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An Evaluation of Practitioner's Experience of Service Users Seeking Community Detoxification from Benzodiazepines

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ABSTRACT

A recent report in Ireland identified that two-thirds of poisoning deaths involved poly drug use with an average of four different drugs involved. Of these, benzodiazepines were the most common drug group involved. Concern has been expressed regarding high levels of benzodiazepine prescriptions globally. Community-based detoxification programs are required, but detoxification is complex with associated high risks, such as overdose. This study utilized a survey to gather the experiences of a range of drug workers in addiction settings in the southern region of Ireland who are tasked with the management of supporting service users who wish to detoxify from benzodiazepines. The purpose of this study is to identify the issues highlighted in the data and consequently inform policy development, service delivery, future training, and pathways to support service users (SUs). Findings indicate that, while practitioners had high levels of confidence in managing community-based detoxes, levels of knowledge of schedules, contraindications, access to support, and appropriate referral pathways were limited. Barriers to supporting detoxes emerged, emphasizing the importance of multidisciplinary and interagency care planning. Changing trends in drug use led participants to indicate a need for pharmacology training and development of specific local protocols.

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Introduction

Prescription drug use has reached epidemic proportions globally (Schmitz 2016). Benzodiazepines (BZDs) are widely prescribed sedative drugs for a range of conditions, particularly used for anxiety-related disorders and muscle spasticity (Longo and Johnson 2000; Mehdi 2012). Individuals experiencing anxiety disorders consider BZDs as effective due to their immediate effect and ability to be taken intermittently in response to the fluctuating nature of anxiety-induced experiences (Salzman 1990). According to Ashton (2002), BZDs are typically used by two distinct groups: low-dose prescribed users and high-use non-prescribed users. Ford et al. (2014) categorize BZD into three groups: prescribed for mental health issues, therapeutic dose users, and high-dose users. This article is primarily concerned with the latter. The long-term use of BZDs is much more controversial, as they lose efficacy and have been associated with adverse reactions. Problems associated with long-term use include rebound of the symptoms for which they were prescribed, alteration of sleep architecture with loss of sleep efficiency, nightmares, agitation, anterograde amnesia leading to cognitive impairment, confusion, depression, psychomotor compromise with increased risk of falls and motor vehicle accidents, withdrawal symptoms upon discontinuation, and risk of dependence and misuse in special populations (Longo and Johnson 2000; Umbricht and Velez 2015). It is argued that high-dose BZD dependence and misuse are increasingly problematic (Liebrenz et al. 2016), and are associated with poorer treatment success (Vogel et al. 2011). There is limited understanding of the reasons for this misuse (Kapil et al. 2014); however, the relationship between addiction and mental health (Schmitz 2016) and trauma (Vogel et al. 2011) is gaining attention (Carruth and Burke 2006).

Up to one million people in the U.K. are long-term prescribed BZD users (Ashton 2002), while the numbers in the United States have has been described as reaching "epidemic proportions" (Cannon et al. 2014). Lifetime drug use among 15- to 34-year-olds in Ireland has increased between 2002 and 2011 from 25.9% to 35.7% (National Advisory Committee on Drugs 2011). The most commonly used drugs in 2010–11 in this age group were alcohol (86.3%), tobacco (37.3%), opiates other than

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heroin (such as codeine, oxycodone, and morphine) (28.3%), cannabis (10.3%), synthetic psychoactive substances (6.7%), and sedatives/tranquilizers (4.8%). The sedative/tranquilizer category of drugs was the only category in which a rise was observed since the previous survey, completed in 2006–07. A recent review of substance use among young people indicated that BZDs were the only substance whose prevalence did not decrease over a 10-year review period (Murphy et al. 2013). In the period 2003–08, there was a five-fold increase in the number of young people who received treatment for BZD use in Ireland (Bellerose, Carew, and Lyons 2011; Murphy et al. 2014). These two studies highlight that BZD misuse is not following the trend of decreasing use, as other substances are. Between 1998 and 2007, BZDs were implicated in nearly one-third (31%) of all deaths by poisoning, with the annual number increasing from 65 in 1998 to 88 in 2007 (Bellerose, Carew, and Lyons 2011), and the number of deaths where BZDs were implicated increased by 24% to 160 in 2013 compared to 129 in 2012, with 41% of poisonings in 2013 involving BZDs (HRB 2015). In 2014, there were approximately two drug-related deaths per day and prescription drugs were implicated in three out of every four of these deaths; while BZDs were the most common drug group in poly drug deaths, other prescription drugs were also implicated, such as methadone and zopiclone (HRB 2016).

While the long-term effects of BZD use have been well-documented, there are differing views on what constitutes addiction. For example O'Brien (2005) argues that long-term prescribed users exhibit dependence but not necessarily addiction or problematic use, while others argue that long-term prescribing is inappropriate and short-term prescriptions (i.e., 2–4 weeks) should be administered (Ashton 2005). Withdrawal treatment is the recommended approach to treatment of BZD misuse (Ashton 2002; Liebrenz et al. 2016). Withdrawal can be difficult for many users. Withdrawal symptoms can be divided into three main groups: anxiety and anxiety-related symptoms, perceptual distortions, and major events—i.e., psychosis or seizures (Hood et al. 2014). Withdrawal treatment is often unsuccessful for a large percentage of users, particularly high-dose illicit users (Liebrenz et al. 2015; Lader 2014). A range of recommendations exist on the appropriate method of BZD detoxification. The consensus is that detoxification schedules should be tailored to the individual and slow, gradual schedules are the most appropriate—months and years, rather than weeks (Ashton 2002; Denis et al. 2006; Ford et al. 2014). Research to date has demonstrated that interventions are more successful when the service user has been involved in determining the schedule, as opposed to being instructed (Aldoori and Rahman 1998; Liebrenz et al. 2016). Despite these findings, support available to individuals requiring BZD detoxification can vary; auxiliary supports, such as psychological therapies, are not always provided and this increases the likelihood of relapse (Ashton 1994; Einarson, Selby, and Koren 2001).

Substance dependence treatment in Ireland is provided by statutory, voluntary, and private agencies and is divided into a four-tier system (Butler 2011). The four-tier model of care includes Tier 1 (information, advice, and screening), Tier 2 (screening, harm reduction, and onward referral to specialist services), Tier 3 (specialized community addiction teatment services), and Tier 4 (inpatient specialist addiction services) (O'Gorman and Corrigan 2008).

Currently, Ireland has no formal policy or strategy to tackle dual diagnosis (DD) (i.e., comorbidity of a mental illness with a substance use disorder). In 2002, the National Advisory Committee on Drugs (NACD) commissioned a research study on the management of DD in mental health and addiction services (MacGabhann et al. 2004). This study identified a number of gaps that, to this day, have not been addressed. For instance, the prevalence of DD in Ireland is not known, the term DD is not explicitly referred to in health and social policy, and there are no guidelines for the management of DD in existing services. The National Action Plan for Social Inclusion 2007–2016 states, "Access to quality health services is a prerequisite for participation in the social and economic life of society. Working to improve the health status of all, and particularly vulnerable groups such as people with disabilities including those with mental illness, drug users…" (Department of Social and Family Affairs 2009). Advocacy groups argue that while aspirational policy documents exist, there is a lack of appropriate services for individuals with a DD and that mental health and addiction services are failing to work together to provide the best outcomes for vulnerable clients. Little has been achieved, apart from some contained informal collaborations by practitioners in an attempt to meet their clients' needs (Connolly, MacGabhann, and McKeown 2015). The view that DD affects a minority of those seeking treatment is diminishing, and many recognize that it is more likely the norm (Miller and Miller 2009). Increasingly, addiction practitioners view addiction and mental health as parallel processes frequently linked to stressful or traumatic events and early developmental issues, such as attachment difficulties, and there is some empirical support for this; however, more research is required and there is a clear gap between research and policy (Flores 2001; Carruth and Burke 2006; Hari 2015).

The aim of this study is to gather data from practitioners working in Tier 2 (Community Drug and Alcohol

Projects), Tier 3 (Non-Residential Specialized Treatment Center), and homeless services in the southern region of Ireland to explore practitioner perspectives on knowledge, competencies, and external supports to facilitate service users (SUs) who seek a community BZD detoxification. Findings may inform policy development, service delivery, future training, and pathways to support SUs who present with polysubstance misuse problems and seek a community-based BZD detoxification.

Method

Ethical approval for this research was gained from the School of Applied Psychology, University College Cork. The study used a purpose-built SurveyMonkey® survey compiled by the research team and informed by the research question. There were 14 questions in total, which can be categorized into demographics of practitioners and service users, competencies, experiences and knowledge of BZDs and their detoxification. Each question additionally facilitated the collection of comments from participants. The survey was distributed via email to 104 front-line staff working with service users in addiction settings. The participants are all practitioners who work in Tier 2 and Tier 3 drug and alcohol services as well as homeless services in the Cork and Kerry area. These practitioners work either in statutory Health Service Executives (HSE) services or voluntary and community projects, and all operate under the same specified case management structures and protocols to ensure effective interagency involvement. All participants are over 18.

A mixed-method design was employed, as qualitative and quantitative research used together produce more complete knowledge of lived experience necessary to inform theory and practice, and can provide stronger evidence for a conclusion through convergence and corroboration of findings (Johnson and Onwuegbuzie 2004). Descriptive statistics and graphs were compiled using SurveyMonkey® software, while the qualitative responses were collated and analyzed using content analysis informed by Hsieh and Shannon (2005).

Results

Demographic data

From a possible 104 workers, 83 (80%) completed the survey. Age and gender of participants were not collected. Table 1 provides the breakdown of occupational roles; some participants chose more than one role. The roles are evenly distributed across three tiers. The services that these individuals work in are signed up to a set case management and key working system that provides for interagency collaboration and onward referral through the tiers, dependent on the service user's needs.

Table 1. Occupational roles of participants.

Q1. What best describes your current role within the addiction services?	
Tier 1	35.8%
Tier 2	29.9%
Tier 3	38.8%
Addiction Counsellor	17.9%
Nurse or GP	15%
Psychologist or Psychiatrist	3%

The number of service users seen weekly by practitioners ranged from 3–78 with a mean of 18. Of this, the approximate numbers of service users requiring BZD detox varied from 10% up to 80%. These service users are not necessarily seeking such a detoxification; rather, participants have identified that they have a range of clients who would need the service should they request it.

Competencies and knowledge

Most participants (86%) stated that they felt competent in working with service users who are on a structured BZD detoxification program. This program follows national guidelines; i.e., service user has requested the detox, has kept drug diaries and attended relevant appointments, and has been appointed a keyworker and a GP willing to manage prescribing of the reducing dose. However, this level of reported competence dropped to 71% when working with service users abusing "street" or non-prescribed BZDs. This cohort of service users tend to binge large amounts of BZDs and engage in poly-substance use. Despite the high levels of competence reported, only 36.4% reported being aware of the contraindications to community detoxification. When asked further if they felt comfortable managing the risks associated with relapse following community detoxifications, 76% stated that they were. The analysis of the qualitative data supplied in the comments sections related to competence generated two main themes: pharmacology and client.

The theme of pharmacology revealed that participants lacked clinical information about BZDs.

> *P19: "I am not medically trained, I feel that I need to understand more fully both the physiological and psychological consequences of supporting a detox."*
>
> *P13: "I feel ill equipped as I do not have medical training, so I feel that I lack adequate scientific knowledge around how benzos effect service users."*
>
> *P7: "Not clear on the risk factors when mixing with other medications, not clear on the risks of internet benzos."*

There is a disparity between the survey responses and the follow-on qualitative reports of the practitioners.

Competence levels were reported as high in the structured questions; however, when given the opportunity to expand on their responses, an overwhelming number reported lacking knowledge concerning the pharmacology of BZDs.

The second theme in this category related to *client*, where client-specific issues were problematic for the management of a community BZD detox:

> *P61: "I feel confident enough if the client turns up for his session as we can monitor his level of use and its effects… I worry when a client doesn't turn up."*
>
> *P37: "Very unpredictable behaviour, unknown quantities, large quantities."*
>
> *P30: "It is very difficult to determine how much the client is taking… always concern about withdrawals and seizures."*

There is evidence of a level of fearfulness and uncertainty by practitioners in relation to the quantities of BZDs being used by their clients. This ultimately has consequences for the confident management of BZD detoxifications in the community. Appropriate clinical supervision, multidisciplinary team approaches, and clear case management structures, as well as specific BZD detoxification protocols, can help mitigate this.

Community detoxification pathways and supports

Most respondents (72%) stated that they were aware of the pathways available to service users who require a BZD detox, and over 98% stated that service users should have a say in their detox schedules; most concur that the pace should be at a comfortable pace for the service user (see Figure 1). This demonstrates that the majority of the practitioners share the views of the literature (Ashton 2002; Liebrenz et al. 2016). However, two-thirds of participants further reported that, in their experience, GPs in the community do not sufficiently support their clients' community detoxification attempts or facilitate SU opinions on their detox schedules, which highlights a significant gap in the support structure for SUs.

The majority of the qualitative responses relating to pathways for BZD community detox indicate that the GP is the point of contact:

> *P15: "GP's would be my first port of call."*
>
> *P7: "Request several weeks of drug diaries and then liaise with the GP… daily dispensing and supervised doses desirable. Weekly review."*
>
> *P4: "Care planned detox in collaboration with community GP's, keyworker, family…."*

However, others were not as clear:

> *P12: "I'm guessing GP."*
>
> *P6: "Community or residential, I've found residential easier, I feel I lack expertise on the community detox procedures."*

Practitioners in the main identified that the GP was the appropriate onward referral for a client wishing to engage in a community-based BZD detox, which is an appropriate intervention for non-medical staff; however, there were mixed reports on the medical supports available:

> *P12: "GPs prescribe Xanax too frequently compare to Valium. Also service users report that GPs want to do detoxes too quickly which have a high failure rate, it is also difficult for the GP to prescribe the amounts of benzos that mimic the amount that people are using on the street."*
>
> *P3: "[Y]es and no to this. Doctors who work closely with our service users and understand where they are at are very helpful… however many service users have difficulty relaying the reasons why they use benzos and have not been treated well due to their other addictions."*
>
> *P15: "I found it hard to communicate with GPs. I leave message and they don't return calls… clients don't feel they have enough power to liaise with GP's."*
>
> *P7: "[S]upport from Doctors varies hugely, service users attempt to get support from community drugs workers and addiction counsellors."*

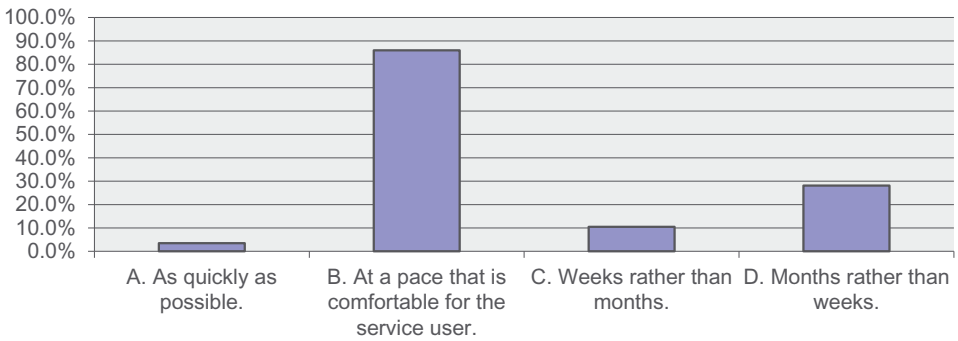

Figure 1. How quickly should a service user be detoxed from BZDs?

P9: "It varies from GP to GP. Some are excellent and remain involved with the patients and the results can be seen when their meds reduce."

This highlights inconsistencies in the involvement of GPs in BZD detox with SUs who are involved in the addiction services. It underlines issues in relation to case management and interagency involvement, which have been identified as critical structures in addiction treatment in the southern region.

Reasons for use

Participants were asked to indicate their perceptions of why service users opt to use BZDs. A prescribed list was provided (Table 2), and more than one selection was available. Additional data were collected in the comments section.

Participants indicated anxiety and addiction as the main reasons why people misuse BZDs. Qualitative responses produced themes including coping, self-medicating, gateway, unresolved trauma, and availability. The majority of the responses related to concepts of self-medicating mental health issues and unresolved trauma:

P9: "[T]hey self-medicate. They become a crutch when there are underlying mental health issues."

P11: "[D]ealing with the impact of traumatic life experiences."

P13: "[T]o escape from trauma."

Traditional models of addiction have been heavily influenced by the disease and genetic models; however, the last decade has seen an increase in research on the levels of comorbid mental health and trauma in addiction clients (McGabhann et al. 2004). The levels of mental health and addiction continue to rise globally year by year, and it is fast becoming the greatest threat to well-being (Whiteford et al. 2013). It is argued that viewing addiction as a self-medication response to trauma and/or mental health provides the client with a more holistic treatment experience more likely to address underlying issues, and thus improve engagement with the therapeutic process and, ultimately, recovery (Killeen, Back, and Brady 2015).

Table 2. Why do you feel service users' abuse benzodiazepines?

Boredom	36.8%
Stress	52.6%
Sleep/Insomnia	28.1%
Depression	38.6%
Anxiety	71.9%
Addiction	70.2%
Other	24.6%

Training and support

Participants were asked what training they required. It is worth noting that qualitative responses for every question produced reference to the need for training:

P11: "All there is to know, need training and soon, its an area that is constantly changing and increasing."

P9: "I think it would be helpful, to have an information pack and worksheets about the above that I could go through with a client on a one to one basis."

Participants appeared to not have sufficient information on the area of BZD detoxification and additionally require training in all of the following areas: BZD pharmacology, risk of overdose, withdrawals, and relapse prevention. Participants were also unclear as to the appropriate pathway, and there was uncertainty about which tier was best-suited to supporting a community detox. Participant responses reported that a number of GPs are not familiar with or adhering to best practice for longer rather than shorter detox schedules. This has implications for client engagement and, more importantly, safety with respect to relapse.

Participants used the survey to request information on GPs in the community who were prepared to support their clients, and also expressed concern about supporting clients in the community without sufficient community supports. This raises two issues: there is clearly an identified need for training across all four tiers; there is also a need to develop a local protocol or policy with clearly signposted pathways and services to complement the existing case management protocols already in place across addiction and homeless service in the southern region. This could mitigate poor experiences for practitioners and their clients if they attend medical services that are resistant.

Results would indicate that, despite the fact that participants reported feeling competent to manage SU's community BZD detoxification, they lacked confidence about their knowledge of the pharmacology, contraindications, and appropriate referral pathways. The professionals who participated in this survey also indicated that, in addition to a lack of knowledge, there were also issues related to communication with GPs in the community. The findings indicate the need for a community-based protocol to complement already existing case management structures, developed with relevant stakeholders across the spectrum of addiction service delivery with clear evidence-based guidelines and points of contact.

Discussion

The increasing health, social, and economic burdens associated with addiction continue to present challenges to

practitioners (Whiteford et al. 2013). It has been argued that the misuse of prescription medication is at epidemic proportions (Schmitz 2016) and of particular concern due to high levels of associated mortality (Health Research Board 2016). This study used a purpose-built survey distributed to a variety of practitioners who work in community-based addiction services in the Cork/Kerry region of Ireland. The aim was to collect data on the experiences of front-line staff who work with service users with addiction problems and who are tasked with the management of supporting clients who wish to detoxify from BZDs. The study sought to explore whether these practitioners believe that they have the knowledge, competencies, and support to facilitate service users who seek a community BZD detoxification.

Our findings indicate that while practitioners had high levels of confidence in managing community-based BZD detoxes, levels of knowledge of detox schedules, contraindications, access to support, and appropriate referral pathways were limited. Our findings also indicated a need for pharmacology training in all aspects of BZDs, such as types of BZDs, detox schedules, withdrawal symptoms, overdose risks, and the development of specific local protocols. As a result, it is clear that a core competency to work in addiction now requires specific training in the pharmacology of BZDs. It is also advisable that local services develop a clear protocol for supporting community-based BZD detoxes. Additionally, participants indicated that seeking appropriate medical support was ad hoc and was dependent on the SUs physicians' willingness to engage in the detox process. While a range of protocols exist, it appears that the usefulness of these is dependent on the given community's access to resources and relationships with other professionals. Thus, it would be appropriate to develop specific local protocols in conjunction with all of the relevant stakeholders, such as addiction, general practice, and mental health services, in a case-management-type structure. This allows for the protocols to take into account the services and resources available and willingness to engage in detoxes in the specific geographic areas. Case management structures are available within addiction services where a multidisciplinary approach to shared care plans can occur (Lyons 2010; McLellan et al. 1999); however, only a limited number of non-addiction support services have signed up for these. This would be especially useful in the cases of BZD detoxes, where a range of professionals are required to work in a cohesive way to maximize the likelihood of a successful treatment outcome; bringing together a greater diversity of agencies would assist in this. Given that withdrawal from BZD is likely to raise other complex issues for the SUs, such a structure increases the likelihood of treatment success and, most importantly, maximizes SU safety.

While the purpose of this study was to examine the management of BZD community detoxifications, it was noteworthy that participants repeatedly linked the misuse of BZD with either mental health or trauma. Therefore, this link should be examined in a systematic way, and a recommendation is to screen for prevalence levels of both mental health and trauma in this population. This will implicitly impact on the management of these servicer users, and therapeutic interventions should be tailored to match the needs of the presenting clients. Given that, in Ireland and globally, the numbers of drug-related deaths are increasing year by year and that prescription medication is implicated in three out of every four of these deaths (Health Research Board 2016), resources should be allocated to training and the development and implementation of local protocols.

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