen, 1988). Quantitative data were analysed using IBM SPSS Version 25.0 and G*Power 3 (Faul et al., 2007) statistical software.

Phase two interviews were conducted by the second author and were digitally recorded and transcribed. Transcripts were coded using analytic memos with second cycle pattern coding used to extract the main themes (Saldaña, 2016). Codes were summative, key words or phrases which captured the essence and meaning of the extract. Themes were the organising concepts used to represent patterned responses (Braun & Clarke, 2013). In this sense, the method of thematic analysis was an essentialist or realist method that attempted to capture the experiences, meanings and reality of participants (Braun & Clarke, 2006) and then provide a coherent, patterned overlay of shared

constructs by combining these into salient themes. Initial coding was completed by the second author with member checking by the first author. Discrepancies in coding were resolved by consensus.

3 | RESULTS

The results are grouped according to the four research questions that captured five dimensions of the Australian Health Performance Framework.

3.1 | Is focused counselling, combined with a medically supervised taper, effective in reducing BZD use and psychological distress? (effectiveness)

Over the preceding 28 days, 87.5% of participants had either reduced or not used BZDs. Compared to their use at intake, 16 participants had reduced their BZD dose and five participants had not used BZDs over the preceding 28 days. On the day of follow-up, 10 of the 24 participants reported they had reduced their dose to nil. In addition to BZD reductions, 46% of participants reported they had also reduced their use of alcohol and other substances over the same time period.

Paired intake Kessler 10 scores were available for 21 of the 24 participants ($M = 27.61$, $SD = 10.15$), and these were compared with their 3-month discharge scores ($M = 21.28$, $SD = 8.39$). A paired samples t test yielded a statistically significant reduction in scores ($t = 3.87$, $df = 20$, $p = .001$, $CI [2.91, 9.74]$, $d = 0.84$). The effect size was large and indicates a significant reduction in self-reported psychological distress in clients following focused counselling for benzodiazepine withdrawal.

Australian Bureau of Statistics (ABS, 2012) scoring guidelines for the K10 classify scores within the range of 22–29 as a *High* level of psychological distress. Scores between 16 and 21 indicate a *Moderate* level of distress. Only around 12% of the Australian adult population is expected to score over 20 on the K10, and scores within the range of 20–24 have been associated with mild mental disorders (Andrews & Slade, 2001, Kessler et al., 2002). Higher scores are associated with more significant disorders and a higher number of mental health consultations. Compared to population norms, participants' scores dropped from a high level of psychological distress to a moderate level of distress following counselling. Qualitative analysis also supported high satisfaction with the service and included the comments, 'I'm functioning the way I am because of [the service], [It's] improved my quality of life' (Participant 21) and 'I received the results I wanted ... can't speak highly enough of them' (Participant 23).

3.2 | Do clients perceive BZD counselling as safe and accessible?

Participants reported a sense of both physical and emotional safety when attending the service. This sense of safety was attributed to the relationships that they developed with service staff, as well as a

warm and welcoming environment. Participant 21 said they 'feel safe and protected with [counsellor], I tell her everything', and Participant 22 stated, 'I always felt extremely comfortable'.

For clients with low incomes and pensioners, the service being accessible was especially important. The service was geographically and physically accessible, and access to public transport, parking and telephone/online counselling was valued. Two participants noted that the service was available free-of-charge for clients with limited incomes.

A barrier to access was that the support line only operated during business hours. Participant 24, for example, stated, 'I've always thought 9-5 Monday to Friday sucks ... [They] should change if serious about providing [an accessible] service'. Indeed, all participants supported a 24-hr helpline being developed to provide specialist information and support for BZD users. Participant 23 noted, 'If I need help [after hours] I go to [the] hospital, but yes [a] 24/7 ... service would be extremely helpful ... [I'm] 100% supportive ... [It] would be amazing'.

Three participants discussed their experiences with national, after-hours telephone support and counselling crisis lines that are routinely recommended by mental health professionals and the media. Of note, these three participants all reported that generic telephone counselling services were not able to assist with providing the specialist BZD deprescribing information and support that they were seeking.

3.3 | During a medically supervised BZD withdrawal, how confident and satisfied are clients with receiving focused counselling? (appropriateness)

As previously described, a strong theme from client interviews was that positive and supportive relationships with counsellors were an important feature of appropriate support. Client outcome ratings were analysed, and 96% of participants either *agreed* or *strongly agreed* that they felt respected by the counsellor (Figure 1). Further, 87% of participants either *agreed* or *strongly agreed* that they had confidence in their counsellor's knowledge and skills (Figure 2).

Clients generally felt that they were afforded a sense of control and self-determination over the withdrawal process and counsellors provided guidance, information and support. Importantly, clients reported that they were 'in charge' of the withdrawal process and that the use of tapering was 'helpful'. Participant 25 stated, 'My counsellor does goal-setting, monitors progress on [the] reduction program, [is] very empathic and supportive, reminds me of the commitment I have made, understands me ... [I am] confident in the counsellors ... I give [the] counsellor 10/10'.

Clients reported that community-based service delivery, as distinct from residential rehabilitation/inpatient models of treatment, was generally appropriate. Community treatments assisted in maintaining existing supports, although Participant 21 believed that integrated models providing both residential and follow-up community support would be helpful.

FIGURE 1 Participant ratings of the item, 'I Felt Respected by the Counsellor'

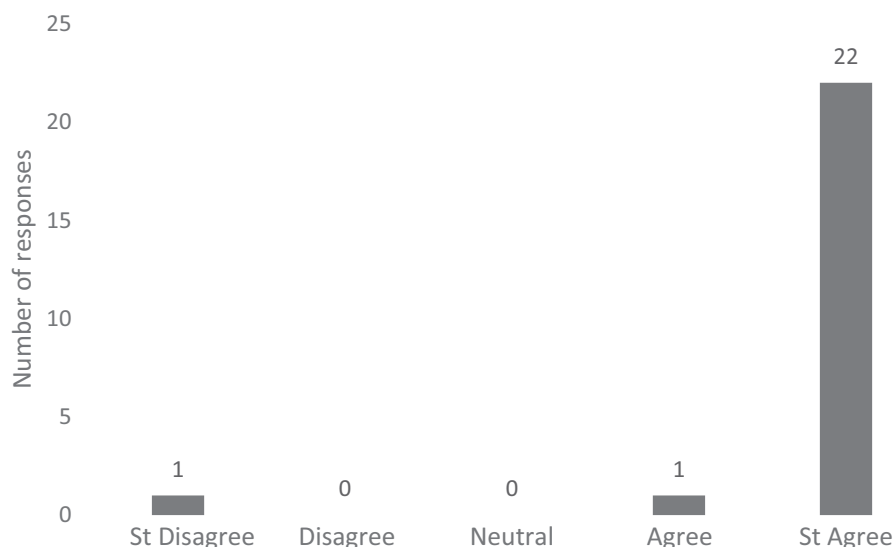
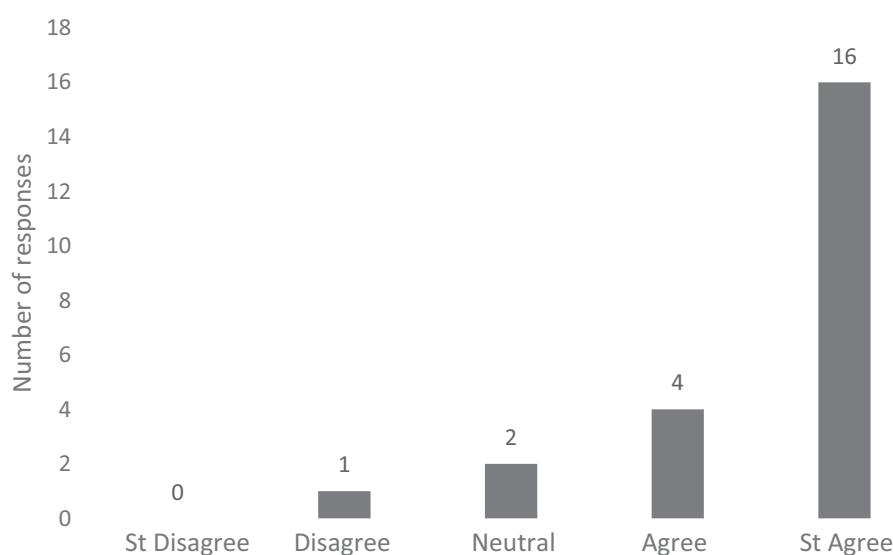


FIGURE 2 Participant ratings of the item, 'I have Confidence in the Counsellors' Knowledge and Skills'



3.4 | Do counsellors work with prescribing doctors to deliver coordinated interventions? (continuity of care)

Working with a benzodiazepine counsellor and other healthcare providers (e.g. the prescribing doctor, psychiatrist and other mental health practitioners) was a major source of frustration for some participants. Participants reported that when health providers cooperated, a high level of coordinated, consistent care was provided. At other times, depending on the medical practitioner, psychiatrist or mental health services involved, collaboration was less likely and the lack of cooperation in supporting clinical goals led to confusion and miscommunication. In these situations, clients tried to educate themselves, often via the Internet, about the advantages, disadvantages and side effects of their medications.

Major themes to emerge from the qualitative data were resentment at the drug side effects, the need for a strong therapeutic alliance with the counsellor, the value of social support during withdrawal, flexible interventions, disempowerment with some health

professionals and haphazard access to services and high-quality information.

4 | DISCUSSION

Although it has been recommended that psycho-social support is a crucial factor in the successful withdrawal from benzodiazepine medications, few studies have evaluated specific interventions that provide such support. The findings from this study suggest that focused benzodiazepine counselling and the availability of a telephone support line were effective in assisting clients to reduce their use of prescription BZDs and other drugs. The decrease in the use of BZDs by participants at follow-up and the significant reduction in psychological distress, with a large effect size, provided evidence for the effectiveness of the intervention. These findings are consistent with Parr et al.'s (2009) meta-analysis that showed improved withdrawal outcomes when tapering was combined with psycho-social support. Parr and her colleagues noted that support

is needed to not only address the management of symptoms associated with withdrawal, but also comorbid conditions such as anxiety, depression and insomnia, which could have led to the initial BZD prescription.

The second research question was designed to explore the safety and accessibility of the service. Participants felt safe and valued the ready access to the BZD telephone helpline. Crucially, strong collaborative and respectful relationships with counsellors led to feelings of trust and safety. The importance of the client–counsellor relationship and ‘common factors’ in counselling outcomes is well recognised within the psychotherapy literature (Wampold, 2015). Furthermore, Knuuttila et al. (2012) found that as substance use counselling progressed, therapist ratings of the relationship improved; however, therapist ratings of the first session were a significant predictor of retention. Clients in the current study valued access to more specialist information about BZD withdrawal, and client education has previously been recognised as an essential component of successful BZD withdrawal (Dou et al., 2019; Mugunthan et al., 2011). Indeed, clients found it problematic when out-of-hours access to a specialist telephone helpline was not available.

In relation to the appropriateness of counselling, participants gave very high ratings when asked if they felt respected and if they had confidence in their counsellor’s knowledge and skills. Community-based counselling interventions for BZD withdrawal and support were considered appropriate, although some clients expressed interest in the integrated residential treatment options, while others were unconvinced about the initial switch to longer acting BZDs (diazepam) in the controlled taper. Nevertheless, tapering to manage withdrawal was well tolerated and was regarded favourably.

Importantly, a client-centred approach that tailored the reduction schedule to individual needs and allowed for client control over the pace of reduction was valued by clients. This client-centred approach can be contrasted with the reticence and barriers that have characterised the attitudes of health professionals to deprescribing (Anderson et al., 2014; Porath-Waller et al., 2015). Further, a lack of control and agency has been noted as an important factor in adults unilaterally discontinuing their psychiatric medications (Keogh et al., 2021) and the lack of involvement in medication decision-making has been found to be a challenge for young people with a mental illness (McMillan et al., 2020). More generally, favourable outcomes for collaborative models involving shared decision-making have also been found for pluralistic models of counselling for young people with substance use (Joyce et al., 2022).

The final research question concerned continuity of care and how effectively different healthcare providers coordinated the delivery of services. As with previous studies, uncoordinated care was found to have a negative impact on BZD withdrawal (Sun et al., 2017; Tannenbaum et al., 2014). This may indicate that some prescribing doctors remain reluctant to actively consider non-pharmacological, psycho-social support options in withdrawal and to address the potential adverse side effects of prolonged BZD use. Although there is some evidence of decreasing BZD prescribing within Australia,

inappropriate BZD use remains a major health risk and this underscores research suggesting that targeted education about BZDs for prescribers is necessary. As Magin and his colleagues contended, changing individual prescriber behaviour will require continuous education. However, they also note that such deprescribing programmes have been designed and implemented successfully to reduce inappropriate antibiotic prescribing (Magin et al., 2018). Additionally, programmes directed at clinicians reducing polydrug prescriptions involving BZDs and other drugs, especially opiates, and providing patient education may play an important role in lowering the risk of overdose deaths and over-prescribing (Parr et al., 2006, 2011; Zoorob, 2018).

Current initiatives to reduce BZD use have tended to focus on the introduction of real time and other government prescription monitoring activities. Nonetheless, the results from a recent analysis of US data (Liang & Shi, 2019) suggested there were no significant associations between the adoption of mandatory prescription monitoring programmes by state governments over the last 20 years and US BZD drug overdose deaths. The findings of the current research are, therefore, timely. They highlight the need to ensure that accessible educational and evidence-based psycho-social supports to discontinue inappropriate BZD use are available for patients who have been identified as at-risk BZD users.

4.1 | Limitations

Several limitations were inherent in the design of the evaluation. Firstly, the extent to which the findings can be generalised is limited by the small sample and the lack of a control group. Selection biases may have also operated in the recruitment of participants, particularly in phase two where a small financial inducement was offered to interviewees. In addition, response bias due to the demand characteristics of participating in an evaluation and social desirability biases may have influenced the outcomes. Postintervention data were collected three months post-discharge and longer-term outcomes were not investigated. A further limitation is that self-reported medication doses and outcome measures were not validated against other independent measures of drug use. Nonetheless, moderate to high correlations have been obtained between self-reported medication data and independent electronic medication monitoring devices (Monnette et al., 2018). In addition, self-report data (e.g. Patient Reported Outcome Measures, PROMS) are frequently used in evaluating health outcomes.

Potential differences in intervention outcomes between counsellors were not systematically investigated, although the very high ratings obtained for counsellor knowledge and skills, as well as feeling respected by the counsellor, may suggest counsellor differences were mediated by the use of explicit, negotiated reduction goals, recommended taper schedules, manualised psychoeducation about BZDs and individualised counselling for comorbid conditions. Finally, benefits to clients that are associated with the use of BZD medications were not systematically explored.

4.2 | Implications

While randomised controlled trials will help substantiate the effectiveness of counselling during tapering for psychoactive medications that cause dependence, our findings show strong client support for the tapering process and for the appropriateness of counselling interventions during withdrawal. Safe and accessible support was provided using a community-based service model, and outcomes were strengthened by well coordinated services and allowing clients to maintain a sense of control over the pace of the tapering. In addition to encouraging the use of counselling as part of the tapering procedure, attention could be given to identifying measures to support deprescribing by doctors, especially in the context of polydrug use.

The findings have policy implications, highlighting the value of counselling and education in programmes that target BZD withdrawal. Nonetheless, there are inherent costs associated with providing focused counselling within broader models of deprescribing for psychoactive medications. However, these costs and questions of scalability and viability need to be balanced with opportunities for enhanced client outcomes including improved daily functioning and reduced psychological symptoms.

5 | CONCLUSION

Inappropriate and long-term use of BZDs remains a significant health concern as these medications continue to be implicated in polydrug overdose deaths. This limited sample study adds to the evidence supporting the use of BZD counselling, education and support in reducing the use of BZDs. Participants resented the side effects of BZDs and identified the need for a strong therapeutic alliance with the counsellor. The value of social support during withdrawal and flexible interventions was acknowledged. Of concern, disempowerment with some health professionals and haphazard access to services and high-quality information were barriers to effective treatment. The findings have policy implications, highlighting the value of counselling and psychoeducation in programmes that target BZD withdrawal.

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