FEDERAL RESEARCH PROGRAMME ON DRUGS

SUMMARY

BENZOCARE

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

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Contract - DR/91

SUMMARY

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Published in 2024 by the Belgian Science Policy Office (BELSPO)
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Ceuterick, M., Van Ngoc, P., Belche, JL., Bracke, P., Scholtes, B. BENZOCARE Summary. Brussels : Belgian Science Policy Office 2024 – 10 p. (Federal Research Programme on Drugs)

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

Sleeping pills and tranquillisers are psychotropic drugs which are generally used for their sedative and anxiolytic effects, also known as benzodiazepine receptor agonists (BZRA). The **BENZOCARE (2021-2024)** study examines the accessibility of care in Belgium (Flanders and Wallonia) for individuals who use this medication long term.

CONTEXT AND OBJECTIVES

Although BZRA are commonly prescribed (in 2022 for example 1 in 5 Belgians took a BZRA), both short-term and long-term use can lead to significant adverse effects. These include physiological and psychological dependence, increased cognitive impairment, and a heightened risk of injuries such as falls, hip fractures, traffic accidents, and even suicide attempts or suicides. Current guidelines recommend that BZRA should not be used for more than one to two weeks for insomnia and four weeks for anxiety, at the lowest effective dose. However, they are frequently prescribed for longer periods, which presents a serious public health issue in Belgium. Faced with this situation, the BENZOCARE research project aimed to:

1. explore the experiences of healthcare professionals who support these patients, by understanding their perspective in treating these patients;
2. analyse the ambiguous role of BZRA in health care by exploring how professionals perceive the role of BZRA in their clinical practice;
3. understand patients' experiences with the healthcare system, by examining how they perceive their treatment and recovery trajectories;
4. study the accessibility of healthcare for individuals with a dependence on BZRA by investigating the needs, barriers, and facilitators identified by both professionals and patients;
5. develop policy recommendations adapted to real-world conditions on how to improve accessibility of care for these patients;

In-depth interviews were conducted with 24 healthcare professionals (general practitioners, psychiatrists, nurses, psychologists, social workers) and 19 patients who had taken BZRA long-term (≥ 6 months) and had either stopped, reduced, or stabilised their BZRA dosage, across Belgium. For data analysis, different analytical approaches were employed depending on the specific research question, including both an inductive and a deductive thematic analysis, interpretative phenomenological analysis, and a discourse analysis. Based on the findings from all interviews, a set of policy recommendations was developed. Following a Policy Delphi approach, these were subsequently

evaluated (in two rounds) in terms of feasibility, support, importance, and necessary conditions for implementation by a panel of 111 experts, including healthcare professionals and patients. In total, 27 recommendations were evaluated by the expert panel.

MAIN FINDINGS

Prescribing dilemma

The gap between official guidelines and actual prescribing practices is especially evident with BZRA. This research looks at how healthcare professionals handle the challenges of prescribing these medications. The study identifies a range of prescribing behaviours that revolve around four main narratives used by professionals. These narratives are based on three key factors: a) the opinions of prescribers about the risks of these medications, b) the power dynamics between doctors and patients during the prescribing process, and c) the types of arguments used in discussions about these drugs. By exploring these narratives, the research highlights the emotional and moral considerations involved in prescribing. It also reveals the unwritten rules that healthcare professionals tend to follow when making prescribing decisions, which explain the divergence between guidelines and prescribing practices.

Setting treatment goals with the patient

This research examined how primary care and mental health professionals set treatment goals with patients using BZRA long-term. Key findings revealed that many professionals did not use standard diagnostic criteria for SUD and instead relied on personal experience. They recognized different patient types influencing treatment choices, often feeling conflicted between promoting abstinence and harm reduction. Whether primary care or mental health care professionals are more in favour of a total abstinence or a harm reduction approach to BZRA, professionals should be guided towards greater patient participation in setting and evaluating goals with patients taking BZRA.

Need of open communication and collaboration in BZRA stabilisation, diminution or cessation

The results of our research showed that some patients felt that they were not sufficiently informed about BZRAs, some of them felt that they had to adhere to the treatment and therefore to the medication prescribed by their doctor, and others explained that they were going through the withdrawal or stabilisation process alone without seeing the point of involving a professional in the process. Patients who have gone through the withdrawal process stress the importance of personalising the pace of withdrawal with a stabilisation, reduction or cessation. These results show how important it is to rely on collaboration and open conversation between the patient and the healthcare professional.

Addressing barriers and facilitators to healthcare access for patients with BZRA SUD

In our study, we examined the accessibility of healthcare services for patients with BZRA SUD from the point of view of healthcare providers and patients. Reducing long-term BZRA use is critical, but deprescribing is challenging due to barriers in accessing care. This study highlights issues such as lack of information, stigma, logistical hurdles, service shortages, and financial difficulties. Key recommendations include strengthening patient-provider relationships, adopting integrated care models, and ensuring universal access to services to address inequalities and improve outcomes. A systemic approach is essential, from prevention to managing dependence.

Towards a coordinated and innovative approach to prevent long-term BZRA use

Based on the study results, 27 policy recommendations were developed and assessed for their feasibility, support, importance and necessary conditions to implement them. We employed a policy Delphi design to allow diverging opinions, from a broad range of experts, with either lived experience, professional expertise, or both. This allows to highlight agreements and disagreements on specific issues.

The recommendations can be divided in three tiers of prevention: 1) preventing the first prescription, 2) preventing a first prescription from developing into long-term use, and 3) addressing long-term use and dependence. Overall we notice that recommendations that gained little support, were the more restrictive ones, either towards the prescriber (e.g. the idea of an ombudsperson to report on overprescribing), or towards the patient (e.g. rising the price per package). Several recommendations stood out for their high level of consensus. One key recommendation in the first tier of prevention is the need for awareness campaigns targeting both healthcare professionals and the general public about the risks of long-term BZRA use. These campaigns should be conducted in a non-stigmatizing and empathetic manner. The bilingual podcast series that we created with testimonials of prescribers and patients with experience in tapering-off, already provides a concrete answer to this need and could also be used as part of a more overarching strategy or campaign. Moreover, our results underscore the critical importance of open communication and collaboration between patients and healthcare providers, particularly in the processes of stabilisation, reduction, or cessation of BZRA. Within the second tier of prevention, the importance of training healthcare professionals to address the challenges patients face during withdrawal stands out. This can be further integrated in already existing training initiatives and programs. Some small changes, like allowing prescribers to directly dispense small doses or tablets (instead of prescribing an entire package), could also create an important psychological effect. Other recommendations stood out for their innovative nature. While they did receive a good level of support and were deemed important, it was less clear whether the necessary conditions are in place yet to develop these further. These proposals represent promising initiatives that focus on the possible role of peer support, through a ‘benzo-buddy’ support system and group therapy for dependence on BZRA. These ideas require further exploration to determine how they might be implemented concretely in Belgium. Furthermore, in tertiary prevention, the idea of tailoring specific residential care programs in addiction care also stood out, although this should be seen as an addition to deprescribing in primary care. A support line (e.g. an online platform or helpline) for patients who are tapering-off was also one of the more novel recommendations, which could offer a valuable addition to professional support in primary care, which is often limited to the time of a consultation. Future (applied) research should focus on these innovative suggestions to assess their feasibility within the Belgian context and identify the necessary conditions for their successful implementation. Overall, these results emphasise the intricate nature

of long-term BZRA use and the need for a coordinated, multidimensional approach that integrates primary, secondary and tertiary prevention through education, awareness raising, and personalized healthcare practices in deprescribing.

Conclusion

The BENZOCARE project highlights the significant challenges related to the prescribing and long-term use of BZRA. The findings demonstrate a gap between guidelines and what actually happens in practice, highlighting the challenges that healthcare providers and patient face with BZRA. Moreover, the research underscores the critical importance of open communication and collaboration between patients and healthcare providers, particularly in the processes of stabilisation, reduction, or cessation of BZRA.

RECOMMENDATIONS

- **Encourage reflexivity in BZRA management:** healthcare professionals should be more encouraged to reflect on their prescribing behaviours by examining how their perceptions of risk, power dynamics with patients, and discussion strategies impact their decisions around BZRA. This can be achieved through offering training (for general practitioners (in training) that addresses the emotional and moral considerations of prescribing, and which helps practitioners navigate the unwritten rules that often shape treatment choices.

- **Develop integrated and collaborative care approaches:** Primary and mental healthcare providers should be encouraged to actively involve patients in setting treatment goals, whether focused on abstinence or harm reduction. Treatment goals should be tailored to each patient's unique needs and circumstances. Open, transparent communication is essential, ensuring patients are fully informed about the risks and benefits of long-term BZRA use as well as the rationale behind their treatment options. A comprehensive healthcare strategy should integrate education, awareness, and personalised care practices, emphasising collaboration among healthcare professionals to provide holistic support for patients managing BZRA treatment and withdrawal.

- **Promote awareness, training and innovative prevention initiatives:** Develop and implement non-stigmatizing awareness campaigns for both healthcare professionals and the general public about the risks associated with long-term BZRA use. Non-stigmatizing public awareness campaigns should highlight the risks of prolonged BZRA use and encourage early intervention. Concurrently, introduce training initiatives for healthcare professionals to enhance their communication skills, support patient engagement in treatment planning, and manage withdrawal effectively. Incorporate and promote innovative prevention strategies, such as a support and advice line, and **peer support models** like a buddy-system, which pairs patients with other peers who provide guidance and emotional support during withdrawal. Highlighting such creative and innovative approaches can inspire adoption and adaptation of successful models in other contexts, fostering a more empathetic and effective care system. Furthermore, the potential of other forms of peer support, such as testimonials and **group therapy** should also be further explored.

- **Strengthening the integration of physical and mental healthcare services:** Greater horizontal integration within regional territories such as by further developing meso-level approaches to integration such as the primary care zones in Flanders, the health and social care zones in Brussels and the planned loco-regional organisations for health and social care in Wallonia could improve patient outcomes and experience and reduce reliance on specialist centres. Similarly greater vertical integration from primary to tertiary care could improve collaboration between different healthcare providers such as general practitioners and specialists. By adopting these recommendations, the healthcare system can bridge the existing gap between guidelines and practices, thereby enhancing patient care and improving outcomes for individuals affected by BZRA use.

- **Tailoring addiction care:** Within addiction care the need for a shared policy statement is voiced. In addition, specific residential care programs should be tailored to BZRA tapering (also as a unique dependence to treat).

READ MORE

Ceuterick, M., Van Ngoc, P., Bracke, P., & Scholtes, B. (2023). From prescribing dilemma to knowledge in practice: The ontological politics of benzodiazepines and Z-drugs. *Social Science & Medicine*, *339*, 116358. https://doi.org/10.1016/j.socscimed.2023.116358

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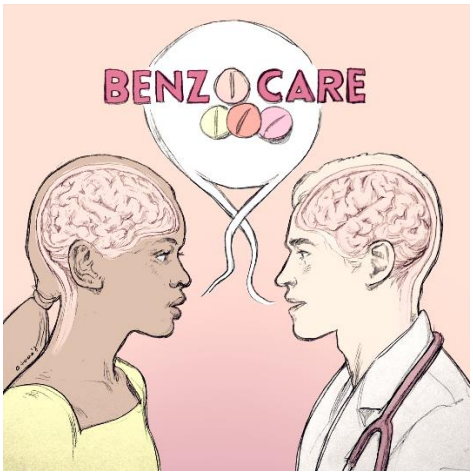

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