Persons with a BENZOdiazepine/Z-drugs use disorder in mental health CARE (BENZOCARE)

Research Project DR/91

Policy Delphi Report

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Preface

This report is part of the BENZOCARE study and provides a comprehensive overview of the results of the policy Delphi study conducted within work packages 5 and 6. The study aimed to develop sound, tailored, and feasible policy recommendations on care for dependence on benzodiazepine receptor agonists. In this report, we detail the methodological process, present the study's findings, and contextualise the recommendations within the existing literature. It serves as a deeper analysis for those interested in exploring the recommendations derived from the BENZOCARE study in greater detail. It can be read on its own, or as an addition and elaboration of the final report. Readers can also consult it to further delve into specific recommendations and their background.

How to cite this report?

Van Ngoc, P., Scholtes, B., Anciaux, M., Desmecht, L., Pais, D., Degroote, P., Bracke, P., Belche, J-L., Ceuterick, M. (2024) The BENZOCARE Study Policy Delphi Report. Brussels : Belgian Science Policy Office 2024 – 67 p. (Federal Research Programme on Drugs).

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1. Introduction

Benzodiazepine receptor agonists (here further abbreviated as BZRA) are mainly used for their anxiolytic and sedative effects. However, both short- and long-term use of this class of psychotropic drugs can result in adverse effects, including physiological and psychological dependence, increased cognitive impairment, and a high risk of injuries such as falls, hip fractures, road accidents, and even suicide attempts or suicides (Dodds, 2017; Lader, 2011, 2014). BZRAs are widely prescribed for longer than recommended by the guidelines, which recommend a maximum use of one to two weeks (for insomnia) and four weeks (for anxiety) in the lowest effective dose (Centre Belge d'Informations Pharmacothérapeutique, n.d.). This overuse poses a major public health problem in Belgium.

In this report, we will discuss policy recommendations for Belgium on the long-term use of and dependence on BZRA. These recommendations will be classified according to their tier of prevention: primary, secondary or tertiary prevention (see 2.3.2).

2. Methods

2.1. Why a Policy Delphi?

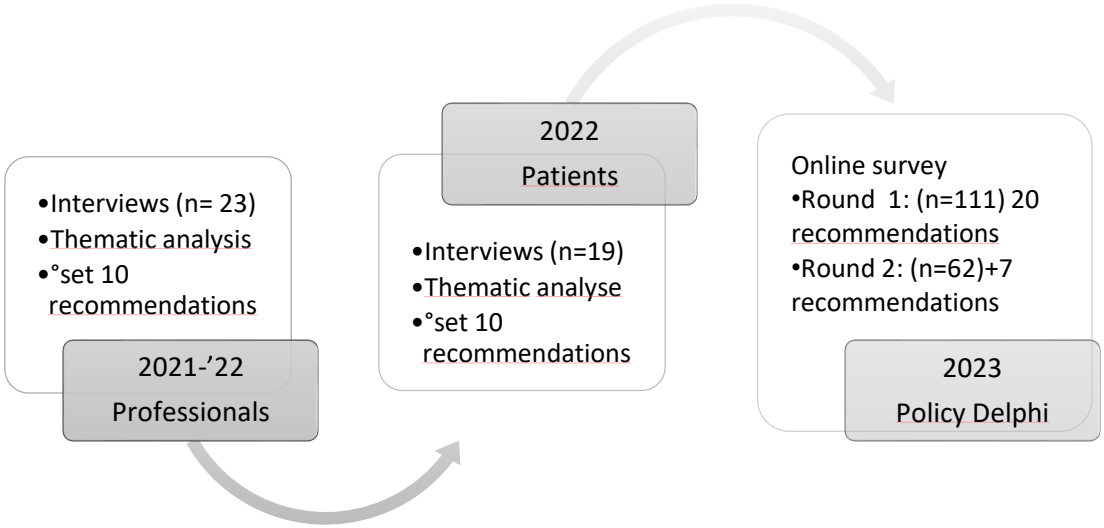
Unlike a classical Delphi method, where the goal is to reach a consensus among participants, the Policy Delphi method aims to highlight agreements and disagreements among participants on a given topic without necessarily achieving consensus. Our objective is to have a diverse and heterogeneous audience that is impacted by policy recommendations on BZRA. Therefore, instead of striving for total consensus and potentially losing alternative opinions, we will prevent an unbalanced outcome that might only reflect the dominant views or the result of limited research. It is crucial for us to ensure that all voices are represented, particularly those of patients. Our goal is to incorporate these perspectives in a balanced and empowering manner as part of a holistic approach. Hence, although we will further discuss the degrees of consensus, it is paramount to understand the diversity of views on the recommendations. Policy Delphi panels have demonstrated their value in shaping mental health and drug policies (Neale et al., 2014; Vampini & Gallelli, 2014). This method facilitates the identification of topics where most experts concur as well as areas where their views diverge (de Loë et al., 2016; Picavet et al., 2012), allowing discordance to be acknowledged as a collective expert perspective (Lintonen et al., 2014). The intended outcome of this work package will be a set of recommendations to address the treatment gap for individuals who use BZRA long term and possibly suffer from a BZRA use disorder, along with an estimation of achievable and realistic goals.

2.2. Panel selection

Healthcare professionals and patients were recruited to participate in the panel through different strategies: a call launched at a conference of health care practitioners (Big Bird study conference), via distribution of (digital) flyers in the network of the research team as well as the follow up committee of the BENZOCARE project. An online registration form was launched for potential participants to express their initial interest in the study and to provide their contact information. Through this recruitment strategy we reached more participants than the initially intended 25 participants per region. The Policy Delphi consisted of four phases: the initial compilation and subsequent classification of recommendations, and two rounds of online surveys.

2.3. The Policy Delphi Process

Figure 1 Methodological process



2.3.1. Initial compilation of recommendations

During the first phases of the project, interviews were conducted with healthcare professionals (n=23; general practitioners, psychiatrists, psychologists, social workers, nurses) and patients who are taking or have been taken BZRA (n=19). See final report for further details about the methodology employed (Ceuterick et al., 2025). Based on the interviews conducted, the research team identified a total of 20 initial policy recommendations. These were discussed extensively and repeatedly within the team to ensure correct formulation.

2.3.2. Classification of recommendations

Each recommendation was then classified according to the different tiers of prevention (Nuyens and Mertens, 2012). Primary prevention is aimed at susceptible populations and refers to all measures that aim at preventing healthy people from taking BZRA (and thus guiding towards alternatives). Secondary prevention is focused on detection and eviting progression of a disease. Translated onto our project, this includes all measures that are directed at preventing a BZRA prescription from becoming chronic use. Tertiary prevention are commonly rehabilitation efforts and, in our case, includes all measures that aim at deprescribing and reducing negative effects of chronic BZRA use. An online questionnaire was created in LimeSurvey by the research team, featuring each recommendation categorised per tier of prevention. Surveys were respectively developed in French and Dutch.

2.3.3. Round 1 (March 2023) (n = 111)

In the first round, participants were asked to evaluate for each recommendation 1) the feasibility, 2) the extent to which participants supported each recommendation and 3) the importance they addressed to the recommendation (see table 1). Feasibility, support and importance were assessed using a five-point Likert scale ranging from 'completely disagree' to 'completely agree'. Response scales were presented in ascending order, to avoid inflated data, acquiescence bias and social desirability bias (the tendency of some respondents to agree with statements or choose positive answers) (Chyung et al., 2018). The feasibility and importance scales were adjusted from Turoff (1970), adding a fifth option 'neither agree nor disagree' in line with Meskell et al. (2014). The scale to measure

support was developed in a similar manner. Furthermore, at the end of the questionnaire, participants had the opportunity to add additional recommendations in an open text box. This generated a total of twenty-seven recommendations.

2.3.4. Round 2 (End of April 2023) (n = 62)

A second round was organised using a new online questionnaire in Limesurvey. During this round, new recommendations that were proposed by participants in the first round, were evaluated in terms of 1) their feasibility, 2) support and 3) importance. Additionally, for all recommendations (from the first round and the new ones proposed by participants during the first round), participants were asked if they deemed the necessary conditions for the recommendation to be feasible already present, with an open-ended question to elaborate on their response. Finally, they were asked to prioritise each recommendation per tier of prevention (primary-secondary-tertiary).

Table 1 Questions per recommendation

Measure	Formulation of question	Scale
Feasibility	How strongly do you agree or disagree with the following statements? *In the current circumstances, it is feasible to …*	Five-point Likert scale ranging from 'completely disagree' to 'completely agree'
Support	How strongly do you agree or disagree with the following statements? *In the current circumstances, I would support…*	Five-point Likert scale ranging from 'completely disagree' to 'completely agree'
Importance	*It is important to…*	Five-point Likert scale ranging 'unimportant' to 'very important'
Open question	*If you would like to elaborate on your responses, please do so here (optional):*	/
Necessary conditions	Are the conditions already met to make it feasible?	'Yes', 'No', 'I don't know'

2.4. Data analysis

2.4.1. Quantitative analysis

Descriptive statistical analyses were conducted on the database containing data from the first and second rounds. To visualise the data, R software and Excel were used to display the information.

2.4.2. Qualitative analysis

For each question, participants were could optionally expand on their answers in an open text box (with no word limitation). A thematic content analysis was carried out on the answers to all the open questions from the first and second rounds (Flick, 2014). An initial coding matrix with recurring themes was generated through an inductive approach. This was reviewed by two interns (MA, LD). The Dutch-language interviews were coded by the Dutch-speaking student (LD), while the French-language interviews were coded by the French-speaking student (MA). Multiple discussions were held between the coders to refine the themes through an iterative process.

2.5. Literature review

From March to April 2024, a literature review was conducted (by DP), according to the Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA), to understand the nuances within each recommendation (Page et al., 2021). "Using the ScienceDirect, PubMed, and Web of Science databases as primary sources, the terms 'benzodiazepines' and 'BZRA', in combination with keywords from each recommendation—such as 'public awareness campaigns' and 'stigmatisation'—were used to establish the criteria for each search. Database searches were also conducted using synonyms to expand the search criteria as much as possible.

The literature review summaries for the policy recommendations are narrative in nature. They explore available research, examining both supportive evidence and potential weaknesses. These summaries provide a comprehensive examination of existing literature, synthesising findings from various studies to offer a balanced perspective on the efficacy and potential limitations of proposed policy interventions, in line with the Policy Delphi approach. The summaries were organised according to their tier of prevention (i.e., primary, secondary, tertiary).

3. Results

3.1. Panel characteristics

As outlined in table 2, the policy Delphi participants consisted of 65.8% health professionals, 28.8% patients, and 5.4% who identified as both a health professional and patient. There was a 69.4% female majority, where 30.6% was male. In the panel, 41.4% were between the ages of 18 to 40, 45% were between 41 and 60, and 13% were 60 years or older. Regarding geographic distribution, 21.62% were from Brussels, 53.15% from Flanders, and 25.23% from Wallonia.

Among the professionals, 29.1% were general practitioners, 1.3% were nurses, 22.8% were pharmacists, 10.1% were psychiatrists, 15.2% were psychologists, 3.8% were social workers, and 17.7% identified as 'other'. Among the participants who identified themselves as 'other', some were placed in the various existing categories, while those who remained in the 'other' category were medical professionals with a specialisation, professionals with a specialisation in mental health care or healthcare workers, researchers, or employees.

The majority of the participants have work experience ranging from 0 to 10 years (21.3%), while 19% fall between 11-20 years, 12.6% between 21 and 30 years, and 9.5% with over 30 years of experience.

Among the participants who identify as patients, 15.6% are employed, 6.3% are unemployed, 28.1% are on sick leave, 9.4% are retired, 6.3% are students, and 34.4% categorise themselves as 'other'. Participants who ticked the ‘other’ box indicated that they were suffering from a handicap or disability. Of the patients, 50 % have completely stopped taking BZRA, 13.2% are currently tapering off BZRA, 15.8% are continuing to use one or more BZRA for an extended period, and 21% are in the 'other' category. Patients who entered ‘other’, listed themselves as occasional users of BZRA.

Table 2 Sociodemographic characteristics of participants

Responding as	**N**	**%**
Patient	32	28,8
Professional	73	65,8
Both	6	5,4
Gender		
Female	77	69,4
Male	34	30,6
Age		
18-40	46	41,4
41-60	50	45,0
>60	15	13,6
Regions		
Brussels	24	21,6
Flanders	59	53,2
Wallonia	28	25,2
Professionals (including who use(d) BZRA)		
General practitioner	23	29,1
Nurse	1	1,3
Pharmacist	18	22,8
Psychiatrist	8	10,1

Psychologist	12	15,2
Social worker	3	3,8
Other	14	17,7
Years of experience		
0-10 years	27	34,2
1-20 years	24	30,4
21-30 years	16	20,3
> 30 years	12	15,2
Current occupation patients		
Student	2	6,3
Unemployed	2	6,3
Worker	5	15,6
On sick leave	9	28,1
Retired	3	9,4
Other	11	34,4
Current BZRA use among professionals and patients		
Using ≥1 BZRA (long term)	6	15,8
Tapering off ≥1 BZRA	5	13,2
Tapered off ≥1 BZRA	19	50,0
Other	8	21,1

3.2. Primary prevention [1-6]

Primary prevention is aimed at susceptible populations and refers to all measures that aim at preventing healthy people from taking BZRA (and thus guiding towards alternatives). As part of this Policy Delphi, a total of six policy recommendations are included within primary prevention.

- **1: Implement an awareness raising campaign among the general public on tapering off benzodiazepine receptor agonists**
- **2: Implement an awareness raising campaign for patients on the challenges of withdrawing benzodiazepine receptor agonists from multiple medications**
- **3: Implement an awareness raising campaign for professionals on the challenges of withdrawing from multiple (psychotropic) medications**
- **4: Implement an awareness raising campaign on the risks of benzodiazepine receptor agonists in an empathetic and non-stigmatising way**
- **5: Add warnings of the risk of dependence on the benzodiazepine receptor agonists package**
- **6: Undertake further research on the mechanisms surrounding the first prescription of benzodiazepine receptor agonists**

Recommendation 1: Implement an awareness raising campaign among the general public on tapering off BZRA

- **Feasibility**

Regarding the feasibility of recommendation 1, 45.05% of the participants responded with 'completely agree', while an equal proportion responded with 'agree'. 6.30% selected 'neither agree nor disagree'. Additionally, 2.70% of participants chose 'disagree', and 0.90% selected 'completely disagree'.

- **Support**

Participants also responded to whether they would support the implementation of recommendation 1 in Belgium, under the current circumstances. 59.46% indicated that they 'completely agree', 29.73% agree, 5.41% 'neither agree nor disagree', 3.60% 'disagree', and 1.80% 'completely disagree'.

- **Importance**

Participants rated the importance of recommendation 1 on a scale. 59.68% rated it as 'very important', 32.26% considered it 'important', 6.45% responded with 'neither important nor unimportant', none (0%) found it 'slightly important' and 1.61% regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 66.13% responded affirmatively, 25.81% replied with 'I don't know', and 8.06% answered negatively.

- **Analysis of answers to open questions**

Some patients advocate for a **shift in mindset**, seeking medical and social recognition of their suffering. Participants call for a campaign, using flyers or social media, grounded in scientific evidence and personal experiences, to destigmatize BZRA use, underscore the significance of support and self-efficacy in the recovery process and the availability of alternatives. Participants emphasise the importance of recognizing that the same campaign message can have different impacts on different individuals because patients have unique journeys and struggles. Therefore, the campaign must be adapted to **reflect the diversity of the population**. The necessary conditions for implementing this recommendation encompass developing expertise among healthcare professionals and patients concerning withdrawal symptoms, tolerance, and diagnosis, as well as fostering a societal acceptance of medication normalisation.

Recommendation 2: Implement an awareness raising campaign for patients on the challenges of withdrawing benzodiazepine receptor agonists from multiple (psychotropic) medications

- **Feasibility**

Recommendation 2 was deemed feasible by 36.93% of participants who responded with 'completely agree', while 47.75% responded with 'agree'. Additionally, 7.20% chose 'neither agree nor disagree', while 6.31% opted for 'disagree', and 1.80% selected 'completely disagree'.

- **Support**

Subsequently, participants were asked to indicate the extent to which they supported Recommendation 2. Among the responses, 53.15% indicated 'completely agree', 36.94% chose 'agree', 6.31% selected 'neither agree nor disagree', while 1.80% expressed 'disagree', and an equal percentage of 1.80% chose 'completely disagree'.

- **Importance**

A total of 53.23% rated recommendation 2 as 'very important', 40.32% considered it 'important', 4.84% responded with 'neither important nor unimportant', 1.61% found it 'slightly important', and none (0%) regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 64.52% responded affirmatively, 29.03% replied with 'I don't know', and 6.45% answered negatively.

- **Analysis of answers to open questions**

Healthcare experts stress the **uniqueness** of each polypharmacy case. Some patients favour a focus on gradual tapering, while others prefer a nuanced approach. It is essential to clarify that the campaign's main goal is not to discourage BZRA use but to raise awareness about polypharmacy withdrawal challenges. Some suggest that the campaign should rely on scientific research, endorsed by doctors and pharmacists, and distributed through a well-crafted, easily comprehensible general brochure on gradual reduction. To implement this recommendation, it is crucial to have healthcare professionals with experience in gradual withdrawal.

Recommendation 3: Implement an awareness raising campaign for professionals on the challenges of withdrawing from multiple medications

- **Feasibility**

Regarding the feasibility of Recommendation 3, 54.95% of the participants indicated 'completely agree', 34.23% agreed, 7.21% selected 'neither agree nor disagree', 1.8% chose 'disagree', and 1.8% opted for 'completely disagree'.

- **Support**

Participants also indicated the extent to which they would support recommendation 3. Among them, 64.86% expressed 'completely agree', 27.03%% indicated 'agree', 7.21% selected 'neither agree nor disagree', and 0.9% chose 'complete disagreement'. None of them chose the option 'disagree'.

- **Importance**

53.23% rated recommendation 3 as 'very important', 35.48% considered it 'important', 9.68% responded with 'neither important nor unimportant', 1.61% found it 'slightly important', and 0% regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 72.58% responded affirmatively, 20.97% replied with 'I don't know',' and 6.45% answered negatively.

- **Analysis of answers to open questions**

Some respondents find this campaign relevant due to the influence of healthcare professionals in managing BZRA. Multiple professionals suggest a **campaign focusing on reducing or avoiding prescriptions** to prevent challenging tapering. Another practitioner thinks the campaign should offer **solutions and reassurance**, demonstrating that tapering is **achievable** for both patients and general practitioners. Some patients also mentioned that it may **not be possible for all patients to discontinue** BZRA, and they expressed their concerns about unexpected negative outcomes. Healthcare professionals emphasise **holistic support** and **interdisciplinary collaboration**.

Recommendation 4: Implement an awareness raising campaign on the risks of BZRA in an empathetic and non-stigmatising way

- **Feasibility**

Regarding the feasibility of recommendation 4, about half (52.25%) of the participants indicated 'completely agree', 26.13% expressed 'agree', 16.22% selected 'neither agree nor disagree', 3.60% chose 'disagree', and 1.8% opted for 'completely disagree'.

- **Support**

64.86% of the participants indicated their support for recommendation 4 with 'completely agree', 27.03% mentioned 'agree', 7.21% chose 'neither agree nor disagree', and 0.90% expressed 'complete disagreement'. None of them indicated 'disagree'.

- **Importance**

66.13% rated recommendation 4 as 'very important', 32.26% considered it 'important', 1.61% responded with 'slightly important', and none (0%) regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 67.74% responded affirmatively, 25.81% replied with 'I don't know', and 6.45% answered negatively.

- **Analysis of answers to open questions**

Healthcare professionals emphasise the importance of showing **empathy** and **reducing stigma** related to patients' substance use disorder. They also advocate for a campaign aimed at educating individuals on the purposes of BZRA prescriptions, the risks and benefits, and providing alternatives. Patients request a broader campaign that highlights the benefits of limited BZRA use, explains the advantages of discontinuation, and addresses tolerance and withdrawal symptoms during tapering, aiming to combat stigmatisation by healthcare professionals. Patients and healthcare professionals agree that the campaign should be led by **individuals** informed of the risks of BZRA dependence, potentially with specialised training. Some patients also feel that general practitioners, who are already busy, need more time to absorb a campaign's message.

Recommendation 5: Add warnings of the risk of dependence on the BZRA package

- **Feasibility**

Regarding the feasibility of recommendation 5, 55.86% of the participants said that they 'completely agree', 26.13% selected 'agree', 9.91% selected 'neither agree nor disagree', 7.21% chose 'disagree', and 0.90% 'completely disagreed'.

- **Support**

63.96% of participants indicated 'completely agree' when asked about their support for recommendation 5. 22.52% chose 'agree', and 8.11% selected 'neither agree nor disagree'.

- **Importance**

Participants rated the importance of recommendation 5 on a scale. 54.84% rated it as 'very important,' 20.97% considered it 'important,' 12.90% responded with 'neither important nor unimportant,' 8.06% found it 'slightly important,' and 3.23% regarded it as 'unimportant.'

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 62.90% responded affirmatively, 27.42% replied with 'I don't know,' and 9.68% answered negatively.

*Note from AFMPS-FAGG: Adding **wording** on outer package is difficult to implement because of the legal necessity of three languages. Additionally, there is no existing **pictogram** which illustrates "dependency" in Belgium. The use of pictograms should be reglemented at European level, implementing pictograms that are then used in all countries (for all relevant medicines), and thus internationally standardised (and known by the public as a result). Furthermore, these (international) pictograms have to be added to all relevant and similar medicines, which is again something that should be implemented at European level, as several medicines are authorised via European procedures. To conclude, the problem of the packages containing already a lot of information in Belgium is also applicable when adding a pictogram. Concerning **black box warnings**, these are boxed warnings in the product information (SmPC/PIL). Same comment as for the pictograms: since different types of procedures (European vs national) exist, this should be implemented at an European level, so that the same warnings are added to the SPC's of similar medicines. Of note, the risk of dependency is already mentioned in the Belgian product information (SmPC/PIL) of BZRA.)*

- **Analysis of answers to open questions**

Patients emphasise the importance of warnings on BZRA packaging to convey their potential risks, taking inspiration from the approach to tobacco packaging. They recommend using **pictograms** instead of written warnings for clarity and support including **information about alternatives and gradual withdrawal**. Both patients and healthcare professionals agree on the need for official regulations compelling pharmaceutical companies to add warnings. However, concerns are raised about warning **effectiveness**, the influence of **pharmaceutical lobbies**, and potential negative consequences like **stigmatisation** and **breaking trust** among patients and practitioners.

3.2.1. Literature review for recommendations 1-5

Over the last 20 years, the federal Belgian government has made significant efforts towards reducing the use of benzodiazepine receptor agonists, amongst others through public awareness campaigns.

Results on interviews with patients and providers show a persistent need for similar and ongoing campaign strategies for encouraging tapering off and raising awareness of the challenges of tapering by educating the general public, patients and healthcare professionals, all in a non-stigmatising and empathetic language. There is also a push for the use of more visible warnings of dependence on BZRA.

Studies have found that targeting the **general public** and working towards the **destigmatisation** of BZRA use helps to **increase self-efficacy** and foster an **environment of personal responsibility**. In a study by Ranjbar et al. (2017), they evaluated the use of public health campaigns over the past 10 years, focusing on medicine use and medicine awareness. They found that campaigns focusing on the appropriate use of medication, **emphasising patient knowledge and understanding**, demonstrated a decrease in BZRA prescriptions. Many of the campaigns shown in the literature showcase an educational aspect to their distribution of BZRA tapering and often appeal to specific (older) age groups (Reeve et al., 2017; Lynch et al., 2020; Mokhar et al., 2018). This indicates a need for a more comprehensive campaign on the usage of BZRA and the process of tapering off.

Based on past evaluations of drug intervention and prevention strategies, they also found that effective tapering interventions often take place **in ambulant clinical settings**. Health professionals are the first point of contact for patients regarding these types of drugs, so effective campaigns can be as simple as brief outreach letters or individualized consultations (Strang et al., 2012; Lader et al., 2009). Many campaigns also do not seem to offer alternative solutions to BZRAs as a way of solving insomnia and anxiety problems. Campaigns that educate professionals and patients on the challenges of tapering off BZRA have also been shown to have a positive impact on the long-term reduction of BZRA usage (Ranjbar et al., 2017). Studies indicate that pharmacists and general practitioners are effective mediators, with patients more likely to seek drug information from them. Community-based campaigns aimed at increasing awareness of BZRA use and tapering have improved both professional and public health literacy (Ranjbar et al., 2017; Strang et al., 2012). In the United States, interventions such as **brochures** on the discontinuation of BZRA therapy have shown positive outcomes in supporting tapering and/or discontinuation of BZRA, as well as facilitating conversations between patients and providers (Pergolizzi, 2020).

While **warnings on packages** are common practice, especially in the US, there is a need to create clear concise messaging and more visual warnings, similar to the tobacco packaging approach. According to a study by McDonald et al. (2017), black box warnings, which are the strictest warnings added to a medication, are quite effective when also **paired with prescriber-patient consultations**. These warnings, though helpful, need prescribers to educate patients on the clear plan of tapering off these drugs and what the warnings mean. Oftentimes manufacturers forgo explicit drug indications, due to the anticipation of off-label prescribing (Pergolizzi et al., 2021).

Patient testimonials, though not widely studied on its direct effectiveness, can also be used in public awareness campaigns as an additional way to build trust and credibility in treatment care. They can serve as an addition in humanising a very difficult process such as tapering off of benzodiazepines and can personalise the struggles of tapering, but also the benefits gained from actual patients. They can be used as additional resources to create community communication (Stein et al., 2023).

Overall, campaigns that have proven to be the most effective are those that were individualised and aimed at both healthcare professionals such as general practitioners and pharmacists, as well as aimed at patients who are chronic users of BZRA. They found that clear and non-stigmatizing language allowed patients and the general public to understand the importance of seeking help without fear of ostracization. The practice of visual warning and concise messaging can also reduce long-term BZRA

usage and off-label prescribing. Common effective campaigns include educational, web-based and patient-centred, verbal education, posters, e-learning, and video campaigns.

Recommendation 6: Undertake further research on the mechanisms surrounding the first prescription of BZRA

- **Feasibility**

Regarding the feasibility of Recommendation 6, 38.71% of the participants expressed 'completely agree', while 46.77% indicated 'agree'. Additionally, 11.29% selected 'neither agree nor disagree', 1.61% chose 'disagree', and 1.61% opted for 'completely disagree'.

- **Support**

Participants expressed their level of support for recommendation 6 as follows: 41.94% chose 'completely agree', 38.71% selected 'agree', 14.52% opted for 'neither agree nor disagree', 1.61% indicated 'disagree', and 3.23% chose 'completely disagree'.

- **Importance**

38.71% rated the importance of recommendation 6 as 'very important', 41.94% considered it 'important', 11.29% responded with 'neither important nor unimportant', 6.45% regarded it as 'slightly important', and 1.61% regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 59.68% responded affirmatively, 32.26% replied with 'I don't know', and 8.06% answered negatively.

- **Analysis of answers to open questions**

Healthcare professionals' views on this particular recommendation are divided. Some see value in further research to uncover unknown causes and address 'thoughtless' prescribing. Others doubt its usefulness, emphasising the **need for systemic change to impact prescription behaviour**.

3.3. Secondary prevention 7-12

Secondary prevention is focused on detection and eviting progression of a disease. Translated onto our project, this includes all measures that are directed at preventing a BZRA prescription from becoming chronic use. As part of this Policy Delphi, six policy recommendations can be included within secondary prevention.

- **7: Increase the price per package**
- **8: Create smaller packages**
- **9: Provide information by the prescriber to the patient regarding the risks of dependency at first use**
- **10: Provide higher remuneration for prescribers for long follow up consultations dedicated to tapering**
- **11: Give access to other healthcare professionals involved in (de)prescribing to the part of the medical file related to prescriptions**
- **12: Allow the carer to dispense one or two doses at the same time to provide the correct dose**

Recommendation 7: Increase the price per package

- **Feasibility**

Regarding the feasibility of recommendation 7, 7.21% of the participants indicated ‘completely agree’, 18.02% chose ‘agree’, 29.72% selected ‘neither agree nor disagree’, 26.13% chose ‘disagree’, and 18.92% opted for ‘completely disagree’.

- **Support**

Participants also indicated the extent to which they would support recommendation 7. 6.31% indicated ‘completely agree’, 7.21% chose ‘agree’, 28.83% selected ‘neither agree nor disagree’, 29.73% indicated 'disagree’, and 27.93% 'completely disagreed’.

- **Importance**

4.84% rated recommendation 7 as ‘very important’, 8.06% considered it ‘important’, 29.03% responded ‘neither important nor unimportant’, 20.97% found it ‘slightly important’, and 37.10% regarded this recommendation as ‘unimportant’.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 37.10% responded affirmatively, 43.55% replied with 'I don't know’, and 19.35% answered negatively.

- **Analysis of answers to open questions**

For future first time prescriptions, some healthcare professionals and patients propose to implement a different price for the same molecule to discourage chronic use. Current consumers of BZRA, particularly those with substance use disorder, should not be affected as they need time to taper off, after which pricing adjustments can be explored. This recommendation also received quite some negative feedback due to **scepticism** from both healthcare professionals and patients. Many believe price increases are ineffective, as BZRA are not freely available. Quite contrarily, some respondents also think **current prices are too high** and the measure would **disproportionately harm vulnerable individuals**, potentially leading to adverse consequences like foregoing necessary treatments or seeking alternative prescriptions. It would eventually lead to further **inequalities** in health care.

Recommendation 8: Create smaller packages

- **Feasibility**

Regarding the feasibility of recommendation 8, 50.45% of the participants indicated 'completely agree', 26.13% chose 'agree', 14.41% selected 'neither agree nor disagree', 4.50% chose 'disagree', and 4.50% opted for 'completely disagree'.

- **Support**

Participants indicated their level of support for Recommendation 8 as follows: 56.76% chose 'completely agree', 18.02% selected 'agree', 15.32% opted for 'neither agree nor disagree', 2.70% indicated 'disagree', and 7.21% chose 'completely disagree'.

- **Importance**

48.39% rated recommendation 8 as 'very important', 33.87% viewed it as 'important', 9.68% selected 'neither important nor unimportant', 4.84% considered it 'slightly important', and 3.23% deemed it 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 61.29% responded affirmatively, 30.65% replied with 'I don't know', and 8.06% answered negatively.

Note from AFMPS-FAGG: The FAMHP cannot oblige marketing authorisation holders to commercialise small pack sizes. Suitable packaging sizes are being proposed and accepted during the authorisation process, but the marketing authorisation holder decides which pack size(s) will be commercialised and which not. Alternatively guidelines on maximum dosage can be adjusted (farmacovigilantie) the guideline is based on the maximum daily dose and duration of the treatment per indication, in the supplementary protection certificates (SPC).

- **Analysis of answers to open questions**

Both practitioners and patients emphasise the importance of smaller packages in preventing daily use, with some admitting to seeking unofficial solutions (like dispensing smaller doses). Patients argue that smaller packages make sense for short-term use, while opinions among healthcare professionals vary on when to implement this change, ranging from after 14 days to the first prescription or even per unit. Creating smaller packages **requires legal measures** to enforce government guidelines and maintain the same price per pill, according to suggestions received. However, scepticism persists among some healthcare professionals and patients, who question the need for additional packaging sizes, the financial impacts on patients, and the pharmaceutical industry's willingness to produce smaller packages.

Recommendation 9: Provide information to the patient regarding the risks of dependency at first use (directed to prescribers)

- **Feasibility**

Regarding the feasibility of recommendation 9, 63.06% of the participants indicated 'completely agree', 27.93% indicated 'agree', 6.31% selected 'neither agree nor disagree', 1.80% chose 'disagree', and 0.90% opted for 'completely disagree'.

- **Support**

Participants also expressed their level of support for recommendation 9. 'Completely agree' was selected by 75.68%, 'agree' by 20.72%, 'neither agree nor disagree' by 2.70%, 'disagree' by nobody, and 'completely disagree' by 0.90%.

- **Importance**

74.19% rated recommendation 9 as 'very important', 24.19% considered it 'important', 0% responded with 'neither important nor unimportant', 1.61% found it 'slightly important', and 0% regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 69.35% responded affirmatively, 22.58% replied with 'I don't know', and 8.06% answered negatively.

- **Analysis of answers to open questions**

Some participants underline that when prescribed in crisis situations, healthcare professionals must **explicitly warn about the dependence forming properties of BZRA**. Healthcare professionals advocate the importance of information consultations not only outlining dependence risks but also incorporating a formal tapering off plan and discussing alternatives during the initial consultation. They propose a multidisciplinary approach and advocate for information dissemination through various channels. To enhance the implementation of prescribing information, healthcare professionals suggest longer (follow-up) consultations, building expertise among practitioners, particularly addressing knowledge gaps among general practitioners, and providing clear guidelines supported by concrete tools and resources. Concerns about time constraints and the availability of alternatives pose challenges to effective implementation among healthcare professionals.

3.3.1. Literature review for recommendations 7,8,9

Prescribing practices and drug distribution behaviours are integral to reducing risk of dependence on medication and can be more cost-effective. Though BZRA are widely utilised for insomnia and anxiety treatment they are also prescribed off-label quite frequently or paired with opioids. Recommendations for increased drug prices, smaller package sizes, and enhancing prescriber-patient communication regarding dependency risks were highlighted by participants.

Internationally, **increasing the price** per medication is often a strategy to deter excessive use and promote more responsible prescribing practices. It is important to recognize that such a price increase could **disproportionately affect** different communities, depending on the current pharmaceutical and prescribing practices. Price increases may lead to shortages and impact individuals who need these medications. Studies have shown that decreases in drug availability can also cause people to source cheaper or more potent medication, sometimes with decreased purity (Russell et al., 2023) such as the online purchase of (designer) BZRA. It could also lead to the creation of financial burdens on health systems and/or individuals and in turn lead to financial revenue for pharmaceutical companies (Russell et al., 2023).

Similarly, the **effectiveness of smaller packages** can be multifaceted in nature. While smaller packages may help in controlling the amount of medication given and can be helpful for effective tapering and prove to be more cost effective, the impact of the management of BZRA use and dependence needs constant monitoring (Russell et al., 2023; Zhang et al., 2019). Smaller packages are more effective when paired with interventions like shared decision-making and proper patient education on tapering and dose reduction. Consideration should be based on a functional assessment of each patient and require ongoing monitoring by prescriber (McDonald et al., 2017). It is essential to balance the choice for smaller packages with ensuring that necessary treatments are provided to patients.

Prescribers play an integral part in educating patients about medications they are prescribed and in ensuring that they understand the potential consequences of long-term use or misuse. By discussing the risks of dependency openly and transparently, prescribers empower patients to make informed decisions about their treatment, fostering a collaborative approach to healthcare that prioritises patient safety and well-being. This practice aligns with guidelines that emphasise the importance of informed decision-making and patient education to reduce the likelihood of dependence on prescribed medications (NIH, 2022).

Overall, while a **boxed warning** and **change in the distribution of BZRA** can be effective in mitigating and raising awareness of the associated risks, it is necessary to pair these strategies with multifaceted approaches like prescriber consultations and provider-patient communication. It is also important to note the possible indirect consequences of implementing these strategies such as unequally affecting low socioeconomic communities and possibly driving people to black market distribution of BZRA products (Russell et al., 2023; Pergolizzi et al., 2021).

Recommendation 10: Provide higher remuneration for prescribers for long follow-up consultations dedicated to BZRA

- **Feasibility**

Regarding the feasibility of recommendation 10, 8.06% of the participants expressed 'completely agree', while 27.42% indicated 'agree'. Additionally, 53.23% selected 'neither agree nor disagree', 8.06% chose 'disagree', and 3.23% opted for 'completely disagree'.

- **Support**

Participants expressed their level of support for recommendation 10 as follows: 'Completely agree' was the choice of 19.35%, 'agree' received 35.48%, 'neither agree nor disagree' was selected by 24.19%, 'disagree' by 16.13%, and 'completely disagree' by 4.84%.

- **Importance**

11.29% rated recommendation 10 as 'very important', 35.48% considered it 'important', 32.26% responded with 'neither important nor unimportant', 16.13% regarded it as 'slightly important', and 4.84% regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 11.29% responded affirmatively, 69.35% replied with 'I don't know', and 19.35% answered negatively.

- **Analysis of answers to open questions**

Many agree with the recommendation, advocating for greater investment of time and effort by healthcare professionals to achieve a comprehensive understanding of patients using BZRA. Participants propose **extending** the recommendation **to mental health care**, emphasising the need for adequate training and multidisciplinary collaboration. Some point out challenges, including concerns about funding and time constraints for healthcare professionals, highlighting the need for a broader approach, such as full reimbursement for necessary psychological consultations.

Recommendation 11: Give access to other healthcare professionals involved in (de)prescribing to the part of the medical file related to prescriptions

- **Feasibility**

Regarding the feasibility of recommendation 11, 16.13% of the participants expressed 'completely agree', while 38.71% indicated 'agree'. Additionally, 30.65% selected 'neither agree nor disagree', 9.68% chose 'disagree', and 4.84% 'completely disagree'.

- **Support**

Participants expressed their level of support for recommendation 11 as follows: 'Completely agree' was the choice of 30.65%, 'agree' received 50.00%, 'neither agree nor disagree' was selected by 8.06%, 'disagree' was indicated by 8.06%, and 'completely disagree' by 3.23%.

- **Importance**

25.81% rated recommendation 11 as 'very important', 45.16% considered it 'important', 16.13% responded with 'neither important nor unimportant', 8.06% regarded it as 'slightly important', and 4.84% regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 27.42% responded affirmatively, 48.39% replied 'I don't know', and 24.19% answered negatively.

- **Analysis of answers to open questions**

Respondents support sharing medical files between doctors and pharmacists for monitoring BZRA use, preventing medical shopping, and providing a comprehensive patient prescription history. Patients also stress the importance of granting access to **psychologists**. Necessary conditions include compliance with laws and GDPR, endorsement by the Order of Doctors, and improved communication for interdisciplinary collaboration. Concerns revolve around the recommendation's inability to prevent medical shopping without regulations and potential risks of stigmatisation and reduced care quality, challenging the trust relationship between patients and healthcare professionals.

3.3.2. Literature review for recommendation 10, 11

Patient-centred approaches allow for a significant reduction in BZRA use. Many studies have found that advising patients and developing more in-depth clinician-patient communication and consultations have greater retention in BZRA tapering. **Higher remuneration** for prescribers for long follow-up consultations dedicated to BZRA could **decrease the usage of BZRA** and allow providers to **spend more time with patients in addressing their individual needs**. To have a standardisation in treatment and prevent medical shopping, shared patient medical records, related to treatment with BZRA, between health professionals also may create enhanced patient outcomes.

Prescribers are encouraged to take **patient-centred approache**s in engaging in personalised consultations with patients about their BZRA usage. Studies suggest that long-term BZRA usage is often due to problematic factors in clinical settings such as neglecting the psychosocial problems of the patient or contradicting information on drug risk given by pharmacists and physicians (Mokhar et al., 2019). There is an overwhelming positive implication in the role prescribers have in supporting their patients as a part of the tapering process of BZRA. As these consultations can prove as additional work for prescribers, there is a need and a pressure to provide financial incentives for prescribers, who invest into long-term BZRA follow-up consultations. Educating providers on helpful ways to address the complexities of long-term BZRA use and develop alternative treatment plans also have shown, in current research, that it is effective in reducing BZRA usage (Mokhar et al., 2018; Gallager, 2013).

Incentivizing follow-up consultations could promote a more patient-centred approach to the deprescription of BZRA. It is crucial to recognize that not all cases of long-term BZRA/Z use signify problematic prescribing or patient behaviour. A study revealed that many patients were unable to articulate the reasons for their medication use following their appointment with the prescriber, suggesting a lack of patient education and awareness regarding the potential drawbacks of these medications. Hence, there's a critical need to provide clear guidance on effective communication strategies tailored to each patient's readiness for change and to highlight current research findings to inform the development of patient-centred deprescribing guidelines for BZRA/Z (Oldenhof et al., 2021; Mokhar et al. 2019).

The integration of shared medical records into benzodiazepine addiction care can hold promise for enhancing patient outcomes and treatment efficacy. As seen in countries like the US, shared medical records facilitate collaborative efforts among healthcare professionals, enabling comprehensive patient assessments and personalised treatment planning. By centralising patient information, including medication history, comorbidities, and treatment preferences, shared records empower healthcare teams to tailor interventions to individual patient needs effectively. This holistic approach, as depicted in the recommendations, aligns with patient centred care principles, prioritising the patient's values, preferences, and treatment goals, but it hasn’t been described yet for BZRA care (Mokhar et al., 2019; Van Ngoc et al., 2024). Moreover, shared records facilitate interprofessional communication, enabling seamless coordination of care and timely interventions. Healthcare professionals can leverage shared records to identify potential risks associated with BZRA use, such as dependence or misuse, and implement preventive measures accordingly (Marquina-Marquez et al., 2022). Furthermore, shared records support continuity of care, ensuring that patients receive consistent and coordinated support throughout their treatment journey. However, the implementation of shared records must address privacy and security concerns to safeguard patient confidentiality and trust. Overall, leveraging shared medical records in benzodiazepine addiction care has the potential to optimise treatment outcomes, promote patient safety, and enhance the quality of care delivery.

Increasing compensation for prescribers who conduct extended follow-up consultations focused on BZRA could help overcome some barriers to reducing long-term medication use. Moreover, sharing medical files could centralise patient information, aiding providers in identifying risks associated with BZRA dependence, although this practice may raise privacy concerns. Nevertheless, it is essential to approach this issue with a patient-centred perspective and to offer comprehensive advice and education to patients regarding the adverse effects associated with these medications.

Recommendation 12: Allow the carer to dispense one or two doses of BZRA at the same time to provide the correct dose

- **Feasibility**

Regarding the feasibility of Recommendation 12, 32.26% of the participants expressed 'completely agree,' while 35.48% indicated 'agree.' Additionally, 22.58% selected 'neither agree nor disagree,' 8.06% chose 'disagree,' and 1.61% were 'completely disagree.'

- **Support**

Participants also expressed their level of support for Recommendation 12 as follows: 'Completely agree' was the choice of 50.00%, 'agree' received 30.65%, 'neither agree nor disagree' was selected by 16.13%, 'disagree' was indicated by 1.61%, and 'completely disagree' by 1.61%.

- **Importance**

Participants rated the importance of recommendation 23 on a scale. 32.26% rated it as ‘very important,’ 41.94% considered it ‘important,’ 14.52% responded with ‘neither important nor unimportant,’ 8.06% regarded it as ‘slightly important,’ and 3.23% regarded it as ‘unimportant.’

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 40.32% responded affirmatively, 33.87% replied with 'I don't know,' and 25.81% answered negatively.

- **Analysis of answers to open questions**

Respondents support the recommendation to prescribe BZRA unit due to the potential for misuse and resale. **Both patients and healthcare professionals emphasise the need for strict regulations**, including pharmaceutical firms creating single pill boxes. Concerns include pharmacist compliance, traceability issues, and the necessity of additional compensation. Healthcare professionals call for accessible and free consultations, regulated by INAMI, while patients stress the importance of professional training on short-term BZRA use. Some doubt the feasibility, citing challenges for pharmacists and potential difficulties for patients in daily pill collection.

3.3.3. Literature review for recommendation 12

The recommendation to allow carers to dispense one or two doses of a BZRA at the same time to **provide the correct dose** offers a nuanced approach to medication management that balances convenience with potential risks. By permitting caregivers to supply multiple doses simultaneously, especially in critical situations or for patients with limited mobility, accessibility to essential medications is significantly enhanced. This approach can be particularly beneficial in emergencies or instances where immediate access to medication is paramount for symptom management. Moreover, for patients requiring intermittent or acute treatment, having **pre-dispensed doses** readily available can streamline medication administration and promote adherence to prescribed regimens, potentially leading to improved treatment outcomes.

However, alongside the potential benefits, it is crucial to recognise and address the inherent risks associated with this practice. Allowing non-professional caregivers to handle and dispense controlled substances poses notable concerns regarding medication safety, adherence to dosing instructions, and the potential for misuse or accidental overdose. The risk of diversion, where medications are used for unintended purposes or accessed by unauthorised individuals, further underscores the need for cautious implementation and oversight (Grissinger, 2010).

To mitigate these risks effectively, a **comprehensive approach** is necessary. This includes robust patient assessment to determine suitability for pre-dispensed doses, clear communication of dosing instructions and potential risks to both patients and caregivers, and ongoing education and support to ensure proper medication handling and storage. Collaboration between healthcare providers, patients, and caregivers is essential, fostering a shared understanding of responsibilities and promoting a culture of safety and accountability (Mokhar et al., 2019; Treibich et al., 2017).

Furthermore, adherence to regulatory guidelines and best practices in medication management is paramount. Careful consideration of individual patient needs, risk factors, and legal requirements should guide decision-making around the provision of pre-dispensed doses. Regular review and evaluation of this practice, coupled with feedback mechanisms and continuous quality improvement initiatives, can help identify and address any emerging challenges or areas for improvement.

In conclusion, while the recommendation to allow carers to dispense one or two doses of BZRA concurrently offers potential benefits in terms of accessibility and adherence, careful consideration of associated risks and implementation strategies is essential. Through thoughtful planning, collaboration, and adherence to best practices, the safe and effective integration of this approach into medication management protocols can be achieved, ultimately enhancing patient care and outcomes.

3.4. Tertiary prevention [13-27]

Tertiary prevention are commonly rehabilitation efforts and in our case includes all measures that aim at deprescribing and reducing negative effects of chronic BZRA use. As part of this Policy Delphi, 15 recommendations are included within secondary prevention.

- **13: Encourage prescribers to add the indication for substance use disorders alongside insomnia/anxiety to patient records when use exceeds guidelines.**
- **14: Establish an agreement between the prescriber, the pharmacist, and the patient to keep the same prescriber and pharmacist throughout treatment**
- **15: Create a shared policy position between professional groups in addiction care concerning the management of BZRA**
- **16: Create an inter-professional communication channel at local level, between pharmacists and GPs to discuss common patients**
- **17: Implement a training course on difficult tapering off processes related to BZRA for professionals**
- **18: Establish and providing a list of local healthcare providers trained in tapering off BZRA for healthcare providers and patients**
- **19: Establish a support and advice line for people who want to taper off BZRA**
- **20: Develop a 'benzo-buddy' system**
- **21: Share patient testimonials about BZRA tapering off.**
- **22: Develop culturally appropriate patient materials**
- **23: Create an ombudsperson for healthcare practitioners to report other practitioners who over-prescribe, prescribe, or delivered unsafely**
- **24: Extend the patient inclusion criteria of the new reimbursement scheme for the compounding of smaller doses of BZRA to residents living in nursing home**
- **25: Extend the patient inclusion criteria of the new reimbursement scheme for the compounding of smaller doses of BZRA to patients who are taking more than one type of benzodiazepines or Z-drugs**
- **26: Offer group therapy to non-hospitalised patients to support the tapering process**
- **27: Tailoring specific residential addiction programmes to BZRA dependency**

Recommendation 13: Encourage prescribers to add the indication for substance use disorders alongside insomnia/anxiety to patient records when use exceeds guidelines

- **Feasibility**

Regarding the feasibility of recommendation 13, 30.63% of the participants expressed ‘completely agree’, another 30.63% indicated ‘agree’, 26.13% selected ‘neither agree nor disagree’, 7.21% chose ‘disagree’, and 5.41% ‘completely disagree’.

- **Support**

Participants indicated the extent to which they would support Recommendation 13. 'Completely agree' was chosen by 34.23%, 'agree' by 26.13%, 'neither agree nor disagree' by 22.52%, 'disagree' by 9.91%, and 'completely disagree' by 7.21%.

- **Importance**

22.58% off the participants rated the importance of recommendation 13 as ‘very important’, 38.71% as important’, 24.19% responded with ‘neither important nor unimportant’, 9.68% found it ‘slightly important’, and 4.84% regarded it as ‘unimportant’.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 56.45% responded affirmatively, 33.87% replied with 'I don't know’, and 9.68% answered negatively.

- **Analysis of answers to open questions**

Healthcare professionals find the recommendation relevant for preventing medical shopping and enabling better consumption monitoring. They suggest encouraging both prescribers and pharmacists to access shared patient records before prescribing or dispensing these drugs, even if not legally mandatory. Healthcare professionals and patients both **advocate for a clear and consensus definition of substance use disorder (SUD)**, highlighting its current debate. They emphasise viewing SUD as a **consequence rather than the primary issue**, urging health care professionals to explain its use in patient records. This necessitates adjustments in medical programs to align with the defined terms.

Additionally, there is a recognised need for increased knowledge to facilitate safe and responsible drug tapering, although disagreements persist around the term ‘substance use disorder’ with knowledge disparities between Flanders and Wallonia identified as an issue by some healthcare professionals. The stigmatising nature of the SUD term is acknowledged by both patients and healthcare professionals, with some patients proposing its replacement with the term **tolerance**. They also underscore the varied forms of **stigmatisation** associated with SUD terms, emphasising their **extensive impact on mental health**.

Recommendation 14: Establish an agreement between the prescriber, the pharmacist, and the patient to keep the same prescriber and pharmacist throughout treatment

- **Feasibility**

Regarding the feasibility of recommendation 14, 27.03% of the participants expressed 'completely agree' another 27.03% indicated 'agree', 24.32% selected 'neither agree nor disagree', 16.22% chose 'disagree', and 5.41% 'completely disagree'.

- **Support**

Participants also expressed their level of support for recommendation 14 as follows: 'Completely agree' was the choice of 37.84%, 'agree' received 25.23%, 'neither agree nor disagree' was selected by 17.12%, 'disagree' was indicated by 14.41%, and 'completely disagree' by 5.41%.

- **Importance**

24.19% rated recommendation 14 as 'very important', 37.10% considered it 'important', 19.35% responded with 'neither important nor unimportant', 9.68% found it 'slightly important', and 9.68% regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 46.77% responded affirmatively, 38.71% replied with 'I don't know', and 14.52% answered negatively.

- **Analysis of answers to open questions**

Many respondents find the recommendation relevant in **combating excessive and/or illegal medication (mis)use**. Some health care professionals note the existing use of such contracts in contexts like methadone prescriptions for opioid overconsumption and dependence. However, comments reveal concerns and necessary conditions for effective implementation. One key aspect is the legal obligation, with professionals advocating for legal foundations to deter medical shoppers and provide alternatives for unexpected absences. Another condition concerns the involvement of a mental health practitioner in diagnosis and treatment. Despite these considerations, there are significant pitfalls highlighted by respondents. Some professionals doubt the effectiveness, citing a **lack of legal basis** and **potential stigmatisation** of regular patients. Concerns also arise about the **inflexibility** of signed agreements, with calls for maintaining patients' freedom to change doctors or pharmacies. Practical issues, such as vacations, supply shortages, and changing prescribers, add complexity to the proposed contracts, leading many to prefer oral agreements and open communication among the three parties.

Recommendation 15: Create a shared policy position between professional groups in addiction care concerning the management of BZRA

- **Feasibility**

Regarding the feasibility of recommendation 15, 27.93% of the participants expressed 'completely agree' another 44.14% indicated 'agree', 21.62% selected 'neither agree nor disagree', 4.50% chose 'disagree' and 1.80% 'completely disagree'.

- **Support**

Participants indicated their level of support for recommendation 15 in the following way: 41.44% selected 'completely agree', while 44.14% chose 'agree'. Additionally, 11.71% responded with 'neither agree nor disagree', 0.90% indicated 'disagree', and 1.80% selected 'completely disagree'.

- **Importance**

Participants evaluated the importance of Recommendation 15 using a rating scale. Of those surveyed, 35.48% deemed it 'very important', while 51.61% considered it 'important'. Additionally, 12.90% responded with 'neither important nor unimportant,' and no participants (0%) classified it as 'slightly important' or 'unimportant'.

- **Conditions**

Participants examined whether the necessary conditions for implementing this recommendation are currently fulfilled. A total of 30.65% answered affirmatively, 53.23% indicated 'I don't know', and 16.13% responded negatively.

- **Analysis of answers to open questions**

Facilitating interdisciplinary collaboration in healthcare necessitates standardised training for professionals, ensuring uniform knowledge about medications like BZRA. There is a need to enhance existing multidisciplinary frameworks to encompass all healthcare stakeholders. Overcoming barriers, including diverse paradigms from healthcare professionals and financial concerns, is crucial for effective collaboration. Emphasising prevention in positioning it as the initial step toward comprehensive patient care. This involves creating shared training spaces where practitioners can learn consistent methods, including a patient-centred approach to withdrawal experiences.

3.4.1. Literature review summary for recommendations 13,14,15

Establishing **effective organisation and communication channels** is paramount in delivering optimal care to patients. To ensure successful outcomes, it's essential to implement strategies that facilitate seamless coordination and continuity of care. These include encouraging prescribers to explicitly indicate the risk of dependency when prescribing medications, establishing prescriber-pharmacist-patient agreements to maintain continuity of care, and developing shared addiction care policies. By prioritising these initiatives, healthcare providers can mitigate risks, enhance patient safety, and promote better treatment outcomes.

Indication warnings added to patient records for substance use disorders alongside insomnia and anxiety when use exceeds recommended time or amounts is a crucial step in patient monitoring and it can enhance the identification of potential risks associated with the use of BZRA drugs. This warning can serve as a proactive measure that alerts health professionals and providers of the potential for dependence or misuse in prescribed medications (Carville et al., 2022; Pergolizzi et al., 2021). This strategy can also support comprehensive care planning, shared decision-making, and regular reviews of treatment efficacy, in line with the principles of personalised care and patient safety emphasised in frameworks for optimising care for individuals prescribed medications associated with dependence or withdrawal symptoms (Carville et al., 2022)

Agreements between prescriber, pharmacist, and patient to maintain a continuity of care and improve medication management has been shown to foster more tailored patient care, improve medication adherence, and allow for a more holistic approach to treatment (Ford & Zarate, 2010), and is currently being implemented in the reimbursed RIZIV-INAMI tapering program. Collaborative practice agreements also further define and establish clear roles and responsibilities for each party, ensuring effective communication and coordination of medication. Though this can be a positive recommendation, there may be possible challenges if communication breaks down (Ford & Zarate, 2010). Patients may face risks such as medication duplication, alert overload, and a potential for polypharmacy. These downsides can compromise treatment outcomes and lead to increased healthcare costs.

A **shared policy position** between professional groups in specialised addiction care concerning the management of BZRA should prioritise patient-centred care interventions to mitigate inappropriate prescription and use of these medications. This approach entails educating patients about the risks and benefits of BZRAs and Z-drugs, fostering shared decision-making, and offering support for appropriate medication utilisation (Pergolizzi et al., 2021). Additionally, promoting collaboration among healthcare providers, including mental health specialists, addiction care professionals, primary care physicians, and pharmacists, is crucial for tailoring treatment plans to individual patient needs and improving outcomes. Furthermore, implementing risk-based monitoring strategies, regular follow-ups, and assessments can help identify patients at higher risk of adverse effects or misuse (Pergolizzi et al., 2021, Lader et al., 2009). Education and awareness initiatives aimed at healthcare providers on safe prescribing practices, appropriate tapering strategies, and non-pharmacological alternatives can further enhance patient care. By endorsing these principles, a comprehensive policy position can be established to optimise the management of BZRAs and Z-drugs within addiction care settings, ultimately improving patient outcomes and safety.

Overall, effective organisation and communication are fundamental to delivering optimal care to patients, specifically in the context of BZRA. By adding indication warnings for potential substance use disorders, establishing prescriber-pharmacist-patient agreements, and promoting collaborative care

policies, healthcare providers can mitigate risks, enhance patient safety, and promote better treatment outcomes.

Recommendation 16:
Create an inter-professional communication channel at local level, between pharmacists and GPs to discuss common patients

- **Feasibility**

Regarding the feasibility of recommendation 16, 24.19% of the participants expressed 'completely agree', while 48.39% indicated 'agree'. Additionally, 20.97% selected 'neither agree nor disagree', 4.84% chose 'disagree', and 1.61% 'completely disagree'.

- **Support**

Participants expressed their level of support for recommendation 16 as follows: 38.71% selected 'completely agree', 41.94% selected 'agree', 9.68% selected 'neither agree nor disagree'. 4.84% indicated 'disagree' and 4.84% indicated 'completely disagree'

- **Importance**

Participants rated the importance of recommendation 16 as follows: 30.65% rated it as 'very important', 50.00% considered it 'important', 11.29% responded with 'neither important nor unimportant', 1.61% regarded it as 'slightly important', and 6.45% regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 41.94% responded affirmatively, 35.48% replied with 'I don't know', and 22.58% answered negatively.

- **Analysis of answers to open questions**

Creating a local interprofessional communication channel between pharmacists and GPs is desired, bridging gaps in interdisciplinary communication for better patient care. Concerns arise about pharmacist motivations, with some believing they profit from BZRA prescriptions, hindering change. Involving **therapists or psychologists** in interprofessional communication is suggested, addressing the time constraints doctors face. Healthcare professionals support this recommendation, proposing **additional observation duties for pharmacists**. **Privacy concerns** and the necessity of this recommendation vary among respondents, with some professionals already engaging in similar practices. Patient feedback emphasises involving third parties like psychologists or psychiatrists in cases of BZRA abuse.

Recommendation 17: Implement a training course on difficult BZRA tapering off processes for professionals

- **Feasibility**

Regarding the feasibility of recommendation 17, 51.35% of the participants answered ‘completely agree’ and 39.64% ‘agree’. 8.11% respondents selected 'neither agree nor disagree,' but none of them voiced their disagreement, and 0.90% were in complete disagreement.

- **Support**

Participants expressed their level of support for recommendation 17 as follows: 'completely agree' was the choice of 61.26%, 'agree' received 33.33%, 'neither agree nor disagree' was selected by 4.50%, 'disagree' was indicated by none (0.00%), and 'completely disagree' by only 0.90%.

- **Importance**

Participants rated the importance of recommendation 17 as follows: 51.61% rated it as ‘very important’, 43.55% considered it ‘important’, 3.23% responded with ‘slightly important’, 1.61% found it ‘unimportant’, and none (0.00%) regarded it as ‘neither important nor unimportant’.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 64.52% responded affirmatively, 25.81% replied with 'I don't know’, and 9.68% answered negatively.

- **Analysis of answers to open questions**

Respondents highlight that similar courses exist in the Netherlands. Some argue against the necessity of implementing these courses, while others question their financial feasibility and propose universal training for various professions. Secondly, participants expressed the challenge of tapering off medications. Both healthcare professionals and patients express concerns, with patients particularly critical. Respondents stress the need for a better understanding of the **individual tapering off process**, linking successful implementation of training courses to overcoming healthcare professionals' lack of knowledge. A perceived barrier for the implementation of this recommendation that was suggested by the respondents is that of lack of knowledge of the healthcare professionals. This lack of knowledge will hold back the willingness of the healthcare professionals to want to implement this recommendation, according to several respondents.

Recommendation 18 : Establish and providing a list of local healthcare providers trained in tapering off BZRA for healthcare providers and patients

- **Feasibility**

Regarding the feasibility of recommendation 18, 27.93% of the participants expressed 'completely agree', while 42.34% indicated 'agree'. Furthermore, 21.62% selected 'neither agree nor disagree', 7.21% chose 'disagreement', and a minor 0.90% were in 'complete disagreement'.

- **Support**

Participants indicated their level of support for recommendation 18 as follows: 'completely agree' was the choice of 45.05%, 'agree' received 34.23%, 'neither agree nor disagree' was selected by 13.51%, 'disagree' was indicated by 6.31%, and 'completely disagree' by 0.90%.

- **Importance**

Off all participants 37.10% rated this recommendation as 'very important', 40.32% considered it 'important', 16.13% responded with 'slightly important', 4.84% found it 'unimportant', and 1.61% regarded it as 'neither important nor unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 38,71% responded affirmatively, 43,55% replied with 'I don't know', and 17,74% answered negatively.

- **Analysis of answers to open questions**

Many healthcare professional's express reservations about the necessity of such a list, arguing that **all professionals should be trained for this task**. Concerns include uncertainty about who should be trained, the criteria for inclusion, and the feasibility of every general practitioner assisting with tapering off. Some healthcare professionals and patient's express dissatisfaction with the current medical system, believing that referring patients to specialised lists would only delay the process. Scepticism arises about the effectiveness of the recommendation in suboptimal medical conditions, and doubts are raised about the inclusion criteria and the voluntary or mandatory nature of the training. Overall, respondents emphasise the **need for a broader reform of the medical system** to address the challenges associated with tapering off medications.

3.4.2. Literature review summary for recommendations 16, 17, 18

When looking into additional strategies to aid professionals in both their prescribing practices and in educating patients on the tapering process, it is important to establish and have evidence-based guidelines and best practices to ensure that patients receive the best care as well as proper **interprofessional communication channels at a local level** to discuss common patients. The tapering process is quite complicated and needs to be individualised based on the patient and their needs, so it is essential that healthcare professionals are specifically trained on the treatment plans for BZRA overuse and patients have a list of providers who are trained and can meet their needs.

To develop a successful training course on the difficulties of the tapering off process, it hinges on understanding the **different scenarios and the various best practices** with tapering off BZRA. The course should prioritise individualised tapering plans tailored to each patient's circumstances, accounting for dosage, type, duration of use, and the patient's withdrawal symptoms. Educating patients about the tapering process and providing ongoing support are integral in fostering engagement in their treatment plan. In the paper by Kuntz et al., (2020) their STORM (support team onsite resource for management of pain) initiative program, which is a pharmacist-led opioid tapering program aimed towards address high opioid use and prescription, had a clinical curriculum set for pharmacists in the context of opioid use management, they found that this program aided patients in getting individualised care and informed professionals of additional tapering options. Professionals should also be trained on optimising the tapering process for reduced withdrawal symptoms and improved patient comfort. By incorporating these items into a training course for professionals, they will be well equipped to navigate benzodiazepine tapering, which would enhance patient safety and treatment outcomes.

Interprofessional communication channels are crucial for effective treatment. Pharmacists play a crucial role in medication reconciliation and report drug-drug interactions to clinicians. Interprofessional team-based models of communication including pharmacists and primary care physicians have been shown to improve patient outcomes in substance use disorders and in managing treatment care. Effective communication and collaboration between integral health professionals across the different stages of addiction care such as initial prescription and long-term dependency can aid in optimal and individualised patient care. A study conducted by Carlson and Potter (2021) revealed that cycles of misuse and addiction have significant implications for broader public health outcomes and how healthcare systems address these challenges. The misuse of prescriptions can also cost healthcare systems significant amounts of money as prescriptions of medication like benzodiazepines can be hard to track and can occur at any point in the chain of distribution.

Additionally, providing **a list of healthcare providers,** who are trained in tapering, to patients can help support individual's agency. The literature supports programs like individualised care and specialty plans led by interdisciplinary teams and often the outcomes of these initiatives lead to successful tapering. For example, Kaiser Permanente Northwest's STORM program, which involved pharmacists in tapering plans and alternative treatment plans, alleviated some burden on primary care physicians and helped patients feel supported in their programs (Kuntz et al., 2020). In the study, they found a 50% reduction in their opioid use within a year. Providing patients with a variety of healthcare professionals trained in tapering allows patients to find a provider that works for them and contributes to creating a collaborative approach in tapering off of BZRAs and can help them feel like they are taking an active step in their treatment.

Overall, the effective strategies to assist healthcare professional education in the tapering off process and in allowing patient choice in treatment relies on interprofessional communication channels and

interdisciplinary evidence-based training. It is crucial to individualise the tapering process to each patient, but with that professionals need an understanding of the various treatment options and the ongoing support and approaches to patients. Initiatives such as the STORM program demonstrate the potential of clinical curricula in equipping healthcare providers with the necessary tools for effective tapering management. Additionally, providing patients with access to a diverse range of healthcare professionals trained in tapering facilitates patient autonomy and contributes to collaborative treatment approaches. By incorporating these strategies into practice and ensuring patients have access to trained providers, we can enhance patient outcomes and support individuals in their journey towards successful tapering off of BZRA.

Recommendation 19: Establish a support and advice line for people who want to taper off BZRA

- **Feasibility**

Regarding the feasibility of recommendation 19, 37.84% of the participants expressed 'completely agree', while 31.53% indicated 'agree'. Additionally, 21.62% selected 'neither agree nor disagree', 7.21% chose 'disagree', and 1.80% 'completely disagree'.

- **Support**

Participants expressed their level of support for recommendation 19 as follows: 'Completely agree' was the choice of 51.35%, 'agree' received 24.32%, 'neither agree nor disagree' was selected by 18.02%, 'disagree' was indicated by 4.50%, and 'completely disagree' by 1.80%.

- **Importance**

Participants rated the importance of recommendation 19 as follows: 33.87% rated it as 'very important', 35.48% considered it 'important', 20.97% responded with 'slightly important', 6.45% found it 'unimportant', and 3.23% regarded it as 'neither important nor unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 43.55% responded affirmatively, 40.32% replied with 'I don't know', and 16.13% answered negatively.

- **Analysis of answers to open questions**

Healthcare providers emphasise the importance of referring patients back to their primary care providers for **monitored tapering**. A recurring concern is the **lack of knowledge** among healthcare professionals, particularly regarding the **pace of tapering** and understanding patients' perspectives. Patients stress the need for doctors to acquire more knowledge about the challenges they face during the tapering process. **Financial barriers** are identified as a potential obstacle, as funding for **training personnel** for the support line would likely come from taxes and requires government approval. Respondents also express concerns about the feasibility of having the support line available at all times.

Recommendation 20: Develop a (peer support) benzo buddy system

- **Feasibility**

Regarding the feasibility of recommendation 20, 17.12% of the participants expressed 'completely agree' while 34.23% indicated 'agree'. 36.04% selected 'neither agree nor disagree', 9.91% chose 'disagree' and 2.70% 'completely disagree'.

- **Support**

Participants also expressed their level of support for recommendation 20 as follows: 'completely agree' was the choice of 28.83%, 'agree' received 38.74%, 'neither agree nor disagree' was selected by 24.32%, 'disagree' was indicated by 5.41%, and 'completely disagree' by 2.70%.

- **Importance**

Participants rated the importance of recommendation 20 as follows: 19.35% rated it as 'very important', 38.71% considered it 'important', 33.87% responded with 'slightly important', 4.84% found it 'unimportant', and 3.23% regarded it as 'neither important nor unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 20.97% responded affirmatively, 59.68% replied with 'I don't know', and 19.35% answered negatively.

- **Analysis of answers to open questions**

Concerns arose about mainly about the **practicalities** of establishing a benzo buddy system, with professionals emphasising the need for training and questioning the feasibility of having enough trained individuals. Patients agreed that benzo buddies should undergo **training**, but concerns were raised about the financial and practical feasibility, including questions about funding, training providers, and 24/7 availability. Some respondents noted worries about potential **stigmatisation** through the system, suggesting a need for prevention as a crucial aspect of addressing addiction.

Recommendation 21: Share patient testimonials about BZRA tapering off

- **Feasibility**

Regarding the feasibility of Recommendation 21, 34.23% of the participants expressed 'completely agree,' while 49.55% indicated 'agree.' Additionally, 8.11% selected 'neither agree nor disagree,' 6.31% chose 'disagree,' and 1.80% were 'completely disagree.

- **Support**

Participants also expressed their level of support for Recommendation 21 as follows: 'Completely agree' was the choice of 43.24%, 'agree' received 42.34%, 'neither agree nor disagree' was selected by 9.01%, 'disagree' was indicated by 1.80%, and 'completely disagree' by 3.60%.

- **Importance**

Participants rated the importance of recommendation 21 on a scale. 35.48% rated it as 'very important,' 46.77% considered it 'important,' 11.29% responded with 'slightly important,' 6.45% found it 'unimportant,' and 0% regarded it as 'neither important nor unimportant.'

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 53.23% responded affirmatively, 37.10% replied with 'I don't know,' and 9.68% answered negatively.

- **Analysis of answers to open questions**

Participants emphasised the need for professional moderation to ensure **appropriate testimonials** are shared, focusing on slow tapering, and avoiding excessive emphasis on difficulties, which could discourage individuals.

Concerns were raised that testimonials might have the opposite effect**, potentially scaring people away from seeking help if the challenges are highlighted**. Patient input stressed the impact of testimonials compared to professional words, suggesting collaboration between professionals and patient experts.

Patients generally supported the idea with specific requirements, including **differentiation among patients**, conveying **hope**, **avoiding demonization of benzodiazepines**, and highlighting **the benefits when used appropriately**.

Recommendation 22: Develop culturally appropriate patient materials

- **Feasibility**

Regarding the feasibility of Recommendation 22, 40.54% of the participants expressed 'completely agree,' while 39.64% indicated 'agree.' Additionally, 14.41% selected 'neither agree nor disagree,' 2.70% chose 'disagree,' and 2.70% were 'completely disagree.

- **Support**

Participants also registered their support for Recommendation 22 as follows: 'Completely agree' was the choice of 54.95%, 'agree' garnered 33.33%, 'neither agree nor disagree' was favoured by 8.11%, 'disagree' was recorded at 1.80%, and 'completely disagree' at 1.80%.

- **Importance**

Participants rated the importance of recommendation 22 on a scale. 54.84% rated it as 'very important,' 37.10% considered it 'important,' 8.06% responded with 'neither important nor unimportant,' and 0% regarded it as 'slightly important' or 'unimportant.'

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 53.23% responded affirmatively, 33.87% replied with 'I don't know,' and 12.90% answered negatively.

- **Analysis of answers to open questions**

Healthcare professionals stressed the importance of addressing the underlying conditions leading to prescriptions. They emphasised **prevention** and cautioned **against overwhelming patients with excessive information**. They also highlighted the necessity of developing materials with **input from knowledgeable experts** and **individuals with relevant experiences**. The focus was on avoiding potential pitfalls based on past patient experiences. Moreover, patients had varied opinions on existing materials but unanimously emphasised the importance of doctors insisting on a slow tapering process.

3.4.3. Literature review summary for recommendations 22

Reflecting diversity entails community collaboration and requires a prioritisation of developing culturally competent resources. Cultural traditions and social practices have often been seen to influence behaviour substantially, especially in relation to substance abuse and substance use attitudes. Culturally adapted intervention plans, though studied minimally in the substance abuse field and in relation to BZRA usage, have been seen to be more effective than generic interventions as they demonstrate and tailor a relationship to the patient (Burlew et al., 2013).

Previous studies have identified several characteristics associated with long term BZRA and opioid usage, including younger populations, non-hispanic white populations, those with anxiety and depressive symptoms, and polypharmacy usage, this is important as each population may consume information on BZRA differently. In a study by Burlew et al., (2013), the 'one-size-fits-all' approach has been found arguably less effective than evidence-based treatments and cultural materials. Culturally specific materials that provide an extra level of individualisation for patients and takes one more step towards increasing patient understanding and increasing relatability. It can play a vital role in

diminishing stigma, fostering engagement, and facilitating successful tapering and cessation outcomes. By incorporating cultural sensitivity into informational material, it can ensure equal access to treatment for diverse populations, possibly enhancing engagement and trust between patients and providers.

Though these materials can bring a greater level of individualization, there is a question of feasibility and whether it would be possible to implement cultural adaptation. As there is an underrepresentation of minority groups in BZRA treatment, this can make it difficult to do research on the effectiveness of certain materials on various ethnic groups. There also may be a challenge to address intragroup diversity and assessing the effectiveness of an intervention for specific subgroups. Barrera & Castro (2006) suggest the importance of incorporating decision rules to adapt interventions and providing guidelines to tailor interventions to specific subgroups. Similarly, Kumpfer et al., (2008) propose providing group leaders with a variety of options for implementing specific activities to increase the likelihood of a favourable response from the community to the intervention.

By embracing a culturally responsive approach grounded in cultural humility, healthcare providers can develop and disseminate materials that resonate with patients from diverse cultural backgrounds, thereby promoting engagement, reducing stigma, and enhancing treatment outcomes (Hook et al., 2013; Jones & Branco, 2023). Through the integration of culturally specific materials into both BZRA tapering materials, but also in long-term use prevention, healthcare professionals can tailor their approach to benzodiazepine care to meet the unique needs and preferences of patients across diverse cultural contexts, ultimately contributing to more inclusive and effective treatment practices. Unfortunately, there is still a limited amount of studies on the use of culturally specific materials in terms of BZRA long-term care, so there is still a need to test the effectiveness of these practices within different cultural and ethnic communities. Cultural competency training and cultural specific materials add a level of individualisation in addiction care treatment, but can be difficult to feasibly integrate in tapering treatment plans, hence initial steps of cultural training and adapting to patients are integral to this recommendation.

Recommendation 23: Create an ombudsperson for healthcare practitioners to report other practitioners who over-prescribe, prescribe, or delivered unsafely

- **Feasibility**

Regarding the feasibility of Recommendation 23, 18.02% of the participants expressed 'completely agree', while 21.62% indicated 'agree.' Additionally, 29.73% selected 'neither agree nor disagree,' 18.02% chose 'disagree', and 12.61% 'completely disagree'.

- **Support**

Participants also expressed their level of support for recommendation 23 as follows: 'Completely agree' was the choice of 25.23%, 'agree' received 18.92%, 'neither agree nor disagree' was selected by 27.03%, 'disagree' was indicated by 12.61%, and 'completely disagree' by 16.22%.

- **Importance**

Participants rated the importance of recommendation 23 as follows: 24.19% rated it as 'very important', 20.97% considered it 'important,' 22.58% responded with 'neither important nor unimportant,' 12.90% found it 'slightly important,' and 19.35% regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 17.74% responded affirmatively, 50.00% replied with 'I don't know', and 32.26% answered negatively.

- **Analysis of answers to open questions**

In the open answer boxes, health care providers expressed concerns about the effectiveness of current reporting mechanisms. They also **feared false accusations**, and **privacy issues**. Some patients emphasised prevention through campaigns and feared abrupt rule implementation potentially leading to medication shortages. We can conclude that participants prefer the figurative carrot (motivating incentives) over the stick (punishment).

3.4.4. Literature review for recommendation 23

To create an ombudsperson system for healthcare practitioners to report instances of overprescribing, unsafe prescribing practices, or delivery of care, a structured system needs to be established within the healthcare regulatory framework. The concept of an ombudsperson has been implemented administratively in several countries, with the ombudsperson serving to safeguard the interests of individual citizens (Mackenney & Fallberg, 2004). In practicality, the primary role of an ombudsperson is to act as an advocate for effective management of healthcare services and act proactively upon the receipt of reports or complaints. In a study by Silva, Pedroso, & Zucchi, they noted different types of ombudspersons that can occur: inefficient, bureaucratic, and effective (2014). An inefficient ombudsperson often receives statements, but does not manage to implement an effective change within the institution. The bureaucratic type collects statements to provide the illusion of change and placating institutional problems. The effective ombudsperson develops strategies with persons within the institution to re-order policies, according to the needs of the population (Silva et al., 2014). In

healthcare, an ombudsperson is seen as a management tool and could potentially operate as a neutral party. In relation to BZRA use and treatments, an ombudsperson may contribute to improving the problems with over-prescription or off-label prescribing practice as a way to protect patients and promote more close monitoring of overlooked areas of healthcare and mental health care, but this is still in its infancy. According to the Federal Ombudsman service for Patients' Rights, ombudspersons also aim to promote communication between patients and healthcare practitioners through primarily preventive measures to avoid complaints. Mediation is the primary use in relation to conflicts and if the complaint is not mediated, the ombudsperson provides recommendations in their annual report to address recurring issues in relation to patient rights. This mechanism would contribute to maintaining ethical standards and promoting responsible prescribing practices within the healthcare system. The introduction of an ombudsperson holds promise for elevating ethical standards and enforcing stricter guidelines regarding the distribution of BZRA, while reinforcing the pivotal role of physicians in prescribing practices. The implementation of checks and balances is crucial in mitigating potential harm to patients, underscoring the transformative potential of an ombudsperson in reshaping perceptions surrounding benzodiazepine prescriptions.

Several healthcare settings around the world have implemented the role of an ombudsperson to address patient concerns and improve healthcare quality. In Canada Ontario's Patient Ombudsman serves as an advocate for patients, families, and caregivers. They handle complaints about public hospitals, long-term care homes, and home and community care services. They have addressed issues related to medication errors and overprescribing, promoting safer prescribing practices through their investigative work and recommendations. In the United States The Veterans Health Administration (VHA) has established the Office of the Patient Advocate (OPA) to assist veterans with healthcare-related issues. Each VA medical centre has a Patient Advocate. The OPA has been involved in addressing concerns related to opioid overprescribing, helping to implement strategies for safer opioid use and pain management practices. The VHA implemented the "Psychotropic Drug Safety Initiative," which includes specific targets to reduce BZRA use. This initiative has led to a significant decrease in benzodiazepine prescriptions among veterans. The California Department of Managed Health Care (DMHC) includes a Help Center that acts as an ombudsperson for patients in managed care health plans, assisting with complaints and grievances. They have addressed issues related to access to medications, appropriate prescribing, and adherence to treatment guidelines. In Australia, the Health Care Complaints Commission (HCCC) in New South Wales (NSW) investigates complaints about healthcare providers and services. It functions similarly to an ombudsperson by advocating for patient rights and safety. The HCCC has handled cases involving inappropriate prescribing practices, ensuring healthcare providers adhere to safe and evidence-based prescribing guidelines. Cases investigated by the HCCC have led to disciplinary actions against healthcare providers who do not follow best practices, and have spurred the adoption of stricter BZRA prescribing guidelines within healthcare organisations. Closer to Belgium, the United Kingdom has a Parliamentary and Health Service Ombudsman (PHSO). The PHSO in the UK investigates complaints about the National Health Service (NHS). It acts as an independent body ensuring that patient grievances are addressed. The PHSO has addressed issues related to medication errors and overprescribing, often leading to policy changes and improvements in clinical practice. The Swedish National Board of Health and Welfare (Socialstyrelsen) has a long-standing tradition of the ombudsman role, with the Health and Social Care Inspectorate (IVO) handling patient complaints and systemic healthcare issues. IVO has investigated cases of overprescribing and medication misuse, making recommendations to improve prescribing practices. IVO has investigated BZRA prescribing practices. These investigations focus on ensuring that prescribers follow national guidelines and that patients are informed about the risks of long-term use. This has led to an increased scrutiny of BZRA prescriptions and the implementation of policies aimed at reducing inappropriate use.

Recommendation 24: Extend the patient inclusion criteria of the new reimbursement scheme for the compounding of smaller doses of BZRA to residents living in nursing home

- **Feasibility**

Regarding the feasibility of recommendation 24, 30.63% of the participants expressed 'completely agree', while 32.43% indicated 'agree'. Additionally, 27.03% selected 'neither agree nor disagree', 5.41% chose 'disagree', and 4.50% 'completely disagree'.

- **Support**

Participants expressed their level of support for recommendation 24 as follows: 'completely agree' was the choice of 45.05%, 'agree' received 27.03%, 'neither agree nor disagree' was selected by 21.62%, 'disagree' was indicated by 1.80%, and 'completely disagree' by 4.50%.

- **Importance**

Participants rated the importance of recommendation 24 as follows: 43.55% rated it as 'very important', 43.55% considered it 'important', 11.29% responded with 'neither important nor unimportant', 1.61% regarded it as 'slightly important', and none (0.00%) regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 37.10% responded affirmatively, 46.77% replied with 'I don't know', and 16.13% answered negatively.

- **Analysis of answers to open questions**

In the open answer boxes, participants voiced some concerns on potential pitfalls in the process of extending the reimbursement criteria: **financial incentives for professionals**, **the need for training and staffing**, and **the lack of slow tapering off programs** in nursing homes. Challenges included **resistance to change** and a **shortage of personnel**. Patients agreed on the need for slower tapering off and more support due to the associated financial burden.

Recommendation 25: Extend the patient inclusion criteria of the new reimbursement scheme for the compounding of smaller doses of BZRA to patients who are taking more than one type of benzodiazepines or Z-drugs

- **Feasibility**

Regarding the feasibility of recommendation 25, 31.53% of the participants expressed 'completely agree' while 34.23% indicated 'agree'. Additionally, 28.83% selected 'neither agree nor disagree', 4.50% chose 'disagree', and 0.90% 'completely disagree'.

- **Support**

Participants expressed their level of support for recommendation 25 as follows: 'completely agree' was the choice of 42.34%, 'agree' received 33.33%, 'neither agree nor disagree' was selected by 18.92%, 'disagree' was indicated by 4.50%, and 'completely disagree' by 0.90%.

- **Importance**

Participants rated the importance of recommendation 20 as follows: 41.94% rated it as 'very important', 48.39% considered it 'important', 8.06% responded with 'neither important nor unimportant', 1.61% regarded it as 'slightly important', and none of the participants rated the recommendation as unimportant.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 46.77% responded affirmatively, 46.77% replied with 'I don't know', and 6.45% answered negatively.

- **Analysis of answers to open questions**

Limited responses were received for the recommendation to extend the patient inclusion criteria for reimbursement to patients who take more than one type of BZRA. One healthcare professional deemed it potentially irrelevant without further explanation. Many healthcare professionals agreed depending on **case-specific factors and financial considerations**. They stressed the need for enhanced training, information, and control for both pharmacists and doctors, with a focus on addressing underlying causes. Patients supported the idea, emphasising **the importance of professionals having more knowledge** and **facilitating a slower tapering off process.**

3.4.5. Literature review summary for recommendation 24 and 25

Long term usage of benzodiazepines poses significant costs to both healthcare and wider society, yet physicians and health care providers continue to prescribe them. Internationally, several strategies have been implemented to curb the widespread usage of BZRAs, such as reimbursement restriction in the Netherlands and a cost-effective analysis of benzodiazepine cessation programs in Spain. A reimbursement scheme aimed at compounding smaller benzodiazepine doses is often considered cost-effective and can lead to more positive outcomes in primary care. This recommendation holds potential for both patients in nursing homes and those taking multiple types of BZRA, as these populations exhibit higher BZRA consumption.

Literature indicates that benzodiazepines are commonly prescribed to nursing home residents, often without appropriate indications, posing additional risks to elderly patients. According to a study by Stevenson et al. (2010), more than a quarter of nursing home residents were prescribed antipsychotics, with nearly 40% lacking suitable diagnoses to support their use, while approximately 13% were taking benzodiazepines, with 42% lacking appropriate indications. A reimbursement scheme could potentially reduce the inappropriate prescribing practices of BZRA and yield a more positive change. Such an approach has been seen to significantly affect the BZRA usage, volume, and incidence, though long-term trends in chronic use may not see substantial decreases, which is the primary aim of reimbursement restrictions (Stevenson et al., 2010).

The design of the reimbursement scheme is crucial, particularly for patients on multiple types of BZRA. Patients who are prescribed multiple BZRA are at higher risk of adverse effects and polypharmacy related complications. Including these patients in reimbursement schemes aimed at compounding smaller doses, healthcare providers can potentially streamline medication regimes, enhance patient safety, and the overall medicational burden (Yang et al., 2008). In a study in the Netherlands, they found that reimbursement policy has a significant initial effect on the volume and prevalence of BZRA use (Stoker et al., 2019). In addition to reductions in chronic use, there was also a decrease in the country's healthcare expenditures and a decrease in the total number of dispense prescriptions.

Overall, extending the patient inclusion criteria of the reimbursement scheme for compounding smaller doses of BZRA to patients taking more than one type of these medications could enhance medication management, improve patient safety, and contribute to more efficient and effective healthcare delivery as well as expanding patient inclusion criteria of a reimbursement scheme for the compounding of smaller doses of BZRA to residents living in nursing homes could potentially lead to a reduction in the inappropriate use of these medications in this population. However, it is crucial to consider the potential confounding factors and design the reimbursement scheme to minimise reimbursement error.

Recommendation 26: Offer group therapy to non-hospitalised patients to support the tapering process

- **Feasibility**

Regarding the feasibility of recommendation 26, 30.65% of the participants expressed 'completely agree', while 46.77% 'agreed'. Additionally, 16.13% selected 'neither agree nor disagree', 4.84% 'disagree' and 1.61% completely disagreed.

- **Support**

Participants also expressed their level of support for recommendation 26 as follows. 'Completely agree' was the choice of 40.32%, 'agree' received 51.61%, 'neither agree nor disagree' was selected by 8.06%, 'disagree' was indicated by 0.00%, and 'completely disagree' by 0.00%.

- **Importance**

A quarter of all participants (25.81%) rated recommendation 26 as 'very important', while an overwhelming 59.68% considered it 'important' as well. Few participants (12.90%) responded with 'neither important nor unimportant' and even fewer (1.61%) regarded it as only 'slightly important'. None regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the necessary conditions for implementing this recommendation are met in the current circumstances. 43.55% responded affirmatively, 37.10% replied with 'I don't know', and 19.35% answered negatively.

- **Analysis of answers to open questions**

Respondents widely support group therapy for ambulant (non-hospitalised) patients who taper off from BZRA emphasising **motivation and peer support**. Suggestions include parallel individual trajectories, optional smaller groups, multidisciplinary collaboration, and increased awareness. Funding must ensure **financial accessibility**. Healthcare professionals need training in benzodiazepine management and group therapy. Geographic accessibility and wider outpatient addiction care distribution are crucial. Concerns about insufficient demand may arise, suggesting the need to address this perception and boost group therapy popularity.

Recommendation 27:
Tailoring specific residential addiction programmes to BZRA dependency

- **Feasibility**

Regarding the feasibility of recommendation 27, 20.97% of the participants expressed 'completely agree', while 43.55% indicated 'agree'. Additionally, 29.03% selected 'neither agree nor disagree' 6.45% chose 'disagree', and none (0.00%) completely disagreed.

- **Support**

Participants expressed their level of support for recommendation 27 as follows: 'Completely agree' was the choice of 38.71%, 'agree' received 35.48%, 'neither agree nor disagree' was selected by 17.74%, 'disagree' was indicated by 8.06%, and 'completely disagree' by 0.00%.

- **Importance**

37.10% of all participants rated the importance of recommendation 27 as 'very important', 30.65% as 'important', 22.58% as 'neither important nor unimportant', 3.23% regarded it as 'slightly important', and 6.45% regarded it as 'unimportant'.

- **Conditions**

Participants assessed whether the recommendation could be implemented under the current circumstances. 33.87% responded affirmatively, 48.39% replied with 'I don't know', and 17.74% answered negatively.

- **Analysis of answers to open questions**

Tailoring residential addiction programs specifically for BZRA/Z is widely supported, contingent on proper interdisciplinary communication between primary care and residential institutions. A slow tapering off from BZRAs is crucial for a successful recovery from BZRA dependence and addiction. While some professionals advocate for residential care in extreme cases, others see **ambulant care as sufficient, providing a safe space for patients to manage withdrawal symptoms and learn coping strategies**. Concerns about the **cost-effectiveness of residential programs** and the **potential loneliness** of being in a group focused on diverse addictions are raised. Patients express a **preference for ambulant care**, contingent on the availability of adequate knowledge and support for benzodiazepine dependence.

3.4.6. Literature review summary for recommendations 19, 20, 21, 26, 27

Peer support networks and tailored addiction care play a vital role in assisting patients throughout their tapering journey. Strategies such as group therapy and buddy systems are utilised to provide both emotional support and practical guidance, fostering a sense of comfort as individuals embark on this challenging process. Research indicates that patients' success rates in tapering off medications, such as BZRA, significantly increase when they have access to a support system comprising peers and family members. This study explores potential methods for patient support during the tapering process, including a support and advice line, benzo-buddy system, sharing patient narratives, culturally tailored materials, group therapy sessions, and individualised addition care programs.

Social support has been identified as a predictive variable, suggesting a potential to facilitate the tapering process across different contexts. Though there has not been specific research on the effectiveness of the buddy system in relation to benzodiazepine and Z-drug tapering, it has been proven to be effective in other cessation processes such as tobacco use and it offers an individualised approach to supporting behavioural change, with minimal cost and high cost-effectiveness. This system is frequently favoured. Patient testimonials also play a significant role in the tapering process with them offering valuable insights and motivation that can resonate with other patients going through the same journey. It helps to reduce the isolative feelings of the tapering process while also destigmatising the process (Welsh et al., 2018). Patient testimonials offer additional social support as they can be paired with other social supports as an indirect aid.

Additionally, **social support initiatives** like group therapy, patient testimonials on tapering, or culturally specific materials can help destigmatise the process of tapering off benzodiazepines. The effectiveness of group therapy on tapering processes, particularly in the context of benzodiazepine tapering, has been seen to have either a positive outcome or have a reduction in the dosage of BZRA consumed (Voshaar et al., 2003). Though there is a general difficulty, found in the literature, with adherence to group therapy reflecting a possible resistance to this social support intervention. Research has indicated that group therapy, when combined with tapering off benzodiazepines, can lead to a small, but significant benefit than tapering alone, as it provides individualised support to the patient (Parr et al., 2009). Group therapy provides a safe environment for both education on the risks of BZRA overuse, but also allows patients to receive external support and opportunities for self-expression, which can help reduce psychological distress and help improve coping and adaptation. It is important to highlight that the implementation of group therapy would require careful consideration to tailor it to the tapering process to meet the requirements of the population (Smith & Tett, 2010).

Tailoring residential addiction care programmes can also add another layer to long-term treatment and can be paired with continuity of care. They offer numerous benefits that support individuals in their journey towards recovery and ensure a targeted approach to addressing addiction. Additionally, they offer comprehensive care that encompasses various therapeutic modalities, including individual and group therapy, medical care, and addressing underlying issues such as trauma and mental health disorders. Peer support within residential programs fosters a sense of community and mutual understanding, promoting accountability and emotional support. The structured environment and 24/7 professional support provide a safe and secure setting for individuals to focus on their recovery. Furthermore, these programs often prioritise mental health, offering therapy sessions and medication management to address co-occurring conditions effectively.

However, cessation within the rather limited time constraints of a residential addiction care program does not meet the needs of all patients as tapering can be a slow process, that ideally is adjusted to

the pace and needs of individual patients. One remaining question is thus: how to organise peer support outside or in combination with residential (after)care?

Furthermore, **residential addiction care programs** also have their drawbacks, including high costs, potential disruption of daily life and responsibilities, and limited accessibility to those with logistical or financial barriers. Additionally, some individuals may struggle with the intensive nature of residential programs or experience difficulties transitioning back to their daily lives post-treatment. Despite these challenges, tailored residential addiction programs remain an invaluable resource for individuals seeking comprehensive and personalised care to overcome addiction and achieve lasting recovery.

In conclusion, the importance of support networks and individualised addiction care cannot be overstated in aiding patients throughout their tapering journey from benzodiazepines and Z drugs. Strategies like group therapy, buddy systems, and culturally tailored materials serve as crucial pillars in providing both emotional bolstering and practical guidance, thereby easing the challenges inherent in the tapering process. While research highlights the effectiveness of these methods in fostering patient success rates, there remains a need for further exploration into their specific impact within the context of benzodiazepine tapering. Nevertheless, the collective evidence underscores the significance of social support initiatives in destigmatizing tapering, enhancing patient engagement, and ultimately promoting successful outcomes in the journey toward cessation.

3.5. Classification and ranking of recommendations per tiers of prevention

Participants were invited to select and rank the most important recommendations to implement in the current circumstances. They were classified by tiers of prevention: primary prevention, secondary prevention, and tertiary prevention.

3.5.1. Primary prevention

For primary prevention, participants were invited to categorise recommendations within the primary prevention. In Table 2, recommendations are ranked by occurrence in the first three positions.

For instance, the recommendation ' Implementing non-stigmatizing and empathetic public awareness campaign of the risks of BZRA in empathetic and non-stigmatising ways' was voted into the first position 22 times and for the second position 19 times. The recommendation 'Implementing an awareness raising campaign for professionals on the challenges of withdrawing from multiple medications' was voted 14 times for the third position.

Table 3 Primary prevention ranking

Primary prevention	Occurrence	
First position	**22**	**Implementing an awareness raising campaign of the risks of BZRA in an empathetic and non-stigmatising way.**
	14	Implementing an awareness raising campaign for professionals on the challenges of withdrawing from multiple medications.
	12	Implementing an awareness raising campaign among the general public on tapering off BZRA.
	5	Adding warnings of the risk of dependence on the BZRA package.
	5	Undertake further research on the mechanisms surrounding the first prescription of BZRA.
	4	Implementing an awareness raising campaign for patients on the challenges of withdrawing BZRA from multiple medications.
Second position	**19**	**Implementing an awareness raising campaign of the risks of BZRA in an empathetic and non-stigmatising way.**
	12	Adding warnings of the risk of dependence on the BZRA package.
	11	Undertake further research on the mechanisms surrounding the first prescription of BZRA.
	9	Implementing an awareness raising campaign among the general public on tapering off BZRA.
	7	Implementing an awareness raising campaign for patients on the challenges of withdrawing BZRA from multiple medications.
	4	Implementing an awareness raising campaign for professionals on the challenges of withdrawing from multiple medications.
Third position	**14**	**Implementing an awareness raising campaign for professionals on the challenges of withdrawing from multiple medications.**
	12	Adding warnings of the risk of dependence on the BZRA package.
	11	Implementing an awareness raising campaign for patients on the challenges of withdrawing BZRA from multiple medications.
	10	Undertake further research on the mechanisms surrounding the first prescription of BZRA.

	8	Implementing an awareness raising campaign among the general public on tapering off BZRA.
	7	An awareness raising campaign of the risks of BZRA in an empathetic and non-stigmatising way.

3.5.2. Secondary prevention

For secondary prevention, participants were invited to categorise recommendations within the secondary prevention. In Table 3, recommendations are ranked by occurrence in the first three positions. For instance, the recommendation 'Provide information by the prescriber to the patient regarding the risks of dependency of BZRA at first use' was voted into the first position 22 times. The recommendation 'Allow the carer to dispense one or two doses of BZRA* at the same time to provide the correct dose' was voted 13 times for the second position and the recommendation 'Create smaller packages of BZRA'.

Table 4 Secondary prevention ranking

Secondary prevention	**Occurrence**	
First position	22	**Provide information by the prescriber to the patient regarding the risks of dependency of BZRA at first use.**
	21	Create smaller packages of BZRA.
	8	Allow the carer to dispense one or two doses of BZRA* at the same time to provide the correct dose.
	5	Create an inter-professional communication channel at local level, between pharmacists and GPs to discuss common patients.
	4	Give access to other BZRA prescribers/providers to the part of the medical file related to prescriptions.
	1	Increase the price per BZRA package.
	1	Provide higher remuneration for prescribers for long follow up consultations dedicated to BZRA*.
Second position	13	**Allow the carer to dispense one or two doses of BZRA* at the same time to provide the correct dose.**
	12	Provide information by the prescriber to the patient regarding the risks of dependency of BZRA at first use.
	11	Create an interprofessional communication channel at local level, between pharmacists and GPs to discuss common patients.
	10	Provide higher remuneration for prescribers for long follow up consultations dedicated to BZRA*.
	10	Give access to other BZRA prescribers/providers to the part of the medical file related to prescriptions.
	5	Create smaller packages of BZRA.
	1	Increase the price per BZRA package.
	15	**Create smaller packages of BZRA.**
	12	Create an inter-professional communication channel at local level, between pharmacists and GPs to discuss common patients.
	10	Allow the carer to dispense one or two doses of BZRA* at the same time to provide the correct dose.

Third position	10	Provide information by the prescriber to the patient regarding the risks of dependency of BZRA at first use.
	9	Give access to other BZRA prescribers/providers to the part of the medical file related to prescriptions.
	4	Provide higher remuneration for prescribers for long follow up consultations dedicated to BZRA*.
	2	Increase the price per BZRA package.

3.5.3. Tertiary prevention

The recommendation 'Implementing a training course on difficult tapering off processes related to BZRA for professionals' was voted into the first position 11 times. The recommendation 'Extend the patient inclusion criteria of the new reimbursement scheme for the compounding of smaller doses of BZRA to patients who are taking one or more type of benzodiazepines or Z-drugs' received 11 votes for the second position, while the recommendation 'Implementing a training course on difficult tapering off processes related to BZRA for professionals' garnered 10 votes for the third position.

Table 5 Tertiary prevention ranking

Tertiary prevention	**Occurrence**	
First position	11	**Implementing a training course on difficult tapering off processes related to BZRA for professionals.**
	9	Creating a shared policy position between different professionals groups in addiction care concerning the management of BZRA.
	8	The establishment of an agreement between the prescriber, the pharmacist and the patient to keep the same prescriber and pharmacist throughout treatment.
	8	Extend the patient inclusion criteria of the new reimbursement scheme for the compounding of smaller doses of BZRA to patients who are taking more than one type of benzodiazepines or Z-drugs.
	5	Establish a support and advice line for people who want to taper off of BZRA.
	4	Offer group therapy to ambulant patients to support the tapering off process.
	4	Establish and provide a list of healthcare providers specialised in tapering off of BZRA.
	3	Encourage prescribers to add the indication for substance use disorders next to insomnia/anxiety to patient records when use exceeds guidelines.
	3	Develop culturally appropriate patient materials.
	3	Share patient testimonials about BZRA tapering off.
	2	Create an ombudsperson for healthcare practitioners to report other practitioners who over-prescribe, prescribe, or delivered unsafely BZRA.
	1	Develop a 'Benzo-buddy' system.
	1	Tailor residential addiction care programmes, specifically to BZRA withdrawal.

Second position	11	**Extend the patient inclusion criteria of the new reimbursement scheme for the compounding of smaller doses of BZRA to patients who are taking more than one type of benzodiazepines or Z-drugs.**
	9	Establish a support and advice line for people who want to taper off of BZRA.
	7	Implementing a training course on difficult tapering off processes related to BZRA for professionals.
	6	Share patient testimonials about BZRA tapering off.
	6	The establishment of an agreement between the prescriber, the pharmacist and the patient to keep the same prescriber and pharmacist throughout treatment.
	6	Offer group therapy to ambulant patients to support the tapering off process.
	5	Tailor residential addiction care programmes, specifically to BZRA withdrawal.
	5	Develop culturally appropriate patient materials.
	2	Encourage prescribers to add the indication for substance use disorders next to insomnia/anxiety to patient records when use exceeds guidelines.
	2	Create an ombudsperson for healthcare practitioners to report other practitioners who over-prescribe, prescribe, or delivered unsafely BZRA.
	2	Creating a shared policy position between different professionals' groups in addiction care concerning the management of BZRA.
	1	Develop a 'Benzo-buddy' system.
Third position	10	**Implementing a training course on difficult tapering off processes related to BZRA for professionals.**
	8	Share patient testimonials about BZRA tapering off.
	6	Extend the patient inclusion criteria of the new reimbursement scheme for the compounding of smaller doses of BZRA to patients who are taking more than one type of benzodiazepines or Z-drugs.
	7	Establish and provide a list of healthcare providers specialised in tapering off of BZRA.
	6	Develop culturally appropriate patient materials.
	5	Offer group therapy to ambulant patients to support the tapering off process.
	5	Tailor residential addiction care programmes, specifically to BZRA withdrawal.
	4	Establish a support and advice line for people who want to taper off of BZRA.
	4	Creating a shared policy position between different professionals' groups in addiction care concerning the management of BZRA.
	3	The establishment of an agreement between the prescriber, the pharmacist, and the patient to keep the same prescriber and pharmacist throughout treatment.
	3	Develop a 'Benzo-buddy' system.
	1	Create an ombudsperson for healthcare practitioners to report other practitioners who over-prescribe, prescribe, or delivered unsafely BZRA.

3.5.4. Overview of results

In what follows, we provide an overall presentation of the results. In figure 2, participants are classified according to the percentage with regard to feasibility and participants' support for the recommendations. Each recommendation is represented by a dot and its corresponding number. The vertical axis represents support as a percentage and the horizontal axis represents feasibility. This graph puts the recommendations into perspective by cross-referencing the participants' representation of the support and feasibility for each recommendation.

Figure 2 Ranking of recommendations according to feasibility and support (%)

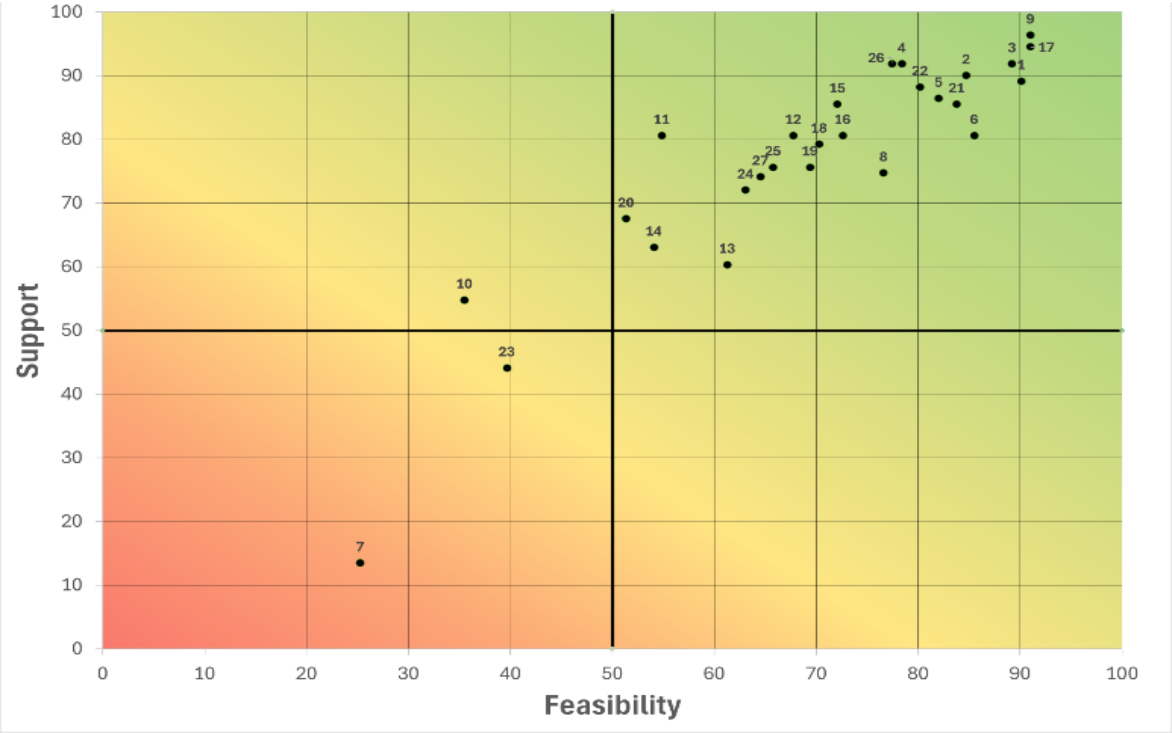


Table 6 shows percentages representing the sum of participants who selected 'completely agree / very important' or 'agree / important' respectively for each recommendation. Each recommendation corresponds with their assigned number. The columns 'feasibility', 'support', and 'importance' are shaded with a colour gradient based on the percentages provided in each cell from green (high percentage) to red (low percentage).

Table 6 Percentage of feasibility, support and importance

Recommendation	Feasibility	Support	Importance
1	90.1	89.19	91.94
2	84.68	90.09	93.55
3	89.18	91.89	88.71
4	78.38	91.89	98.39
5	81.99	86.48	75.81
6	85.48	80.65	80.65
7	25.23	13.52	12.9
8	76.58	74.78	82.26
9	90.99	96.4	98.38
10	35.48	54.83	46.77
11	54.84	80.65	70.97
12	67.74	80.65	74.2
13	61.26	60.36	61.29
14	54.06	63.07	61.29
15	72.07	85.58	87.09
16	72.58	80.65	80.65
17	90.99	94.59	95.16
18	70.27	79.28	77.42
19	69.37	75.67	69.35
20	51.35	67.57	58.06
21	83.78	85.58	82.25
22	80.18	88.28	91.94
23	39.64	44.15	45.16
24	63.06	72.08	87.1
25	65.76	75.67	90.33
26	77.42	91.93	85.49
27	64.52	74.19	67.75

Table 7 then lists each recommendation, the level of consensus and the direction of consensus, based on the article by Meskell et al. (2014). The level of consensus can be classified as 'high consensus', 'moderate consensus', 'low consensus' or 'none'. This level of consensus is defined according to the legend below. In addition, the direction of the consensus is defined as either '+', '-', or '='. If it is a '+', this means that the consensus is in favour of the recommendation, if it is a '-', this means that the consensus is against the recommendation and if it is an '=', this means that the consensus is where people have not positioned themselves in favour or against the recommendation. The box is empty when there is no consensus.

Table 7 Level and direction of consensus for all recommendations

Statement number	Feasibility		Support		Importance		Conditions	
	Level of consensus	Directions	Level of consensus	Direction	Level of consensus	Direction	Level of consensus	Direction
Q1	High	+	High	+	High	+	Moderate	+
Q2	High	+	High	+	High	+	Moderate	+
Q3	High	+	High	+	High	+	High	+
Q4	Moderate	+	High	+	High	+	Moderate	+
Q5	High	+	High	+	Moderate	+	Moderate	+
Q6	High	+	High	+	High	+	Low	+
Q7	**None**		None		Low	-	**None**	
Q8	Moderate	+	Moderate	+	High	+	Moderate	+
Q9	High	+	High	+	High	+	Moderate	+
Q10	Low	=	None		Low	+	**None**	
Q11	**None**		High	+	Moderate	+	Low	=
Q12	Low	+	High	+	Moderate	+	Moderate	+
Q13	Low	+	Low	+	Low	+	**None**	
Q14	**None**		Low	+	Low	+	**None**	
Q15	Moderate	+	High	+	High	+	Low	=
Q16	Moderate	+	High	+	High	+	Low	+
Q17	High	+	High	+	High	+	Moderate	+
Q18	Moderate	+	Moderate	+	Moderate	+	**None**	
Q19	Low	+	Moderate	+	Low	+	**None**	
Q20	**None**		Low	+	**None**		Low	=
Q21	High	+	High	+	High	+	Low	+
Q22	High	+	High	+	High	+	Low	+
Q23	**None**		None		**None**		Low	=
Q24	Low	+	Moderate	+	High	+	**None**	
Q25	Low	+	Moderate	+	High	+	**None**	
Q26	Moderate	+	High	+	High	+	**None**	
Q27	Low	+	Moderate	+	Low	+	**None**	

Level of consensus for feasiblity and support columns	
Categorisation of the percentages of agreement in each category of the scale.	
High consensus	≥ 70% in completely agree or completely disagree or agree or disagree or neither agree nor disagree
	≥ 80% in completely agree and agree; disagree and completely disagree
Moderate consensus	≥ 60% in completely agree or completely disagree or agree or disagree or neither agree nor disagree
	≥ 70% in completely agree and agree; disagree and completely disagree
Low consensus	≥ 50% in completely agree or completely disagree or agree or disagree or neither agree nor disagree
	≥ 60% in completely agree and agree; disagree and completely disagree

Level of consensus for importance column	
Categorisation of the percentages of agreement in each category of the scale.	
High consensus	≥ 70% in important or very important or slightly important or unimportant or neither important nor unimportant
	≥ 80% in very important and important; slightly important and unimportant
Moderate consensus	≥ 60% in very important or important or slightly important or unimportant or neither important nor unimportant
	≥ 70% in very important and important; slightly important and unimportant
Low consensus	≥ 50% in very important or important or slightly important or unimportant or neither important nor unimportant
	≥ 60% in very important and important; slightly important and unimportant

Direction of consensus		
The direction of consensus indicates the prevailing opinion on the statement, whether in favour or not.		
Direction of consensus	+	In favour
	-	Not in favour
	=	Consensus in the "neither agree nor disagree" category

4. Conclusion

As part of this report, we presented 27 policy recommendations assessed in terms of their feasibility, support, importance, and the necessary conditions for implementing them. These recommendations are categorized according to the tier of prevention they can be categories in: primary, secondary, and tertiary prevention of long-term use of BZRAs. From these recommendations, we can establish a prioritized list of policy recommendations to be implemented in Belgium. Among the key recommendations, there is the implementation of public awareness raising campaigns among the general public on tapering off BZRA and for patients on the challenges of withdrawing BZRA from multiple medications. Additionally, providing patients with information regarding the risks of dependence at the time of a first prescription could enable patients to make an informed decision about their treatment choices. Furthermore, implementing a training course on the difficulties of withdrawal related to BZRA for professionals is highlighted. These recommendations received a high level of consensus regarding their feasibility, support, and importance, and the participants were in favour of these recommendations. Some received a moderate level of consensus concerning the necessary conditions to implement these recommendations in Belgium under the current circumstances.

On the other hand, some policy recommendations were characterised by a low level of consensus among the participants. Notably, the following recommendations received more varied assessments: to provide higher remuneration for prescribers for long follow-up consultations dedicated to BZRA, to encourage prescribers to add the indication for substance use disorders alongside insomnia/anxiety to patient records when use exceeds guidelines, to establish an agreement between the prescriber, the pharmacist, and the patient to keep the same prescriber and pharmacist throughout treatment, to develop a 'benzo-buddy' system. These recommendations received a low level of consensus in at least two categories, including feasibility, support, importance, and conditions. For example, regarding the recommendation to develop a benzo-buddy system, there is low consensus, yet the consensus that exists leans positively toward support for the recommendation. However, the participants did not reach an agreement on its feasibility and importance. Other recommendations had more than two categories with no consensus, such as increasing the price per BZRA package and creating an ombudsperson for healthcare practitioners to report other practitioners who over-prescribe, prescribe, or deliver unsafely. The more varied opinions on these recommendations are further explained under analyses of answers to the accompanying open questions.

Prioritising the implementation of highly consensual recommendations is advisable, given their broad support and feasibility. However, it is important to note that recommendations supported more by experts than by patients, or vice versa, should not necessarily be dismissed outright. Less consensual recommendations may require further review and modification to address concerns regarding their feasibility, support, importance, and the necessary conditions for their implementation.

The diversity of recommendations and the levels of consensus underscores the complexity of addressing long-term BZRA use. A comprehensive approach that includes education, awareness, and training in healthcare practices will likely be necessary to achieve significant improvements. To effectively prevent long-term BZRA use, it is essential to integrate multiple strategies that collectively address different aspects of the issue. This includes raising public awareness to inform and educate patients, ensuring that healthcare providers are adequately trained to manage and support patients through withdrawal, and creating a supportive healthcare environment where informed decisions are encouraged and facilitated. By adopting a multi-faceted approach, the likelihood of achieving

improvements in the management and reduction of long-term BZRA use in Belgium will be significantly enhanced.

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