

# *Chains of Addiction & Links of Support*

Responding to Benzodiazepine Use in Ballymun;  
A GP-Community Partnership Addiction Project

by

Jane Carrigan

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# GLOSSARY OF ABBREVIATIONS AND TERMS

BENZOS	Benzodiazepines
BLDTF	Ballymun Local Drugs Task Force
BYAP	Ballymun Youth Action Project
GMS	General Medical Services Scheme
HSE	Health Service Executive
LDTF	Local Drugs Task Force
NACD	National Advisory Committee on Drugs
PCT	Primary Care Team
SLEEPERS	A slang term for benzodiazepines
RSCI	Royal College of Surgeons in Ireland

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Jane Carrigan  
Researcher

# CHAPTER 1

## EXECUTIVE SUMMARY

### 1. Executive Summary

This report outlines the operation and development of the GP-Community Partnership Addiction Project over its first three years of implementation (September 2006-September 2009). The GP-Community Partnership Addiction Project is managed by the Ballymun Family Practice and funded by the Ballymun Local Drugs Task Force (BLDTF).

The report presents the following:

- The aims and objectives of the Project and details of how it operates (Chapter Two);
- The background of the Project and its development (Chapter Two);
- The research design and methodologies employed (Chapter Three);
- The effectiveness of a letter as a brief intervention technique for benzodiazepine use (Chapter Four);
- The experience of having an addiction counsellor on site within the GP practice environment from counsellors and GPs' perspectives (Chapter Five).
- Conclusions and Recommendations (Chapter Six)

The four general practices (who make up the Ballymun Family Practice) in Ballymun that took part in this research were successful in becoming part of local Primary Care Teams, announced in 2002 under the primary care strategy *Primary Care – A New Direction* (2001).

The main aim of the GP - Community Addiction Project was to develop services for patients with benzodiazepine problems that present in primary care. The model proposed was that GPs in the practice would be supported by an addiction counsellor who would be integrated into each practice (working approximately 10 hours per week in total). Prior to project commencement, GPs received training in motivational interviewing from the local drug/alcohol training provider, URRÚS, in order to complement existing training/skills in this area or further develop these for use within the practices. Within the time period from January 2007 to December 2010, 124 patients of the Ballymun Family Practice attended the Addiction Counselling Service with the gender profile remaining largely the same (male: 58, female: 66). A range of addictions (i.e problematic use of other drugs apart from benzodiazepine use) were referred and presented to the GP – Community Partnership Addiction Project during this time. The majority of referrals to the addiction project came through the GP practices. However local agencies could also refer their clients to the counsellor provided that he/she was registered with one of the practices. A review of referral forms from mid 2008 to the end of 2010 suggests that of those who attended the GP Addiction Project within this time period, a small minority reported benzodiazepine as the sole primary drug of choice (n=14). More significant, was the reported use of benzodiazepines as an additional drug with a large number of clients using benzodiazepines, not as their primary drug of choice (or its use as reason for referral), but alongside the problematic use of other drugs for example; alcohol, cocaine, methadone etc.

The project itself was developed as a response to a study published by the Ballymun Youth Action Project (BYAP) in 2004 entitled *Benzodiazepines – Whose Little Helper? - The role of benzodiazepines in the development of substance misuse problems in Ballymun*. The report highlighted an acceptance and normalisation of benzodiazepine use in

Ballymun but also recommended the development of non-pharmaceutical alternatives to benzodiazepine prescribing. Recent research from the Health Research Board highlighted a national increase of just over 63% (from 1,054 in 2003 to 1,719 in 2008) in the number of cases reporting benzodiazepine as a problem substance.

A mixed method approach, in which both quantitative and qualitative methods were used, was adopted for this research. Prescriptions of benzodiazepines from the four practices were analysed quantitatively while qualitative research using focus groups with GPs and in-depth interviews with addiction counsellors was conducted.

The drugs, which were counted as part of the study included benzodiazepines such as Alprazolam (Xanax), Bromazepam (Lexotan) Chlordiazepoxide (Librium), Diazepam (Anxicalm, Valium) Flurazepam (Dalmane) Flunitrazepam (Rohypnol), Lormetazepam (Noctamid), Triazolam (Halcion), Temazepam (Nortem, Tenox). Also included as part of the list were drugs that are colloquially known as 'Z drugs'. These drugs while chemically different from benzodiazepines, have the same effects on the body and act by the same mechanisms. The Z drugs that were counted were Zaleplon (Sonata), Zolpidem (Stilnoct), Zopiclone (Zimovane, Zopitan, Zileze).<sup>1</sup>

The quantitative aspect to this project aimed to determine whether the offer of the services of an addiction counsellor had additional benefits in the reduction of benzodiazepine use when added to a standardised letter sent to long-term users of benzodiazepines (n=134).<sup>2</sup> Essentially two interventions were evaluated: a letter inviting patients to reduce their intake (sent to Group 1, n=54) and a letter inviting patients to reduce and to avail of the services of an addiction counsellor (sent to Group 2 including methadone protocol patients, n=80). In 2000 the Ballymun Local Drugs Task Force, in their Revised Action Plan noted that benzodiazepine use was impeding progress for those on methadone maintenance programmes. As such it was decided to send methadone protocol patients the same letter as was sent to group 2 patients, and also to be in a position to extract their results as a distinct grouping (24/80 above).

The brief intervention of a standard letter and the intervention of a letter with the offer of the services of an addiction counsellor did result in decreases in some prescription rates. The decrease was particularly noticeable in the cohort who was also availing of methadone maintenance treatment. It is also relevant to note that 6 out of 24 went on to attend the addiction counsellor. GPs also identified a range of improvements that could be implemented in order to improve the outcome of the letter as an intervention.

A number of findings also emerged from the qualitative interviews with addiction counsellors and GPs, with both groups recognising that benzodiazepine addiction is a particularly challenging addiction to treat. Counsellors and GPs noted the effectiveness of the referral system in operation in the project. A system of encouraging attendance had been adopted by both the counsellors and the practices themselves in terms of issuing reminders to clients and as a result very high attendance rates at the service were observed. The experience of integrating the counselling service within the practices was reported as very positive and complementary to each other's services. There was also recognition of the importance of developing a range of strategies that can be employed as alternatives to prescribing benzodiazepines or which provide complementary supports

<sup>1</sup> By benzodiazepine use we are referring to all of these drugs. The HSE Reports on Benzodiazepine Use (referred to on p14) does not include these 'Z drugs'.

<sup>2</sup> In a previous study Cormack et al (1994) had defined long term benzodiazepine use as patients who were "receiving at least one prescription for benzodiazepine every two months and had taken benzodiazepine continuously for at least six months". The same definition of a long-term user of benzodiazepine was applied to this study.



for those on benzodiazepines.

The project provided a tangible way of developing and fostering links in the community and promoted a multidisciplinary approach to the issue of drug use. The recommendations in the report included the following:

- Addiction counselling services should be considered as an effective strategy to complement existing general practitioner practices
- The use of a letter is an effective intervention in reducing benzodiazepine use
- The delivery of a counselling service as reported in this research should be considered as a model for future pilot projects
- Future research in this area should take into account the client perspective and feedback on the project.

This project evolved from one that primarily envisaged meeting the needs of clients with a benzodiazepine addiction to one that now also has the ability to address other addiction issues that may present within a general practitioner setting. The findings and outcomes of this initiative have the potential to inform and influence the work of primary health care teams in Ballymun and beyond. The Ballymun Local Drugs Task Force will continue to monitor the project and its capacity to respond to clients presenting to GPs with addiction problems.

## CHAPTER 2

### DESCRIPTION & CONTEXT OF PROJECT

#### 2.1 Aims and Objectives

The primary aim of the pilot project was to develop services for patients with benzodiazepine problems that present in primary care. The model proposed was that GPs in the practice would be supported by an addiction counsellor who would be integrated into each practice (approximately 10 hours in total per week). A key aspect of this proposal was the availability of the services of an addiction counsellor on site. This free service for patients would allow for ease of access and seamless referral.

The objectives of the pilot programme were as follows:

- To help patients with a range of benzodiazepine problems
- To demonstrate the effectiveness of brief interventions in this area
- To prove that integrated team work (i.e. working with an addiction counsellor within primary care) is an effective form of intervention
- To show that minimum training for GPs can develop skills that are helpful to patients and their families

The project provided a valuable opportunity to increase the role of the general practitioners in the management and treatment of benzodiazepine use in Ballymun.

#### 2.2 Main Project Elements

Some of the key features of the Project included;

- i. Counsellor on site-located at a primary care level, which would deal with substance misuse issues around benzodiazepines
- ii. Easy referral to a counsellor which is discreet and operates within a team approach
- iii. A set number of hours of counselling available per week to each practice
- iv. Training on Motivational Interviewing provided for GPs
- v. Research element incorporated into the project.

#### 2.3 Location of Project

This new initiative was located in the new Ballymun Health Centre and was integrated within the overall provision of a range of other services in the Centre. The Project is managed by the Ballymun Family Practice and funded by the Local Drugs Task Force. Ballymun Family Practice consists of four separate surgeries/practices.

These four practices in Ballymun were among the first to take part in the pilot primary care teams (PCT) set up nationally in 2005. The four practices cater to a patient population of approximately 10,000 - 12,000. The Ballymun Primary Care Pilot was established as one of the 10 national projects to develop a model of primary care service delivery as outlined in the Primary Care Strategy: *Primary Care - A New Direction* (2001). The PCT was set up to meet the needs of the emerging profile of Ballymun, a population with extremely high health and social needs. It is now well established and all four surgeries work closely as part of this team. The PCT is situated in the new Health Care Centre which was opened in 2006 and is located within the Civic Centre in Ballymun. This locates local primary care and some relevant network services in the one location. This integrated approach to primary care included the establishment of a multi disciplinary team which included GPs, psychiatric and public health nurses, physiotherapists, occupational therapists, speech and language therapists, social workers, dieticians and family support services.

The four general practices that make up the Ballymun Family Practice took part in this project. The GPs at the Ballymun Family Practice, previous to the establishment of the project, had worked in a complementary fashion with existing drug services in the area. GPs had also collaborated with, shared information and provided input on other activities/projects of the Ballymun Local Drugs Task Force (BLDTF). In this regard, the implementation of the GP-Community Partnership Addiction Project was a very appropriate development which further enhanced this working relationship.

## 2.4 Development of Project

The addiction counselling service began in the Ballymun Family Practice in September 2006. The service started with counselling being provided for 9 hours per week. The amount of hours has varied as the service continued and has expanded. In 2010 the average hours of counselling per week was between 10-12 hours. On Tuesdays, for example, the counsellor generally meets clients from 9.30am-2.30pm while on Wednesday clients arrive for their sessions between 7.30am and 12.30pm – this earlier start is to facilitate clients who attend the methadone scripting/GP clinic.

The research undertaken and incorporated into the project had four main aims. It sought to:

- i. Document the addition of an addiction counselling service to a busy GP practice
- ii. Obtain the counsellors and GPs' views on benzodiazepine use in the community
- iii. Detail and document the complexities involves in benzodiazepine prescribing and addiction
- iv. Determine quantitatively whether the offer of addiction counselling has additional benefits in the reduction of benzodiazepine use when added to a standardised letter sent to long-term users of benzodiazepines.

## 2.5 Background and Context

This GP-Community Partnership Addiction Project was developed as a response to a study published by the Ballymun Youth Action Project (BYAP) in 2004 entitled *Benzodiazepines – Whose Little Helper? - The role of benzodiazepines in the development of substance misuse problems in Ballymun*. The report (2004: 40-43) highlighted that 'within Ballymun there is a generalized acceptance of benzodiazepines' and that this 'normalization' of benzodiazepine use can have immense consequences not only for the individuals concerned but for their families and the wider community. The research also suggested that 'focusing attention primarily on doctor's clinical decisions is only a partial response to the situation' and that the 'restriction of prescribing practice alone will not address the psychosocial issues, and is likely to create additional patient trauma'. One of the main findings that provided the impetus for seeking funding for the development of the project can be captured from the following quote contained in the report:

*The "medicalisation" of this reality does not seem appropriate. Other interventions, whether individual or structural, designed to address the levels of experienced stress need to be fostered and used.*

(2004: 40)

Relevant recommendations from the study (2004: 45) included the following:

- That the patterns of benzodiazepine prescribing in Ballymun and elsewhere in Ireland be examined. This would entail a closer examination of prescribing practice, including duration, review procedures, dosage and drug.
- That there is investment in the development of services to complement medical practitioners. In particular, it was noted that there was a need to develop non-pharmaceutical alternatives to benzodiazepine therapy.
- It is hoped that the findings of this research will contribute to a clearer

understanding of the role that benzodiazepines play in Ballymun. It is also hoped that, in the spirit of the community based research approach, it will enable all stakeholders to gain insight and identify strategies which will contribute to effective change.

Following completion of BYAP research on the role of benzodiazepines in Ballymun, two follow-up meetings of local practitioners were convened in early 2005. The main aim of the meetings was to explore alternative responses to some of the issues identified in the research *Whose Little Helper?* During one meeting, it was noted that the recent work undertaken by Rolande Anderson of the Irish College of General Practitioners (ICGP) in the area of alcohol could provide a useful template for the development of services to complement GP practices in the area of benzodiazepines. At that time, the Local Drugs Task Force had access to the Emerging Needs Fund under the National Drug Strategy (2001-2008). This initiative fell under actions 41 and 39 of the National Drug Strategy and in addition related to recommendation 8 of the Report of the Benzodiazepine Committee as detailed below;

**Action No. 41-** *To oversee the implementation of the recommendations of the Benzodiazepine Working Group, which is due to complete its work by the end of June 2001 as part of the overall strategy of quality improvement of current services. (National Drug Strategy 2001-2008)*

**Action No. 39-** *To ensure that adequate training for health care and other professionals engaged in the management of drug dependency is available, including, if necessary, arrangements with third level institutions and professional bodies. (National Drug Strategy 2001-2008)*

**Recommendation No.8-** *“where possible alternative therapies to the prescribing of benzodiazepines should be considered by clinicians. (Report of the Benzodiazepine Committee, 2002: 42).*

More recently, as part of the review of the Methadone Treatment Protocol in 2010, the issue of improving the standards of prescribing benzodiazepines was recommended as an immediate action to help reduce poor benzodiazepine prescribing practice across all sectors of services in the HSE. In this regard, the report *The Introduction of the Opioid Treatment Protocol* (2010) refers to the need for the implementation of recommendation 10 from the report of the Benzodiazepine Committee (2002) which states:

*Clinic doctors should communicate with clients' general practitioners involved in the treatment of drug misusers regarding the prescribing of benzodiazepines. In most cases the clinic should, with the agreement of the general practitioner, take responsibility for the prescribing of benzodiazepines and so prevent double or multi-prescribing to known drug users. (2010: 34)*

## 2.6 Benzodiazepine Use and Ballymun

There are two groups of benzodiazepines- the 'anxiolytics' which are prescribed for anxiety and mild depression, and the 'hypnotics' which are prescribed for insomnia (severe sleep problems). Some of the common drugs within these categories include diazepam, temazepam and flurazepam (O'Mahony Carey, 2008). Benzodiazepines are in the depressant drug category, however when mixed with other 'downers', for example alcohol or opiates, they can have a stimulant effect.

In 2010, the Health Research Board published an overview of problem benzodiazepine use in Ireland from the period 1998-2007 (with data on treatment from 2003-2008 and deaths from 1998-2007). In the years from 2003-2008 the annual number of treated cases reporting benzodiazepine as a problem substance increased by just over 63% from 1,054 in 2003 to 1,719 in 2008 (2010: 1-3). This research highlighted that there are higher numbers reporting benzodiazepines as an additional problem drug, but there was a bigger increase among those who reported benzodiazepines as their main problem drug. In terms of deaths attributed to benzodiazepine use in Ireland, they accounted for 31% of all deaths by poisoning recorded for the ten-year period (as recorded by the National Drug-Related Deaths Index). The annual number of deaths in 2007 in which benzodiazepines were implicated was 88 cases, with previous years also remaining consistently high (Bellerose et al: 2010).

Quigley (2001: 331) acknowledges the legacy that benzodiazepine has had and notes that benzodiazepines, originally developed as a safer alternative to barbiturates have 'become a mainstay of medical practice over the last three decades'. Therapeutic uses of benzodiazepines include treatment for sleep disorders, anxiety, depression and assisting people in coping with difficult situations such as bereavement. While benzodiazepines are among the most widely prescribed drugs in the western world, a number of concerns have been raised about their use, such as the risk of developing dependence, risk of accident, cognitive impairment and abuse of benzodiazepines particularly among drug users (Quigley: 2001). In 2000 Michéal Martin, then Minister of Health, established the Benzodiazepine Committee, which was designed to address inappropriate use of benzodiazepines. The Report of the Benzodiazepine Committee (2002) noted that while there were many benefits to benzodiazepine use, many of the negatives associated with its use were the result of inappropriate long-term use. It found that there were still many long-term prescribed benzodiazepine users in Ireland and suggested that 'it would appear that in many cases the prescribing of these drugs is excessive and perhaps has become a matter of routine' (p6). The Report also presented a study, undertaken by the Eastern Regional Health Authority that examined General Medical Services Scheme (GMS) data on benzodiazepine prescriptions during 1999-2000 in the EHRA area. The study revealed that benzodiazepines were being prescribed to approximately one in ten persons overall, up to one in five older people, and their use was higher among females than males. A study by William Teljeur, Bennett and Kelly (2003) noted that with an increase in deprivation, prescription rates for some drugs increased and others decreased; they concluded that benzodiazepine use increased with deprivation.<sup>3</sup>

## 2.7 Prevalence of Use in Ballymun

Ballymun Youth Action Project (2004:30-33) identified some key findings from an investigation of benzodiazepine dispensing patterns in Ballymun using community pharmacy-based dispensing records.

- The total number of instances of tablet dispensing over 4 one-week periods totalled 751 with no significant change observed across time.
- The majority were issued free of charge under the GMS scheme
- 40 doctors had prescribed tablets, however 77% of all prescription items studied across these time periods were written by 4 doctors.
- Two thirds of prescriptions were dispensed to females and one third to males
- Diazepam as the most common drug dispensed followed by flurazepam.
- Time since first record of benzodiazepine dispensing for almost two fifths of the population (39%) was 5 years or more.

*\*\*The findings refer to a retrospective study of the prescriptions for benzodiazepines that*

<sup>3</sup> Chapter Five reports on a focus group with GPs at the commencement of the project in which GPs described the impact they felt that years of benzodiazepine prescribing had on Ballymun.

were dispensed in a small number of pharmacies over four separate one week periods from December 2000 and July 2002 (2004: 30)

More recently in 2006/2007, Ballymun Local Drugs Task Force undertook a local household prevalence study among the Ballymun population aged between 15-64 years. This was a booster sample that could be comparatively analysed against the national population. The findings highlight that in 2006/2007 Ballymun figures for sedatives and tranquillisers were comparatively higher than that within the national population.

**Table 1 Prevalence of Sedatives, Tranquillisers and Anti-depressants use in Ballymun and Nationally**

<b>All Adults 15-64 years</b>			
	<b>Ballymun</b>	<b>NRDTF*</b>	<b>NACD**</b>
<b>Sedatives/Tranquillisers</b>			
Lifetime (Ever)	13.6	11.3	10.5
Recent (Last Year)	8.6	4.1	4.7
Current (Last Month)	7.6	2.3	3
<b>Anti-Depressants</b>			
Lifetime (Ever)	10.6	9.6	9.2
Recent (Last Year)	4.0	3.8	4.3
Current (Last Month)	3.3	3	3.1

\*North Regional Drugs Task Force Area (includes 5 Local Drugs Task Force areas)

\*\* National Advisory Committee on Drugs (national figure)

Source: NACD (2008) Drug Use in Ireland and Northern Ireland 2006/2007; Bulletin 2 and BLDTF, Local Household Prevalence Data 2006/2007

## 2.8 Benzodiazepine prescribing within the GP practices

In July 2007, all four GP practices that make up the Ballymun Family Practice had computerised their records. It should be noted that there are two administrative centres within the Ballymun Family Practice and for ease of reporting through this research Practice 1 and 2 are used to refer to the practices downstairs and upstairs respectively. This meant that a GP Benzodiazepine Report for each GP working in the practice could be generated. These HSE reports allow prescription rates from individual GPs to be seen in the context of national prescription rates. The BYAP research findings suggested that 'the level of benzodiazepine prescribing in Ballymun today may be notably higher than the national level' (2004: 8). However it should be noted that one of the focus groups which was conducted as part of the BYAP 2004 research did indicate that prescribing in the GP practices in the Health Centre is "tight" (p 25). This observation suggests a belief among participants in that research that the practices in the Centre were not providing unnecessary access to benzodiazepines. The HSE reports, which display individual GP prescription rates for benzodiazepines seems to support this belief for example in October 2009 Practice 1, GP 1 and Practice 2, GP 1 had prescription rates of 43% and 9% respectively below the national rate.

The following chapter details the study design and methodologies used in this research.

## CHAPTER 3

### STUDY DESIGN & METHODOLOGY

#### 3.1 Research Design

A journal article that featured in the British Journal of General Practice heavily influenced the initial planning of the research phase of this project. The article, written by Cormack, Sweeney, Hughes-Jones and Foot (1994:5) detailed the evaluation of 'an easy, cost-effective strategy for cutting benzodiazepine use in general practice'. The aim of that study was to assess the effectiveness of a letter from a GP suggesting a reduction in the use of benzodiazepines, and whether the impact of the letter could be increased by the addition of information on how to tackle drug reduction. While their study was used a model for the quantitative element of the research, there were significant differences; most notably the fact that instead of providing more information on reducing benzodiazepine, this study offered the services of an addiction counsellor, and secondly, while the 1994 study was purely quantitative, this research added a qualitative element through focus groups and in-depth interviews with GPs and addiction counsellors.<sup>4</sup>

A mixed method approach, in which both quantitative and qualitative methods were used, was adopted for this research. The methods used in this study were:

- Qualitative research using focus groups and in-depth interviews
- Quantitative analysis of prescriptions of benzodiazepine

The use of mixed methods has become increasingly popular in recent years (Bryman, 2006). Greene, Caracelli and Graham (1989) identified five purposes for mixed method evaluations: triangulation, complementarity, development, initiation and expansion. The rationale for the research design in this project was complementarity in that it was hoped that the results from one method could elaborate and enhance the results from the other. Although statistics of prescription rates may explain part of the picture, it cannot tell the whole story. The study *Benzodiazepines, Whose Little Helper?*, which was referred to in Chapter Two (BYAP, 2004) acknowledged, for example, that swapping and sharing of benzodiazepines seemed to be a frequent occurrence in the area and they also argued that the prescribing practices of doctors did play a contributory role in the normalising of benzodiazepine use. By using a qualitative approach using focus groups with GPs and in-depth interviews with the addiction counsellors in combination with quantitative research, it was hoped that a more holistic picture would emerge.

#### 3.2 Quantitative Research

The findings of the BYAP (2004) research suggested that the level of benzodiazepine prescribing in Ballymun was notably higher than the national level. They also indicated that a considerable proportion of patients who are initiated on benzodiazepines continue to take them for many years. Consequently they recommended that the patterns of benzodiazepine prescribing in Ballymun and elsewhere in Ireland be examined. With this in mind, and in order to provide some statistical data on the impact of the intervention of a letter, a quantitative aspect of the research design was included in this research. Quantitative data was generated by monitoring benzodiazepine prescriptions of long-term benzodiazepine users one year before they were sent the letter and six months afterwards. A full analysis of the data generated can be seen in Chapter Four.

<sup>4</sup>The Cormack et al study (1994) also included a control group of patients in their research. It should also be noted that their study was building on an earlier British based study which was smaller in scale but which had found that a letter from a GP advising patients to cut down of their drugs was as effective as a group run by a psychologist.

### 3.2.1 Aim of Quantitative Dimension of Project

The quantitative aspect to this project aimed to determine whether the offer of the services of an addiction counsellor had additional benefit in the reduction of benzodiazepine use when added to a standardised letter sent to long-term users of benzodiazepines. Essentially two interventions were evaluated: a letter inviting patients to reduce their intake (sent to Group 1) and a letter inviting patients to reduce and to avail of the services of an addiction counsellor (sent to Group 2). In 2000 the Ballymun Local Drugs Task Force, in their Revised Action Plan noted that benzodiazepine use was impeding progress for those on methadone maintenance programmes. As such it was decided to send methadone protocol patients the same letter as was sent to group 2 patients.

There are four practices currently operating in the Ballymun Health Centre under the umbrella term Ballymun Family Practice. Initially it was estimated that there were approximately 400 patients that would meet the criteria to be included in the study – details of the criteria applied can be seen in the following section. Long term users of benzodiazepines, who met the criteria of the study, were randomised into Group 1 and Group 2 with methadone protocol patients treated as a separate group who were not randomised but placed directly into Group 2. Effectively this cohort can be seen as a third group (Group 3) with the rationale for this decision influenced by both ethical and pragmatic reasons. Group 1 were sent a letter inviting them to reduce their intake of benzodiazepine while Group 2 were sent a letter asking them to reduce their intake and inviting them to avail of the services of an addiction counsellor. For the purposes of this study, results for Group 3 will be presented separately. It should be noted that all patients were not attributed to groups together but by practice – this meant that each practice had patients in each group.

There are two administrative centres in the Ballymun Family Practice and for ease of reporting Practice 1 and 2 are used to refer to the practices downstairs and upstairs in the Health Centre respectively. For ethical reasons, the services of the addiction counsellor were available to all patients regardless as to whether they had received a letter or not. The letter used by Cormack et al (1994) served as a model and the final versions, (see appendix B and C) which were literacy proofed, were approved by the Royal College of Surgeons in Ireland (RCSI) Research Ethics committee.

### 3.2.2 Sample and Definition of Long-Term Benzodiazepine Use

In a previous study Cormack et al (1994) had defined long term benzodiazepine use as patients who were:

*“receiving at least one prescription for benzodiazepine every two months and had taken benzodiazepine continuously for at least six months”.*

The same definition of a long-term user of benzodiazepine was applied to this study. The inclusion criteria for the study were patients over 18 years of age who were long terms users of benzodiazepines. Patients whose benzodiazepine use was sourced through psychiatric services were excluded from the research. It was agreed that alcohol dependency was not a reason for exclusion due to the fact that benzodiazepine use may mask alcohol dependency. GPs were asked to identify from their records long-term users of benzodiazepines who fitted the criteria and the relevant letters were dispatched.

It is important to note that the drugs which were counted as part of the study included benzodiazepines such as Alprazolam (Xanax), Bromazepam (Lexotan) Chlordiazepoxide (Librium), Diazepam (Anxicalm, Valium) Flurazepam (Dalmane) Flunitrazepam (Rohypnol), Lormetazepam (Noctamid), Triazolam (Halcion), Temazepam (Nortem, Tenox). Also



included as part of the list were drugs that are colloquially known as ‘Z drugs’. These drugs while chemically different from benzodiazepines have the same effects on the body and act by the same mechanisms. The Z drugs that were counted were Zaleplon (Sonata), Zolpidem (Stilnoct), Zopiclone (Zimovane, Zopitan, Zileze).<sup>5</sup>

### 3.2.3 Characteristics of Sample

Table 2 highlights the age and gender profile of the sample per GP practice. This ratio of almost three females for every male was in line with research from BYAP (2004), which noted that whilst benzodiazepine use was found to occur among all age groups, more women than men were found to use them.

**Table 2 Characteristics of the Sample**

<b>Characteristics of the sample from Practice and Group Perspective</b>				
	<b>Practice 1</b>		<b>Practice 2</b>	
	<b>Group 1</b>	<b>Group 2</b>	<b>Group 1</b>	<b>Group 2</b>
Median Age:	61	57.5	61	44.50
Mean Age:	60	54.24	55.33	47.85
No. who are also on methadone protocol		2		22
No. of females:	26	22	13	39
No. of males:	7	4	8	15

As can be seen from Table 2, Group 2 in Practice 2 has a much younger profile. This may be attributed to the fact that Practice 2 has a much higher proportion of long term benzodiazepine users, who met the criteria of the study and who are also on the methadone maintenance programme (n=22) as compared to practice 1 (n=2). This cohort seemed to merit closer analysis.

#### Cohort on Methadone Maintenance Programme

One key difference between the two practices is the number of long-term users of benzodiazepine who are also on methadone – this difference became apparent when comparing the age profiles of each practice. The average age of Group 2 in Practice 2 for example is 47.85 compared to 54.81 in Practice 1. However if we remove those on methadone maintenance from Group 2 in Practice 2, the average age is 56.56 which is much closer to Practice 1.

In order to explore the data further, this cohort was extracted from both Practice 1 and 2 and broken down in terms of age and gender. Table 3 illustrates these results:

**Table 3: Profile of Patients on Methadone Maintenance**

<b>Profile of Patients on Methadone Maintenance</b>	
Median Age	36.5
Mean Age	36.13
Male	8
Female	16
Overall number	24
Ratio of male: female 1:2	

Overall, 134 patients were sent a letter by post; 54 were placed in Group 1 and sent a letter inviting them to consider reducing benzodiazepines, whilst 80 (24 of whom were

<sup>5</sup> By benzodiazepine use we are referring to all of these drugs. The HSE Reports on Benzodiazepine Use (referred to on p14) does not include these ‘Z drugs’.

availing of the methadone maintenance programme) were placed in Group 2 and sent a letter inviting them to consider reducing benzodiazepines and alerting them to the services of an addiction counsellor.

### 3.3 Qualitative Research

#### Focus Groups with GPs

The study by BYAP on benzodiazepine use in Ballymun (2004) indicated that the level of benzodiazepine prescribing in Ballymun is comparably higher than the national average. All groups interviewed in that research study identified prescribing by doctors as one of the sources of their benzodiazepine use. The prescribing of benzodiazepines has been described as “a complex cultural and social process with political, economic, moral as well as medico-social implications” (Clare, 1991, p187). With this in mind, a focus group with GPs took place before the project began. One of the key advantages of a focus group is that it can provide extremely rich data as it allows participants to respond to each other’s views and discuss the differences or similarities with their experiences. Bloor, Frankland, Thomas and Robson (2001) acknowledge the usefulness of focus groups in terms of both complementing other methods in a multi-method study and providing contextual information as well as an interpretative aid to quantitative findings. Five GPs took part in the focus group and the focus group provided the opportunity to hear GPs’ views on benzo use, their experience of prescribing benzos and their expectations of how a counselling service would work. The interview schedule used in this focus group can be seen in Appendix A.

In autumn 2009 near the completion of the project, a follow up focus group with GPs took place. This focus group, taking place three years later than the initial focus group, allowed GPs to give their reflections on how the addition of an addiction counsellor had worked in practice, whether their initial concerns and expectations about the project were realised and how they felt about the research undertaken and suggestions for improvements. This focus group provided valuable insights and Chapter Five describes the findings in more detail. The interview schedule used for this follow up focus group can be seen in Appendix E.

#### In-depth Interviews with Addiction Counsellors

Semi-structured interviews with two addiction counsellors took place in June 2009.<sup>6</sup> One counsellor was interviewed over the phone and one on-site at the GP practice. The interview schedule used in the interviews can be seen in Appendix D. Similar to focus groups, semi-structured or in-depth interviews offer a number of advantages including the depth of information and insights provided and validity (Denscombe, 2003).

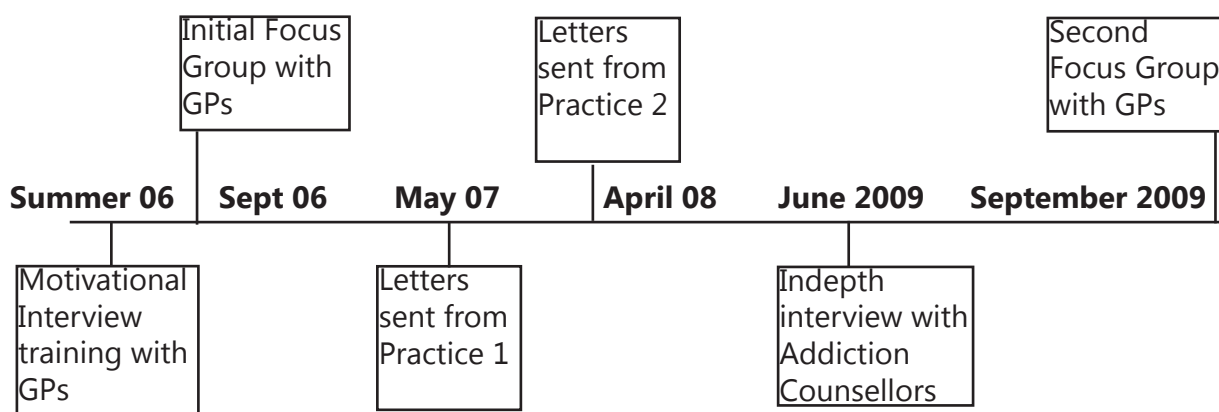
A full discussion of findings from the interviews and the focus group can be found in Chapter Five.

### 3.4 Data Collection

As mentioned above, a focus group was held with GPs at the onset of the research. GPs were also asked to identify long-term users of benzodiazepine and from this list, patients were allocated groups and sent the relevant letter inviting them to reduce their use of benzodiazepine. This did not commence until ethical approval was given by the RCSI. Practice 1 compiled their list first and letters were sent in May 2007, while letters from Practice 2 were sent in April 2008. Data collection was ongoing throughout 2007 and 2008. During the project in-depth interviews with the addiction counsellor were conducted and a focus group with GPs took place at the end of the research.

<sup>6</sup> Since the commencement of the GP Community Addiction Project 3 counsellors, have spent varying periods of time employed by the project. The current counsellor has been in position for almost 3 years.

The following chart illustrates the timeline of the research



### 3.5 Data Analysis

The qualitative interviews were transcribed and read a number of times by two researchers who independently identified a number of themes. Once the themes were identified and agreed (by both), the interviews were analysed again and coded.

The quantitative data was analysed using Excel and is descriptive and exploratory only with further data needed to provide more sophisticated analysis.

### 3.6 Limitations

It is hoped that this small-scale research project will provide a holistic picture of the complexities of benzodiazepine prescribing and addiction. However, it is important to acknowledge the limitations of the research.

- The quantitative data is based on prescriptions of benzodiazepines only. Measuring prescription rates is in itself quite a crude measurement in the sense that it does not take into account that not all medication may be consumed by the patient.
- Although the views of GPs and addiction counsellors were sought in this research, no clients were consulted. It is suggested that future research should include clients' perspectives and views.

# CHAPTER 4

## LETTER AS A BRIEF INTERVENTION TOOL

### 4.1 Introduction

As detailed in the previous chapter, this element of the project aimed to determine whether the offer of the services of an addiction counsellor had additional benefits in the reduction of benzodiazepine use when added to a standardised letter sent to long-term users of benzodiazepines. Essentially two interventions were evaluated: a letter inviting patients to reduce their intake (sent to Group 1) and a letter inviting patients to reduce and to avail of the services of an addiction counsellor (sent to Group 2). Long term users of benzodiazepines who were also methadone protocol patients were sent the same letter as Group 2 patients (Group 3).

At the commencement of the project, GPs anticipated that the number of long-term benzodiazepine users that would qualify for inclusion in the study would be in the region of 400. This proved to be an over-estimation. Originally, from 158 patients listed, a number were not included in the sample for a variety of reasons including misidentification, imprisonment, death and serious illness. The final sample consisted of 134 people, 100 females and 34 males.

### 4.2 Establishing Baseline Benzodiazepine Use

Both Gorgels et al (2005) and Cormack et al (1994) convert prescribed benzodiazepines into diazepam equivalents with Cormack et al. treating 5mg Diazepam as one tablet – see Appendix F for more details of the conversions used. The method used by Cormack et al. in establishing baseline data of benzodiazepine was influential in this study; and as with Cormack et al's study baseline data was generated by monitoring prescriptions issued to patients a year prior to the letter being sent then dividing the total number of tablet equivalents by two. By considering one year, any seasonal variations could be avoided. Prescriptions issued to all groups were monitored.

However Cormack et al's study used much more sophisticated statistical analysis and differed from the present study in a number of key ways:

- In order to evaluate the effect of the interventions on benzodiazepine consumption the number of tablet equivalents taken in the monitoring period was divided by the number taken during the baseline period for each patient in the study and then t-tests were performed to determine whether one intervention was more effective than the other. The present study however compares the six month period post letter being sent with the baseline data only.
- Cormack et al's study used advice from a pharmacist to calculate consumption of benzodiazepines based on prescriptions issued before the beginning of the baseline period and before the end of the monitoring period. The study also created a second baseline by measuring benzodiazepine use six months before the letter being sent in order to analyse patterns of benzodiazepine use prior to the intervention – this was not done in this study.

As can be seen from above, Cormack et al's study was able to provide much more sophisticated analysis whereas the analysis in the present study is exploratory. However there is potential for this data to be investigated further.

### 4.3 Results and Discussion

In Group 1 patients were sent a letter advising them to consider their current benzodiazepine use. In monitoring this group's benzodiazepine use six months post the letter being sent) 16 people did decrease their benzodiazepine use and the average decrease was 133.59 tablets (with each tablet the equivalent of 5mg of diazepam). Table 4 details the age and gender profile of patients who did decrease their benzodiazepine use.

**Table 4 Age and Gender Profile of Group 1 patients who decreased their benzodiazepine use**

Group 1	Decreased
Numbers	16
Average Age	60.625
Male	3
Female	13
Average Decrease	-133.59
As a % of Group	29%

It is worth noting that 54 patients were in Group 1, which means that just over 29% of patients decreased their benzodiazepine use. For some patients the letter seemed to have no effect although it should be noted that medical notes reveal that a number of patients did bring up the subject of the letter if only to explain that reducing was not an option for them at present.<sup>7</sup>

If we examine Group 2 (the group who received a letter asking them to consider their benzodiazepine use and offering the services of a counsellor) we can see that there seems to have been more success with this intervention.

Table 5 shows that out of 80 patients who were placed in this group, 31 (over 38%) reduced their prescription for benzodiazepines.

**Table 5 Age and Gender Profile of Group 2 Patients who decreased their benzodiazepine use**

Group 2	Decreased
Numbers	31
Average Age	52.03
Male	7
Female	24
Average Decrease	-240.17
As a % of Group	38%

In order to get a more in-depth picture, the data from those who were availing of methadone maintenance were extracted. Table 6 indicates the results from this cohort (n= 24) who placed in Group 2 and who were also on the methadone maintenance programme.

<sup>7</sup> This measure should be considered as a crude indicator only, GPs were not asked to record whether patients mentioned they had they received this letter. Medical notes however do reveal 15 patients out of the 134 did this but this is likely to be an underrepresented figure.

Table 6 Age and Gender Profile of Group 3 Patients who decreased their benzodiazepine use

Methadone Group	Decreased
Numbers	9
Average Age	36.11
Male	5
Female	4
Average Decrease	-511.92
As a % of Group	37.5%

As can be seen from Table 6, nine out of twenty-four from this cohort (37.5%) reduced their benzodiazepine use. Indeed in further analysis of appointments with the addiction counsellor (January 2007-December 2010), it was discovered that six out of the twenty-four (25%) in this Group 3 cohort had availed of the counselling service.<sup>8</sup>

Table 7 Overall results for both practices.

		Number in Group	Mean Age of Group	Numbers who Decreased	% Decrease
<b>Practice 1</b>	Group 1	33	60	10	30.3
	Group 2 (incl. methadone maintenance patients)	24	54.24	11	45.83
	Group 3 (methadone maintenance only)	2	46.5	2	100
<b>Practice 2</b>	Group 1	21	61	6	28.57
	Group 2 (incl. methadone maintenance patients)	32	44.5	11	34.37
	Group 3 (methadone maintenance only)	22	34.84	7	31.81

#### 4.4 Suggested Improvements to the Letter as a Brief Intervention Tool

The focus group with GPs, which took place towards the end of the project, identified a number of key ways that the project could be improved upon with particular regard to the sending out of letters. In this second focus group GPs were asked about what impact, if any, they thought the letter had. Most GPs were not optimistic about how effective the letter itself had been with one GP (Practice 2, GP4) reporting no one mentioning the letter and others reported feeling that it had only a very limited response.

*I'd only about six patients mention the letter to me, and they all came to justify how they couldn't possibly reduce and were a little bit, not offended by the letter but felt they needed to justify and no one took up, I think one took up the offer of the counselling, and then no one else even mentioned that they got it*

(PRACTICE 1, GP1)

<sup>8</sup> In comparison, only one person from Group 1 availed of the counselling service and none from Group 2 excluding methadone protocol patients. The results from Group 2 are noteworthy as this group (as with Group 3) received a letter explicitly inviting them to avail of the addiction counselling service; the differences between groups underlines the complexities of benzodiazepine use and is explored further in the following chapter.

*Another GP commented on the difference between results in this study and the one that had been so successful in England there's something different in the culture and the health beliefs here.*

(PRACTICE 2, GP1)

In practice however, the results seem to be more positive than what the GPs perceived. There is an interesting parallel here with the fact that at the beginning of the study GPs overestimated the number of long-term users in their practice which suggests perhaps that in the day-to-day work of a busy practice it may be difficult to get a full picture of what is occurring.

A number of practical improvements were suggested including:

1. Using shorter letters
2. More awareness of literacy considerations
3. Personally handing out letters rather than posting them

One GP felt that the letter was long and would not be of the usual length she would send to patients. Another stated the letter might be difficult for some patients to read. Another GP felt that in their practice they had discovered that posting letters simply didn't work and while the GP felt that this could be caused by postal difficulties in an area undergoing regeneration he also felt that

*Letters aren't taken particularly seriously here.*

(PRACTICE 2, GP1)

GPs agreed that letters posted out did not seem to work.

*Here a lot of the time, letters could mean trouble.*

(PRACTICE 2, GP4)

*Official looking things aren't viewed pleasantly.*

(PRACTICE 1, GP1)

An important insight in the final focus group with GPs was the value of finding out what actually works in a local context. Written communication with patients is a common feature of health care however it was clear from the focus group that what does seem to work are letters handed to patients with their prescriptions.

*I mean what does work is actually handing them out with the prescriptions and I think in future that might be worthwhile doing something like that, because you know letters for the, [...] asking people to come in and have their medication reviewed, they tend to, by and large, recognise that, come in for their appointments, not always now but a lot of them do, so that we give someone a prescription, quite often we attach a letter saying, you need a medication review please make an appointment to see us before your next prescription and they will come in to see us, so but that's handed by the receptionist.*

(PRACTICE 2, GP1)

Overall, despite the challenges that the project presented, there was overwhelming agreement that it was a positive development for all those who participated.

*I think it's an exciting project; it was great to get it done here.*

(PRACTICE 2, GP3)

## 4.5 Summary of Main Points of the Effectiveness of a Letter as a Brief Intervention

- GPs overestimated the number of long-term users of benzodiazepines who fitted the criteria of the study.
- One surgery had more patients availing of methadone maintenance than the other which indicates that the profile of patients in each practice is different.
- Analysis of the sample of long-term benzodiazepine users did reveal a younger cohort who were also on the methadone maintenance programme.
- In line with other research, more women than men were identified as long-term users of benzodiazepines.
- The brief intervention of a standard letter did result in decreases in some prescription rates.
- The brief intervention of a letter with the offer of the services of an addiction counsellor did also result in decreases in some prescription rates.
- The decrease was particularly noticeable in the cohort who also availed of methadone maintenance treatment.
- GPs identified a range of improvements that could be implemented in order to improve the outcome of the letter as an intervention. Those improvements included: using a shorter letter, more literacy awareness and personally handing letters to patients within the practice.



## CHAPTER 5

### FINDINGS FROM INTERVIEWS/FOCUS GROUPS WITH GPs & ADDICTION COUNSELLORS

#### 5.1 Introduction

As highlighted in the methodology chapter, various interviews and focus groups were undertaken with GPs in the practices and addiction counsellors. The in-depth interviews with the addiction counsellors took place in the summer of 2009 following over two years of implementation of the service. In terms of gathering qualitative information from the GPs, the first focus group occurred in September 2006 at a time when the addiction counsellor had yet to be formally appointed. The final focus group with GPs took place in October 2009 and by then an addiction counsellor had been integrated into the practice for over two years. This focus group allowed for reflection on the research project in general and the impact of the on-site counselling service in particular.

A number of themes emerged including how benzodiazepine prescribing is managed in the practices, the perceived results of the project, how the referral process works, the integration of a counsellor within GP practices, issues and challenges that arose and suggestions for improvements.

#### 5.2 The local context of benzodiazepine use

The historical context of benzodiazepine use in Ballymun came to the fore in the initial focus group with GPs with the feeling that benzodiazepine use was prevalent in the area. A number of GPs reported on their frustration of finding themselves in a situation where large numbers of people had been previously prescribed benzodiazepines and as a consequence a clear sense of expectation among patients had been established. Many times GPs referred to a culture of benzodiazepine use:

*There's a whole culture here, the culture here that people would have, would be that benzodiazepines are drugs that are used if they had a crisis or were anxious or depressed.*

(Practice 2, GP1)

*I think again what happened over the years was, you know, there would be a lot of people who would come in and they would be prescribed the benzos and they're on them all the time and then because of the culture that's here, you know, for any slight crisis or whatever, people would just come to the doctor looking for their benzos and... people think that they need that treatment for anything that goes wrong in their life.*

(Practice 1, GP2)

Against this historical context of benzodiazepine prescribing, a number of GPs reported on the difficulties of having to manage people's expectations and sense of entitlement to benzodiazepines. One GP noted the persistence of some patients in relation to benzodiazepines and described a scenario in which long-term prescriptions may begin:

*It's the experience here that if somebody had decided that the treatment for what they are suffering is benzodiazepines then they will come back, ... they will come back and they will often keep coming back and because we're a group practice they will see any one of a number of doctors, until they eventually find a doctor who will prescribe a small amount and then they will keep coming back until their prescription ends up*

*being continued. I think that's how long-term prescriptions start.*

(Practice 2, GP2)

### 5.3 The complexity of benzodiazepine use

Both addiction counsellors were aware of the complexities of benzodiazepine addiction, with one noting how quickly it can seem to develop:

*It's one of those, like, that can start off quite mild, sure within weeks, months, like you know it just seems to have spiralled out of control.*

(Addiction Counsellor 2)

It was also felt by counsellors that benzodiazepine addiction was a particularly difficult addiction to deal with, one describing it as a slow process that was often one of the last addictions clients themselves tried to tackle.

*I won't say it's kept hidden because you know, you can sense and you can see sometimes the way some people could present but it's always the last piece to be mentioned you know when you take a little bit of a history particularly around somebody maybe who wants to, who might be interested in doing a methadone detox, and it's when you start looking at 'well is there any other medication, are you on prescribed medication' and then you're down to a seven day, 'what have you used in the last seven days?', you know and 'I had a couple of sleepers', but if you get to the couple of sleepers, well it actually turns out to be a lot more than a couple of sleepers you know so it's hard to kind of actually quantify it really.*

(Addiction Counsellor 2)

There was overwhelming agreement that benzodiazepine use and its reduction is a complex area. A number of GPs had experience of a time when prescribing benzodiazepine was seen as a good thing and are now faced with a situation in which benzodiazepine prescription is seen in a negative light. One GP reported their frustration at how prescribing benzodiazepines is sometimes presented as a black and white area whereas they felt that the reality on the frontline was often much more complex than that. They noted that some medical professionals simply don't prescribe benzodiazepines and live in an 'ivory tower' whereas this option was not open to GPs who were working on the ground.

*There's no guidelines it's just a no or detox but there's no sort of broad based approach and I would hope that by using an addiction counsellor and that we would have a more realistic approach for how we work in the community [...] like the psychiatrists just won't prescribe, they say no and walk away from it, but we don't have the opportunity to do that, we have to live with it.*

(Practice 2, GP1)

There was an acknowledgement among the GPs that unprescribed benzodiazepine use was a problem. One GP also noted that a holistic approach for dealing with benzodiazepine use is needed and that simply reducing its use or stopping prescriptions would not automatically solve the problem.

*The benzodiazepine is only a symptom of something much greater you know, they're not on it for fun and, so you know we're not trying to belittle it and we could easily remove all the benzos and they go on to something else [...] there's a coping mechanism that's missing.*

(Practice 1, GP1)

### 5.3.1 Patterns of Prescription

In the focus group the GPs recounted strategies that have been in use in their practice such as having a system that controlled prescriptions for long-term users. These include dispensing for short periods of time and in small quantities.

*Anyone on chronic scripts never gets more than a month at a time and a lot of them [...] are on weekly dispensing so that it's very controlled and there's no dipping into them, and [...] we would post date the script, you know if they ring before they're actually due, we post-date them on the computer, so there's no building them up, stockpiling, they're literally only on the dose they're on and there's no hidden ways of getting more.*

(PRACTICE 1, GP1)

GPs referred to the Department of Health and Children's booklet *Benzodiazepines, Good Practice Guidelines for Clinicians* which recommended phased dispensing and small quantities of prescriptions.

*In that it says the best way of controlling it is small amounts at a time, regular dispensing arrangements. And it does work definitely and you'd often say to a client look that has to be every week. So that you know, on a bad day, if there's more tablets there you're going to want them, so if you've only got seven tablets to last you seven days, you're going to be less likely to dip in than if you've 28 tablets to last you four weeks, you now that kind of way, and it does make a difference definitely.*

(PRACTICE 1, GP1)

One GP (PRACTICE 2, GP4) reiterated this and felt that almost without realising it, GPs in the practices had changed their way of prescribing in recent years.

### 5.3.2 Alternatives to Prescribing Benzodiazepine/ Training

GPs reported a number of strategies that they use as an alternative to prescribing benzodiazepines. Overall they recognised the importance of exploring all avenues in order to try to have a "coherent approach that makes sense and seems right" (Practice 2, GP1). The simplest strategy that was employed was to sit down and talk to the person and find out why they were anxious and looking for medication.

*We give time to people that are suffering from anxiety, we often give quite a lot of time over a period of time .... While we mightn't consider ourselves trained counsellors we spend a lot of time counselling, talking to people.*

(PRACTICE 2, GP3)

Another alternative that was sometimes used was to cross refer to the community mental health services.

*We're lucky now in that we have a psychologist and a community mental health nurse so that if someone is having anxiety and panic attacks, I quite often refer them to those avenues.... before they weren't available and that's one of the reasons why benzos were so widespread there were no resources available for people with you know major psychological problems, difficult lives, anxieties, panics.*

(PRACTICE 2, GP1)

GPs recognised the importance of training in different approaches as a means of dealing with current benzodiazepine use. This was despite varying experience of training received and practical application of the techniques of cognitive behavioural training and motivation interviewing. Practice 2, GP2 noted the importance of this training in order to

be able to “have something else to offer the person to do to help with their symptoms apart from taking a tablet”.

Overall, there was an acknowledgement among GPs of the effect of minimal interventions on long term benzodiazepine use. Other strategies used by GPs included providing relevant literature on how to deal with anxiety and also referring patients to appropriate websites that outline coping strategies and techniques for dealing with anxiety.

## 5.4 Client Profile in Project

All GPs agreed that there was a diverse profile of benzodiazepine users in terms of age and gender with two distinct groups emerging. It became clear that one cohort were younger users, many of whom were also on methadone, while another cohort are elderly people who have been on benzodiazepines for a long time, some for over 30 years. While some GPs questioned the harm of a very low dose of benzodiazepine over a number of years and the usefulness of asking this cohort to reduce; another felt strongly that this group should be included as she felt that very often they may not be using the benzodiazepines themselves but rather supplying them to family members.

*I still think we're right to invite them because [...] you say how many of them are you actually taking? Ah one or two and son is getting a few and daddy getting and they're going around the house and cousins and whoever kind of needs one, so I think we're right to address the group, I don't think they're a crisis group and I don't think they're the major focus but they're worth it.*

(PRACTICE 1, GP1)

While one GP felt that in her experience there were a lot more women than men on benzodiazepines among elderly users another felt that there was no gender predominance in younger users. Both addiction counsellors also reported a gender balance in terms of clients who attended.

## 5.5 Project Implementation

### 5.5.1 A Multi-Disciplinary Approach

In 2002, the then Minister of Health, Michael Martin announced the approval of ten Primary Care Teams under the primary care strategy *Primary Care – A New Direction* (2002). The four general practices in Ballymun who took part in this research were successful in becoming part of local Primary Care Teams. This integrated approach to primary care included the establishment of a multidisciplinary team which included GPs, psychiatric and public health nurses, physiotherapists, occupational therapists, speech and language therapists, social workers and dieticians.

Both GPs and Addiction Counsellors in the course of this project commented on the benefits of working in a multi-disciplinary team. One addiction counsellor (1) noted that a team approach had huge benefits to clients dealing with addiction. Another felt that this approach offered practical benefits to people.

*It really is the way to go for the future, that everything is situated in one building, ... you know, that especially for young mums or people who might only be able to get out once or twice a week that if they want to go to their GP, they can actually visit the dietician as well, or they can go downstairs to a bit of physio or upstairs...*

(Addiction Counsellor 2)

The integration of an addiction counselling service into a busy GP practice was not without its challenges, however greater benefits were emphasised by both GPs and addiction

counsellors as will be further described.

### 5.5.2 Flexibility

One of the key elements envisaged for the Project was that it would be flexible to clients' circumstances and needs. The initial focus group with GPs clearly identified this as a crucially important concern. One GP had experience of working in a drug clinic, which used a very structured model of counselling with one-to-one hour-long sessions being offered. In their experience that type of model did not work and they felt that the idea of keeping appointments and sitting for an hour talking to one person about their addiction placed a huge demand on poly drug users who were usually living quite chaotic lives.

*I suppose I have some misgivings about the model of counselling that has a one-to-one one hour consultation with people because the people I was seeing in the drug clinic who are quite heavily addicted, poly drug users and often quite chaotic, that model did not work well. That they were not able to keep appointments, they weren't able to be in a room with another person, talking personally for an hour.*

(PRACTICE 2, GP2)

There was general agreement among the GPs at the initial stage of this project that a new more flexible model needed to be created. When advertising the position of addiction counsellor, one GP noted that even at that stage a key concern was to have a flexible model- 'We were anxious not to prescribe the post' (Practice 1, GP1).

*Instead the emphasis was on getting free thinking people who are able to evolve the position and create a model that might work and work closely with us that we can all amend it.*

(PRACTICE 1, GP1)

### 5.5.3 Referral Process Employed

GPs noted that patients could request a referral to see the addiction counsellor. However the most reported means of referral from GPs were as a result of discussions initiated by the GPs themselves.

Within such circumstances, different styles are used to engage clients. One doctor reported that they firstly highlight that a helpful person is present and can assist them when they feel like they want to talk about the issue. Even though the patient may wish to see the counsellor on site, one doctor reported that they may need to be helped through the steps of speaking to somebody. Another doctor refers to two or three very chaotic clients whereby it was sometimes necessary to have the "methadone script as the carrot" and that the script was ready for them to collect following their visit with the counsellor. According to the doctor this "has worked well".

*The carrot could be maybe the week they see the counsellor they don't have to see the doctor, [...], they can do a urine but go, you know and there's a prize, you know, there's an incentive, you know you're not double waiting, they might be an hour in the centre waiting to see us.*

(PRACTICE 1, GP1)

The word "counsellor" was also reported as possibly being a less than useful word when trying to refer individuals to the service with one doctor noting,

*That there's something about the word counsellor that people run from.*

(PRACTICE 1, GP1)

An example of a circumstance was provided when the client asked the doctor directly to

make a referral to the counsellor.

*But, there would be a few people, I'm thinking of one, who is, he's coming down off his methadone, he's stopped it because he can't cope any further, and he's asked could he be referred to some counsellor to help get off it, so there would be a few who would do that.*

(PRACTICE 2, GP1)

GPs and counsellors were both asked about the workings of the referral system and how effective they thought it was. The majority of the referrals to the counsellors came through either GPs or Project Workers. One of the main considerations in the development of the service was the importance of the counselling service to link in with, and refer to other drug related service and supports in the Ballymun area. Although described earlier as a "one stop shop", the same counsellor noted the importance of not working in isolation and working with other external agencies for the benefit of the clients.

*It's almost as if we can be self-sufficient, there's no need to think we are because there's so many other agencies and services so local, you know, all wanting and wishing the best for the clients and the people that walk through their doors you know and you can nearly feel it at times.*

(Addiction Counsellor 2)

Feedback from both counsellors highlighted instances whereby they received referrals from agencies in Ballymun and situations that the counsellors referred out to agencies.

*Recently I had reason to refer to the De Paul trust. I know it's only a phone call away, in actual fact the building is only around the corner so you walk over with the referral, you meet the people and this is I suppose, this is the complementary thing, you know, that one service actually adds to another and how that service feeds back in like you know, so overall it does, you know I mean the complementary therapies, I know that YAP has its doors wide open for us so if there is somebody really stressed or wants a bit of relaxation you just have to lift phone and there's always someone there 'yeah sure send them over, we've a late night on such and such a night, there'll somebody here, send them over'*

(Addiction Counsellor 2)

Both counsellors expressed satisfaction with how the referral system operates.

*I feel it works, I feel it works [...] you know, the referral will be left in my cubby down there and when I get it I just date it, and it's you know the date of the referral, the name of the GP who did the referral and a telephone number. And then as the list starts to roll, the referral is just taken out then and it's processed in the usual way, so it's taken off the waiting list and it's put into the present clients that are attending for counselling and then when after six, eight, ten weeks or six months when the sessions are coming to an end, just remove it out of the file, and you put it in and it's an easy way of keeping a tag on those who have finished up, or those who have gone on to treatment, those who have gone for detox, you know, it's very easy to just look back in because it's there sitting looking at you like.*

(Addiction Counsellor 2)

### 5.5.3.1 Impact of Training on Referral

The training in motivational interviewing that the doctors received at the beginning of the Project was reported at follow-up to very clearly influence the nature and selection of referrals by the doctors to the counsellor.

*I found the training we did with YAP very helpful because there we did sort of*

*motivational interviewing, so I tend not to refer people now until they've reached a certain level of motivation and I wait until they're ready whereas before I used to, it was sort of, I used to refer them much earlier.*

(PRACTICE 2, GP3)

Similarly this doctor reported at follow-up how a referral to a counsellor was based more firmly on other elements apart from the need just to refer because a service is available.

*Well that was because it was like ticking a box, it was like, I need to talk to somebody so go to counsellor, I think now I've an understanding of the need for motivation because it's not just ticking a box, they have to be prepared to buy into it.*

(PRACTICE 2, GP1)

All agreed that the motivational interviewing training was effective and that they would be positive towards obtaining further training and in particular they highlighted the importance of refresher training every few years. The training received was also reported to be helpful beyond the project in question. In particular, one doctor reported at follow-up that it was beneficial in relation to all their consultations and "not just related to this group of clients" and that it was helpful "in dealing with our kids, and everything else, at every level" (Practice 2, GP3). One GP noted that improvements in the referral process had an impact on attendance levels. Similarly, the following quote highlights how the presence of a counsellor can contribute favourably to the criteria used and selection of referrals:

*I think one of the things about having a counsellor is that GPs are always psychologically minded you don't get to general practice without being, but you're even more psychologically minded when there's a counsellor around and everything is done better and therefore I think the referrals are different.*

(PRACTICE 2, GP3)

#### 5.5.4 Attendance

Both counsellors reported very good attendance rates at the service. Some clients would routinely come for appointments over a period of months while others would come for a number of sessions (sometimes just 5 or 6) when something was going on in their lives.

*I would have seen some people, yeah I would have actually, weeks not months, weeks, addiction takes a while to em to kind of get a grip of, like you've to build up a person in more than one way like you know, giving them confidence in their own way of dealing with things.*

(Addiction Counsellor 1)

In terms of having a client contract in place, there were different approaches used by each counsellor. One had a formal contract that was provided to clients while the other included it as a discussion topic on a client's first visit. However the issue of attendance was built in to the client contract/initial discussion.

*Well, you'd, I'd always give, I'd always give them the contract when they come to see you, once they get this, if they can't make the session they would phone, to the secretary at the desk and if they didn't phone they'd get one chance and then they go down to the bottom of the list.*

(Addiction Counsellor 1)

*When I'd be meeting somebody for the first time I'd build it in as part of it, you know if you feel you can't make an appointment or for whatever reason you can't make it or don't want to come in, just let me know, like there's absolutely no consequences, if you can't make it, you can't make it and that's that.*

(Addiction Counsellor 2)

It became clear through interviewing the counsellors that a sophisticated system to encourage attendance had been adopted by the practices as a whole. All clients, for example, are contacted by phone or text the day before their scheduled appointment with the counsellor and it was noted by the counsellors that the high attendance rates could have been influenced by the effort made by both the receptionist and counsellors in terms of sending out reminders to clients regarding their next appointment.

*Nine times out of ten, whoever confirms on the Wednesday will turn up, or whoever confirms on the Tuesday will turn up [...] It's most unusual that someone will say 'yes I'll be there' and it's just no show, that's most, most unusual.*

(Addiction Counsellor 2)

If there are two missed appointments with no explanation, the counsellor will ring on the third, if there is still no response that client's appointment would then be given away that week to someone on the waiting list.

## 5.6 Perceived Results of the Project

The first focus group revealed that GPs had clearly identified two cohorts of patients in relation to benzodiazepine use – an older group who had been on benzodiazepines for years and a second younger group who were on methadone. Perceived results in relation to the success of the project were understood by GPs in relation to these two distinct groups.

### 5.6.1 Older Cohort of very long term users of benzodiazepines

One cohort identified was an older one who had been on benzodiazepines for years. For this older cohort the project was felt in general to have made very little difference.

*I didn't find they wanted the engagement of an addiction counsellor, I didn't particularly feel they needed it in their day to day life and they had no particular wish to reduce their benzos anyway. So I think pretty much in my practice it had minimal to no impact on that cohort of patients*

(PRACTICE 1, GP1)

One GP (PRACTICE 2, GP1) noted that with this group there was little willingness or motivation to change and the majority of patients in this group would be on a reasonably low dose, leading another GP (Practice1, GP1) to conclude that some of the patients are on a prescription of benzodiazepine for so long that they are immune to it. Nonetheless there was agreement that it was still important to include this group in the research and that the presence of this cohort of patients at the very least served as a reminder to GPs about the very real danger of long term prescriptions. There was also acknowledgement that reducing this group's benzodiazepine use involved tackling long term health beliefs and was in itself a much more complex undertaking.

*I think the thing about it is, one of the things was, was to try to tackle the belief that you know benzos were good for you, and you need to be on them and we were to try and get at that health belief, and I think sending a letter out was sort of a shot across the bows with that, I mean I think the health beliefs are still very deeply rooted, they still believe you know if you're upset or someone dies you need valium immediately, do you know what I mean? It's like it's, you can't just change that, we've managed to cut down the use, we don't prescribe new ones, or very rarely, but actually cutting down on people who are on chronic scripts, I think we got as far as we can go and we're not going to get any further.*

(PRACTICE 2, GP1)

### 5.6.2 Younger Cohort who are on Methadone Maintenance Programme

The project was viewed to have much more impact on the younger group of patients who



were battling other addictions too apart from benzodiazepines. This cohort of patients was younger, generally on methadone but also facing a range of other addictions. The impact of the introduction of the addiction counsellor to this group was judged to be particularly successful with this group.

*I think from the point of view of an addiction counsellor, the people that it would have particularly helped would have been the methadone, people on cocaine, people on heroin who didn't want to go on to methadone but wanted to get off heroin and people who had drink problems. Those would be the big groups I think who actually having an addiction counsellor particularly helped.*

(PRACTICE2, GP1)

A review of referral forms from mid 2008 to the end of 2010 suggests that of those who attended the GP Addiction Project within this time period, a small minority reported benzodiazepine as the sole primary drug of choice (n=14). More significant, was the reported use of benzodiazepines as an additional drug with a large number of clients using benzodiazepines, not as their primary drug of choice (or its use as reason for referral), but alongside the problematic use of other drugs for example; alcohol, cocaine, methadone etc. Furthermore, for some clients who were referred and attended the Addiction Project, benzodiazepines were not part of their drug using behaviour at that point in time and other drugs were the primary cause of concern for the client and the GP. Given the complexities of addiction and changing patterns of use and drugs of choice for an individual, this profile has highlighted the need of the GP Addiction Service to respond and engage with all issues of addiction as it presents within the general practitioner setting rather than targeting the service specific at benzodiazepine use.

There was overwhelming agreement that the addition of an addiction counsellor to the practices involved has been an extremely positive development particularly for the methadone using cohort.

*It's come to the point now ... within our practice it has enhanced it [the methadone programme] so much in terms of patient care, that it would, I would now feel it's almost wrong to have a methadone practice without the option of a readily available addiction counsellor with which to refer patients because they're such a vulnerable group and addiction is so intertwined in their lives*

(PRACTICE 1, GP1)

In the initial phase of this research project, the perception among the GPs of the numbers of long terms users of benzodiazepines was much greater than what was found in reality. The fact that benzodiazepine prescribing is not as high as was anticipated has resulted in GPs feeling more comfortable about their prescribing rates.

*It certainly got rid of my guilt, because I don't think we prescribe as much benzos as we thought, we had notions there were huge prescriptions coming out and we were totally guilty and now we realise no it's as minimum as we can get it, we're at a practice level we're as organised as we can and we have to just accept that bit is there and get on with it and you feel much cleaner or purer about it. So it's been very good from that point of view.*

(PRACTICE 1, GP1)

One GP noted that the project and the introduction of the counselling service have lessened feelings of helplessness in relation to benzodiazepine prescribing. As a result GPs are now much more empowered.

*It's just really helpful that there's just more of a structure and framework and you know, support system that you can offer people more if they do decide that they're going to*

address it.

(PRACTICE 2, GP4)

## 5.7 Project Integration and Co-ordination

One of the primary aims of the Project was to pilot the co-location of an addiction counselling service within a local GP practice/s. The environment of any GP practice can be a highly busy and structured environment in order for needs of all patients to be met. The additional delivery of a counselling service, an approach that recognises “talking therapy” could be viewed as being in direct contrast to the medical environment wherein it is located. One of the counsellors below recalls how her initial reaction to the initiative was one which queried her role in a medical setting.

*I actually wondered where my role was as such you know because, the GPs on their own seem to do such a good job but obviously there was a place for the talk therapy as well.*

(Addiction Counsellor 2)

The GPs in the practice had experience of working in a multi-disciplinary team. One GP noted that there is now a psychologist and community mental health nurse attached to the practice, which provides a practical alternative to medication for patients suffering anxiety/panic attacks. Another GP found that having someone in the practice that was providing addiction counselling provided invaluable support for GPs.

*I have taken up someone who is already a patient who was buying on the street and has a heavy problem and where I would have ran from it because I couldn't cope with it, I agreed to take her on to detox her. And the reason I couldn't cope with it was because I didn't feel skilled but I feel if she is in counselling, addiction counselling and committing to that I feel well I feel I can deliver my bit and I feel more secure that I'm not a lone soldier.*

(PRACTICE1, GP1)

The experience of the nature and extent of integration of the service within the GP practice was reported as very positive and complementary to each other's services. The first counsellor felt that it was a good idea for the counselling service to be based in the health centre – he felt that it 'worked powerfully' as counsellors were seen as part of the team.

*I would see the health service as being a good area because, like the doctors have, in one practice there are five doctors, that could be 2000 people or more, and like there, I would personally there should be a counsellor attached to every doctor's practice. And I felt it worked very powerfully.*

(Addiction Counsellor 1)

The other counsellor also felt that this presence of an addiction counselling service within a general practitioner practice was a great development, in that individuals can avail of many different services at once and that these services can then also refer out to more specialist services in the community if needs arise.

*It's almost like, it is ideal. I mean if I would have had this a few years ago you'd kind of say, say, 'God isn't this fantastic' because it's not every little place that has, you know. I've worked in other areas and it's not every area that has an almost one stop shop and it's almost like a little centre and it's from this centre that a whole lot of other ripples go out, you know, and I can see where the different services link in.*

(Addiction Counsellor 2)

Both counsellors felt it made a big difference being on site in the health centre. One of the counsellors felt that even after a short length of time they were beginning to be known in

the community. This point was also reiterated by the other counsellor as outlined below;

*It is a huge bonus I feel it's, it really is the way to go for the future that everything is situated in one building, these people deserve this and an awful lot more. You know, that especially for young mums or people who might only be able to get out once or twice a week...To have all the different modalities around, it's fantastic you know.*

(Addiction Counsellor 2)

*Because em you were seen as part of the team, you were seen by the person, by the patient themselves, you were seen around the place, I'd walk around a bit so 'there's [Name] the counsellor', and you'd get people talking to you in general, outside even, and it would take away that myth attached to counselling you know.*

(Addiction Counsellor 1)

Both counsellors felt that they were very much part of a team from the very beginning of their role as a counsellor within the GP practice. The only limitation of the service which was reported by both counsellors was the physical space in which the counselling took place. Due to the original layout of the building and availability of rooms, in some instance the counsellor would meet a client within the doctor's surgery. It was felt that the arrangement of the room was not overly favourable to the counselling style. Despite the physical limitations both counsellors adjusted rooms to maximise their potential (for example by moving chairs around, so that the client would not be in view of the examination or doctor's table).

*It is a doctor's surgery and as you can see it's equipped as a surgery you know whereas in the normal, in the normal counselling mode I suppose you'd be looking for a more conducive atmosphere that mightn't have the distractions or mightn't have all the bits and pieces that remind them of what it's like to come into a GP. You know, if you had this little space, little room, that would have two easy arm chairs, maybe a little table that you could but a box of tissues, a glass of water on, a few books, bits and pieces of information, you know, that you'd have your own little bits and pieces to hand that would be the ideal.*

(Addiction Counsellor 2)

One of the key aims of the research study was to document the inclusion of an addiction counselling service to a busy GP practice. Doctors noted once again at follow-up that there was a difference in the various approaches and ways of working for both the counsellor and/or the general practitioner. Each profession had their distinct remit but could also be easily facilitated and supported by the other.

*The work that addiction counsellors do would be so different to the way we would interact, even having done the motivational interviewing, it's just, we're good if someone comes in, and we can make a plan with them to cut down benzos and talk with them about what we're going to do but looking at their whole life and their coping skills, and we don't have time for that and it's not really, you know, just having someone who's really trained and really focused on that particular side of it, ... makes a huge difference to people.*

(PRACTICE 2, GP1)

All doctors interviewed had very positive feedback in terms of how well the counsellors adapted to, and fitted into, the environment. Moreover, they felt that the presence of having an addiction counsellor on site allowed for the issue of 'addiction' to be kept to the fore and to acknowledge and recognise how extensive it features locally in the lives of people and also how central it is to their everyday practice.

*...we've been very lucky in the two counsellors we've had have been fantastic, you*

*know, they've really fitted in well to the practice so it's very much part of the practice now.*

(PRACTICE 2, GP1)

*I think it has been extremely positive for the patients or for the clients that she has seen herself, but also I think for us, it's just, she's been a great source, it's just, it's very comforting to note that there's somebody working on addiction, it's in our face the whole time, and then we also have to keep, keep it because you can move on to other things, you can take diabetes or something else, you know your interest can move but it has kept us, for me anyway, it's still at the front of my practices, to be mindful of addictions, it's there the whole time. I think she's been fantastic.*

(PRACTICE 2, GP3)

One doctor commented how different the practice is now with the existence of the addiction counsellor and noted how different it would be if this element of the service was ever discontinued.

*I'd miss it horrendously if it disappeared.*

(PRACTICE 1, GP1)

Doctors at follow-up were asked if having an addiction counsellor on site has changed the way they work. All doctors agreed that it did make a difference with one doctor describing its impact as making it 'more holistic in many ways' (PRACTICE 2, GP 4) and another noting that 'it has definitely enhanced our treatment of patients with addiction, without a doubt' (PRACTICE 1, GP1). Furthermore, there was an opinion among the doctors that having an addiction counsellor on site contributed to the overall understanding of addiction and also of the person with the addiction as the following quotes highlights;

*The addiction counsellor will get a fuller picture of what's going on in a person's life, from a social point of view, family point of view, we'll know the bare bones but there will be meat in the bones that she will know about that we probably wouldn't always get access to ...*

(PRACTICE 2, GP4)

Doctors were also asked if they felt it was effective and if the project could have been doing something differently. A specific example of where doctors at follow-up noted the effectiveness of having a counsellor on site was in terms of the early identification or intervention -where problems may be starting to emerge for an individual. This feeling is exemplified in the following quote:

*I think what I've found very helpful having her is that if a methadone client, particularly them because you see them so much and they're so vulnerable anyway, if they go off the rails you can get in so fast, so if someone comes in and says I've started taking a lot of tablets or the urines have gone dirty, and she will facilitate and prioritise them you can 'nip it in the bud' and that's worth anything, you know.*

(PRACTICE 1, GP1)

One doctor felt that she was very much empowered as a result of the project than she initially anticipated;

*I think it would be fair to say we feel much more empowered as a result, three years later we're much more empowered than we were, now would we anyway, who knows? But I certainly would feel it you know and less, less kind of feeling of helpless in a sea of benzos.*

(PRACTICE 1, GP1)

Overall it was felt that the attributes and traits of the counsellor are well suited to a multi-disciplinary team in that they are often in a position to give a different view of a situation.

*But the counsellor does give you a different view on a person, [...] now if you're seeing someone weekly or fortnightly for methadone, as you say, you befriend them no matter who they are, if you see someone that often you end up friends, which isn't always a good therapeutic relationship and you forget that they can be highly manipulative, do you know what I mean? And it takes someone else to assess that from the outside to say that, forgotten that almost because you're seeing them so often.*

(PRACTICE 1, GP1)

### 5.8 Issues and Challenges

One of the main perceived issues at the beginning was the difference in ways of working and approaches to work. Counselling was perceived to be the "talking therapy" whereby the client dictated the pace. This contrasted to the limited time available in the general practice to explore more deep-rooted issues with clients. At follow-up, doctors recalled once again how there was different ways of working at the beginning as the following quote highlights;

*That clash of cultures of the leaving the appointments open and there's an appointment free, get them in, do you know what I mean? There was a bit of a clash of cultures between general practice and counselling and also there was eh a sort of, slower uptake because it has to filter through the practice and the population, that this is available.*

(PRACTICE 2, GP1)

As noted above one doctor observed the slow initial pace of the project. However, the importance of the lead in time in a practice in order to let the new initiative settle in and become part of the practice was also conveyed. Another doctor reported how it has been a "learning process" for all concerned. It was also noted how, with time, a difference in the thinking behind the way counselling worked and the impact that even one consultation may have on an individual was evident.

*... so it was a slow, so there is a slow initial phase, until it gets going, I think, as you said, that would have to be recognised, accepting that people come for one consultation, that's all they're able for but that's actually helpful, just even to have that one consultation, you don't have to go through the twelve consultations and tick a box at the end for that to be a useful intervention, seeing someone once can give us more insight can give the person some new tips that they can use the next time they destabilise, so there was a whole lot of learning that went on to get to where we are now which is a very positive stage.*

(PRACTICE 2, GP1)

A key issue highlighted by the GPs was the problem of attendance. Doctors recalled the frustration in the initial stages of the project commencement, "when the counsellor had four or five appointments and not one would show" (PRACTICE1, GP1). One GP stressed that 'the challenge is for everybody to make sure that the person attends the appointment' (PRACTICE2, GP1). It was noted though that this challenge wasn't unique to the Project but was also similar to other initiatives around psychological interventions (e.g. psychologist, community mental health nurse).

*I suppose one of the things is that happens here is that people cope with chaos very well and when they don't cope and they want, they ask for help and will go and talk to someone but quite often by the time they've done one or two sessions they've started coping again with the chaos around them and they stop wanting to look at what*

*started the chaos in the first place.*

(PRACTICE 2, GP1)

Interestingly one GP felt strongly that improvements in how and when GPs introduced the counsellor to patients had made an impact on attendance.

*...people didn't turn up, now they're turning up because they're being better chosen, so if they're being better chosen by us we must have changed our choosing criteria, we've changed it in order that they will turn up, so we have to have changed the way we refer, it's not just that she is an excellent counsellor.*

(PRACTICE 2, GP3)

GPs described the current situation as now very different. This increase in attendance was largely attributed to the pro-active nature of the current and previous counsellor. In the case of the current counsellor, it was noted that her reminder phone call, in addition to her non-threatening manner and overall satisfaction among clients helped ensure fewer missed appointments.

*She would be doing things like making a phone call on a certain day, I had one patient who was particularly vulnerable, so she rang him on a Saturday morning, because we were just a bit concerned about him, so she rang as a bit of support, stuff that we don't really do, ringing up somebody, [...] that was the priority for her, just to check in with that person on a Saturday and get them through the weekend, so you know having that sort of support makes a huge difference*

(PRACTICE 2, GP1)

At follow-up, doctors also reported that when the funding for the counsellor position was made available, they really were not aware of the various elements of the role, what they required, how it would unfold and how would the various disciplines work together within the same environment.

*... and we had no idea what the person was going to do, we were trying to describe it without knowing, whereas the second time we knew what we wanted, so it's been a learning curve for everybody.*

(PRACTICE 1, GP1)

Similar to the feedback from the counsellors, doctors acknowledged the physical resources and use of scarce space as an issue. The following is an example of a quote which highlights this challenge;

*I feel a little bit sorry for her because every time she comes to our practice she's in a different room, I hope she's ok with that, but there's an element of which room is free today, you know*

(PRACTICE 1, GP1)

Doctors also noted through the interview process on the second occasion that there was an emerging keenness from addiction counsellors to work in the general practice and to work together in relation to addiction use as it occurs rather than merely within the confines of an addiction centre.

*Rather than working out of addiction centre, which many of them had, they preferred the idea of working out of a general practice base ...*

(PRACTICE 1, GP1)

## 5.9 Main Points from In-depth Interviews and Focus Groups with GPs and Counsellors

- Two cohorts of benzodiazepine users were identified – an older group who had been using benzos for a significant number of years and a younger cohort who were also on methadone maintenance treatment.
- GPs felt that the intervention of a letter made little or no difference to the older cohort whereas it was reported to have greater impact on patients who were also experiencing other addictions.
- Counsellors recognised that benzodiazepine addiction is a particularly difficult addiction to deal with. Both described it as a slow process and noted that very often it was the last addiction that patients themselves tried to tackle.
- Both counsellors and GPs noted the effectiveness of the referral system. The majority of referrals were from GPs, however other agencies in the area did make referrals to the service or provided onward referral options for the client. The importance of linking in with other services was acknowledged and emphasised.
- Despite an initial slow uptake very high attendance rates at the service were observed. A system of encouraging attendance had been adopted by both the counsellors and the practices themselves in terms of issuing reminders to clients.
- The experience of the nature and extent of integration of the service within the practices was reported as very positive and complimentary to each other's services. There was recognition of the different work practices between GPs and counselling. However, all GPs reported the positive impact the presence of a counsellor on site had; on both them as professionals and on the clients. The only limitation of the service which was reported by counsellors was the physical space in which the counselling took place.
- GPs recognised the importance of training in different approaches as a means of dealing with current benzodiazepine use. In particular, their use of motivational interviewing was an effective strategy for use in primary care. They highlighted their interest in obtaining further training and in particular highlighted the importance of refresher training every few years.
- GPs reported the difficulties of dealing with patients' expectations in relation to benzodiazepines and in particular the challenges they face when dealing the historical legacy and culture of benzodiazepine use. There was overwhelming agreement by both counsellors and GPs that benzodiazepine use and its reduction is a complex area.
- While GPs were positive about a counselling addiction service, a key concern was the need for any model of counselling to be extremely flexible in order to facilitate clients' circumstances and needs.
- There was also recognition of the importance of developing a range of strategies that can be employed as alternatives to prescribing benzodiazepines or which provide complementary supports for those on benzodiazepines.

## CHAPTER 6

### Conclusions and Recommendations

#### 6.1 An addiction counselling service is an effective strategy to complement existing general practitioner practices.

The evidence from the research conducted found that the integration of an addiction counsellor into a GP practice, although not without its challenges, was deemed to be a hugely positive development by both GPs and the addiction counsellor, both in terms of the service they provided and the support both groups were able to offer to each other. The presence of an addiction counsellor provided a holistic and multi-disciplinary view of addiction rather than a substance specific approach. The potential value of this service being available in a GP setting, particularly to patients also on methadone, is apparent in the study. It is clear that the benefits of having an addiction counsellor on site should be considered.

#### 6.2 The delivery of counselling service reported in this research could serve as a model for future pilot projects.

Specific elements of the service including training on motivational interviewing, flexibility, system of referral and interventions/strategies to improve attendance (reminder phone calls, personal contact) could serve as a model for future developmental projects. However, it may be that what works in one geographical context, for many reasons, may not work in another. Cultural variations must be taken into consideration and time spent with practitioners who have worked in the area, learned or discovered successful strategies of information dissemination with patients/clients, for example, will offer benefits to any future project.

#### 6.3 The intervention of a letter is an effective intervention in reducing benzodiazepine use

The project endorsed previous research which showed that the writing of a letter from a GP to a long term user of benzodiazepines is a cost effective and useful intervention. In particular, the results highlight that for those presenting with other addictions as well as benzodiazepines (in particular methadone) it can be a simple and effective strategy. However, it is recommended in going forward that the dissemination of letters could be reviewed to be provided through the GP/receptionist (at the time of contact) rather than via postal methods.

#### 6.4 Including a Client Perspective

A limitation of this report is that due to ethical concerns and resources, the client perspective on the initiative of having an addiction counsellor on site in a primary care setting, was not explored. Bearing in mind that benzodiazepine addiction is often a hidden addiction, future research should take into account the client perspective.

#### 6.5 Future Work

This project evolved from one that primarily envisaged meeting the needs of clients with a benzodiazepine addiction to one that now also has the ability to address other addiction issues that may present within a general practitioner setting. The Ballymun Local Drugs Task Force will continue to monitor the project and its capacity to respond to clients presenting to GPs with addiction problems.

As can be seen from this report, the project provided a tangible way of developing and fostering links in the community and promoted a multidisciplinary approach to the issue of drug use. The findings and outcomes of this initiative have the potential to inform and



influence the work of the Primary Health Care Team and the overall primary health care strategy in Ballymun and beyond.

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## Appendix A

### Obtaining GPs' views on benzodiazepine use in general practice in Ballymun

- In your experience is prescribing benzodiazepines problematic  
Probe: why? Can you give examples? Is this just particular to this area?
- Can you describe your experience of benzodiazepine use in this community?  
Probe for examples
- What monitoring procedure is in place for benzodiazepine use?  
Probe: procedures, difficulties if any?
- What are your criteria for prescribing benzodiazepines?  
Probe: does everyone operate the same criteria? How does it work?
- Can you outline any circumstances where benzodiazepines would not be prescribed even at the patient's request?
- Have you explored any alternatives to benzodiazepine use?  
Probe: Do you have any experience of alternatives? What sort of alternatives have you used? Do they work/not work?
- What are your expectations of having an addiction counsellor on site?  
Probe: expectations and fears, if any? Has anyone worked with a counsellor in the past?

## Appendix B

### Letter sent to Group 1

Dear

I am writing to you because I note from our records that you have been taking ..... for some time now. Recently, family doctors have become concerned about this kind of medication when it is taken over long periods. Our concern is that the body can get used to these tablets so that they no longer work properly. If you stop taking the tablets suddenly, there may be unpleasant withdrawal effects that you will experience. Research work done in this field shows that repeated use of the tablets over a long time is no longer recommended. More importantly, these tablets may actually cause anxiety and sleeplessness and they can be addictive.

I am writing to ask you to consider cutting down on your dose of these tablets and perhaps stopping them at some time in the future. The best way to do this is to take the tablets only when you feel you need to. Try to take them only when you know that you have to do something that might be difficult for you. In this way you might be able to make a prescription last longer.

Once you have begun to cut down, you might be able to think about stopping them altogether. It would be best to cut down very gradually and then you will be less likely to have withdrawal symptoms.

If you would like to talk to me personally about this, I would be delighted to see you in the surgery whenever it is convenient for you to attend.

Yours sincerely

---

GP signature

## Appendix C

### Letter sent to Group 2 and Group 3

Dear

I am writing to you because I note from our records that you have been taking ..... for some time now. Recently, family doctors have become concerned about this kind of medication when it is taken over long periods. Our concern is that the body can get used to these tablets so that they no longer work properly. If you stop taking the tablets suddenly, there may be unpleasant withdrawal effects that you will experience. Research work done in this field shows that repeated use of the tablets over a long time is no longer recommended. More importantly, these tablets may actually cause anxiety and sleeplessness and they can be addictive.

I am writing to ask you to consider cutting down on your dose of these tablets and perhaps stopping them at some time in the future. The best way to do this is to take the tablets only when you feel you need to. Try to take them only when you know that you have to do something that might be difficult for you. In this way you might be able to make a prescription last longer.

Once you have begun to cut down, you might be able to think about stopping them altogether. It would be best to cut down very gradually and then you will be less likely to have withdrawal symptoms.

Recently the services of a counsellor, trained in helping people reduce \_\_\_\_\_ use, have become available to us and we would like to offer this service to you. If you would like to make an appointment with the counsellor please ring the following number \_\_\_\_\_. In order to find out how effective this service is, later on, a researcher may contact people who took up this offer of counselling support. This would be to find out what they thought of it.

The number again to make an appointment to see the counsellor is \_\_\_\_\_. If you would like to discuss these matters personally I would be delighted to see you in the surgery whenever it is convenient for you to attend.

Yours sincerely

\_\_\_\_\_  
GP signature

## Appendix D

### Interview Schedule : Obtaining Addiction Counsellors views on benzodiazepine use

Can you tell me about your experience of working as an addiction counsellor in Ballymun?  
How have you found working here? Is it different from other areas you've worked in?

Probe: When did you start working in Ballymun? How many days are you here? Where are you based in the health centre? How many patients would you generally see during a week? What would a typical working day be like for you?

What type of client is referred to you?

Can you describe the referral process a client goes through to make contact with you?

Probe: Can a client contact you directly? What is the protocol for missed appointments?  
How effective is the referral process – what works well, what doesn't?

What, in general, has been your experience of clients seeking advice on benzodiazepine use?

Probe: in your view is benzodiazepine use a major problem? What are the concerns clients express about its use? Do you have concerns about benzodiazepine use in Ballymun?  
Would any client have mentioned the letter they may have received as part of this study?

To what extent does the counselling covered relate to general drug addiction issues apart from just benzo use?

Do you think a counselling service should be on site or in the community? Why?

How effective do you think a counselling service is in dealing with benzodiazepine addiction?

Do you think the gender of the counsellor makes a difference to how effective the service is?

Probe: Are there other factors that impact on the effectiveness of the service?

What changes would you make to the counselling service currently on offer to patients?

Is there anything you would like to add that I haven't asked you about?

## Appendix E

### Interview Schedule with GPs

How do you feel the introduction of an addiction counsellor to the practices has worked?

Probe: Is it very different to how you imagined it to be? How does the integration work? How do you refer clients? What in general is the reaction of clients to a referral? What are the criteria for referring clients?

What difference has it made to your work, if any?

Are there any challenges involved?

Probe: Are there any difficulties with having an addiction counsellor on site? Can you give any examples? In what way could things be improved?

How have people found the physical sharing of space?

Probe: Does this impact on integration? What has it involved?

One part of the project was the sending of a letter to long-term users of benzodiazepines, what impact do you think those letter had?

Probe: Why do you think it had that impact or lack of impact? Can you give examples? Why do you think it had that effect?

What impact, if any, has training had in motivational interviewing?

Probe: Is it effective? What use has training been? What do you think about further training?

Was the project worthwhile doing?

Probe: What were the strengths and weaknesses? Why do you think that – can you give examples? Suggestions for future work?



## Appendix F

### Calculating Prescribed Benzodiazepine Use

Both Gorgels et al (2005) and Cormack et al (1994) convert prescribed benzodiazepines into diazepam equivalents with Cormack et al. treating 5mg Diazepam as one tablet.

The following conversions in this study were used:

Diazepam (Anxicalm, Valium) 5mg	1
Alprazolam (Xanax) .25mg	1
Bromazepam (Lexotan) 3mg	1
Chlordiazepoxide (Librium) 12.5mg	1
Flurazepam (Dalmane) 7.5mg	1
Flunitrazepam (Rohypnol) .5mg	1
Lormetazepam (Noctamid) 1mg	1
Triazolam (Halcion) .25mg	1
Temazepam (Nortem, Tenox) 10mg	1
Zaleplon (Sonata) 10mg	1
Zolpidem (Stilnoct) 10mg	1
Zopiclone (Zimovane, Zopitan, Zileze) 7.5mg	1





