

A mixed methods evaluation of a support and counselling service for benzodiazepine dependency

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The Service

- Community-based NGO providing support & counselling services to individuals living with a BZD dependency
- BZD counsellors work with prescribing doctors to provide individualised support for clients who are considering controlled BDZ withdrawal (Ashton tapering model)
- Trained volunteers provide a State-wide information & support service (telephone & online) during business hours

The Mixed-Methods Evaluation

Phase 1

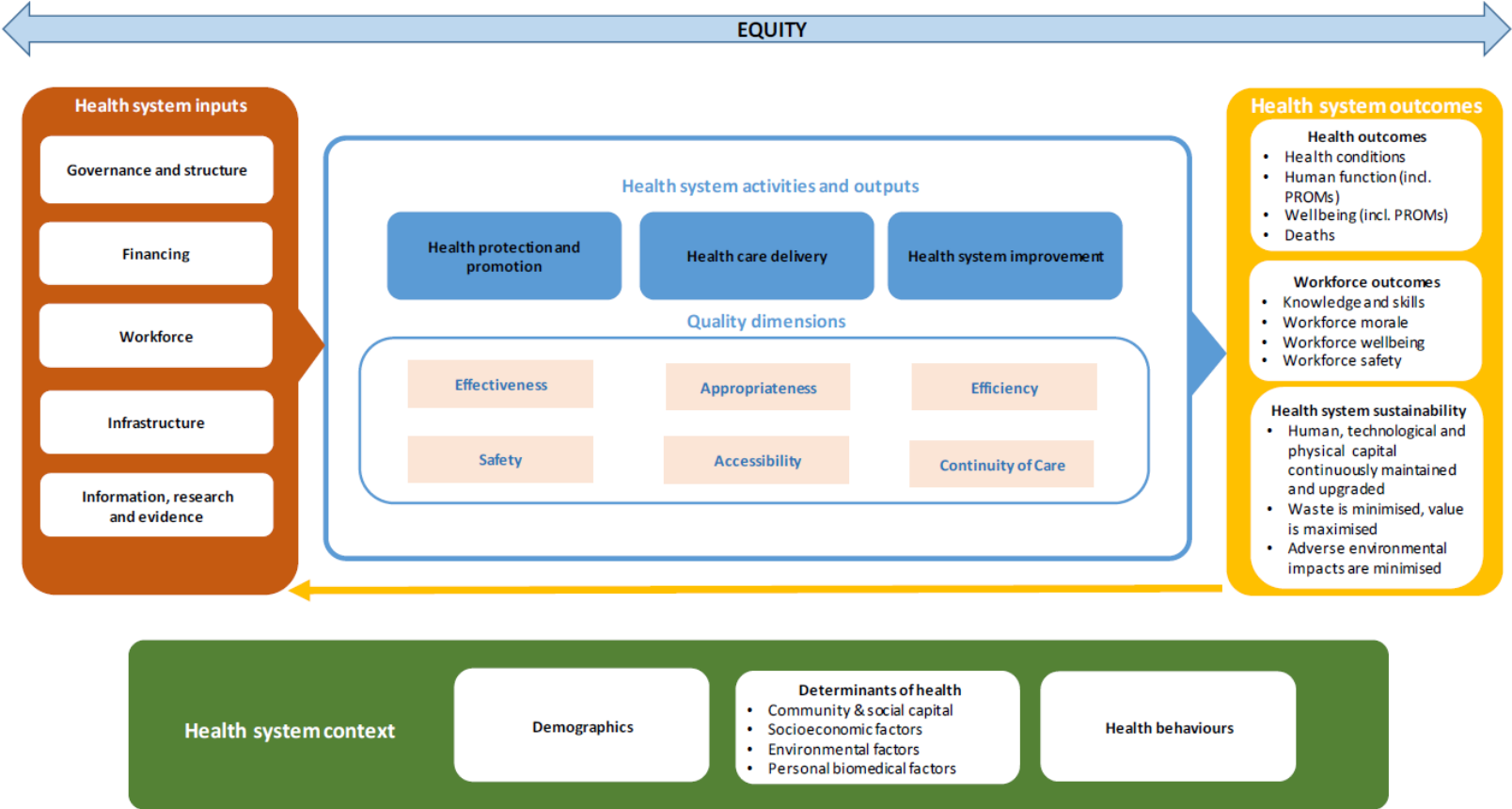
- questionnaire data: Victorian AOD Self-Completion Form (intake & follow-up, n = 24)

Phase 2

- interviews with clients (n = 6)
- interviews with counselling, supervision, program support & management staff (n = 8)
- focus groups with volunteers (n = 12)

Six quality dimensions of the AHPF

Australian Health Performance Framework (COAG, 2017, p. 8)



Health system context

Demographics

Determinants of health

- Community & social capital
- Socioeconomic factors
- Environmental factors
- Personal biomedical factors

Health behaviours

MEASURES & DATA COLLECTION

Victorian AOD Self-Completion Form

- Drug Use Disorders Identification Test (DUDIT)
- the Kessler 10 (K10)

Semi-structured interview & focus group protocols

PREMS (felt respected & confidence in counsellor)

FINDINGS

Effectiveness: Client BZD use (n =24)

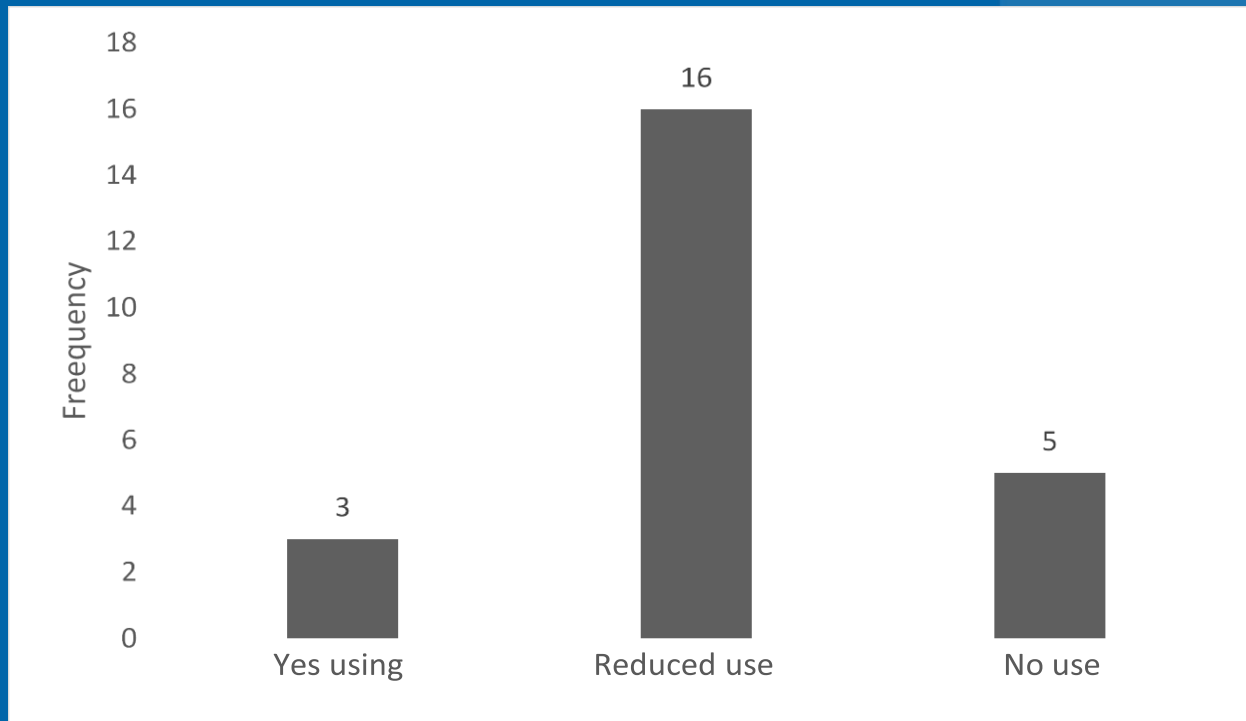


Figure 1. Use of benzodiazepines over the past 28 days.

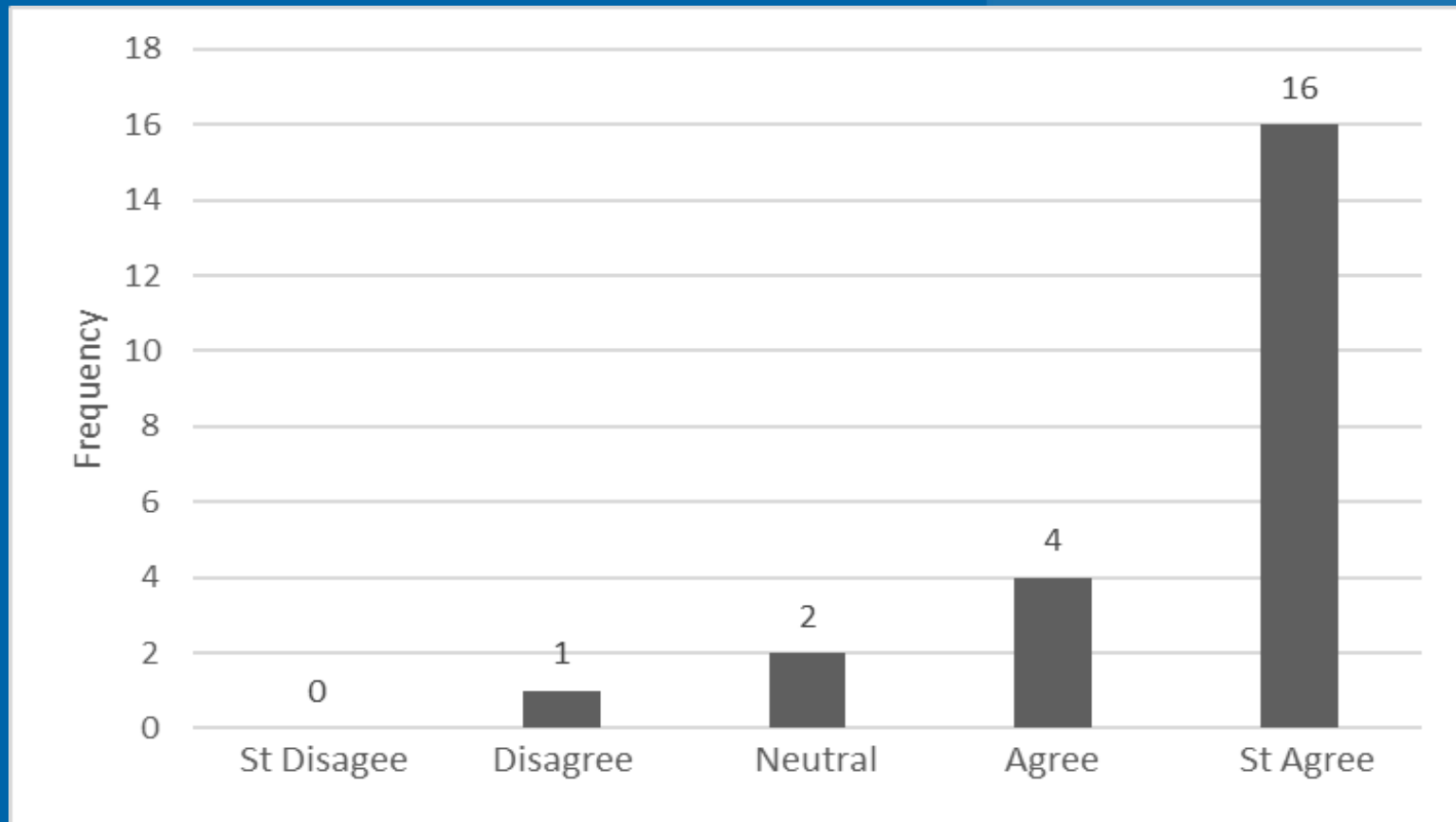
Effectiveness: Pre & Post Kessler 10 ratings, (n = 21)

- Compared 21 clients' pre-counselling psychological distress scores (M = 27.61, SD = 10.15) with their post-counselling scores (M = 21.28, SD= 8.39)
- Statistical analysis showed a significant reduction in distress ($t = 3.87$, $df = 20$, $p = .001$, $d = 0.83$)
- Effect size ($d = 0.83$) classified as large

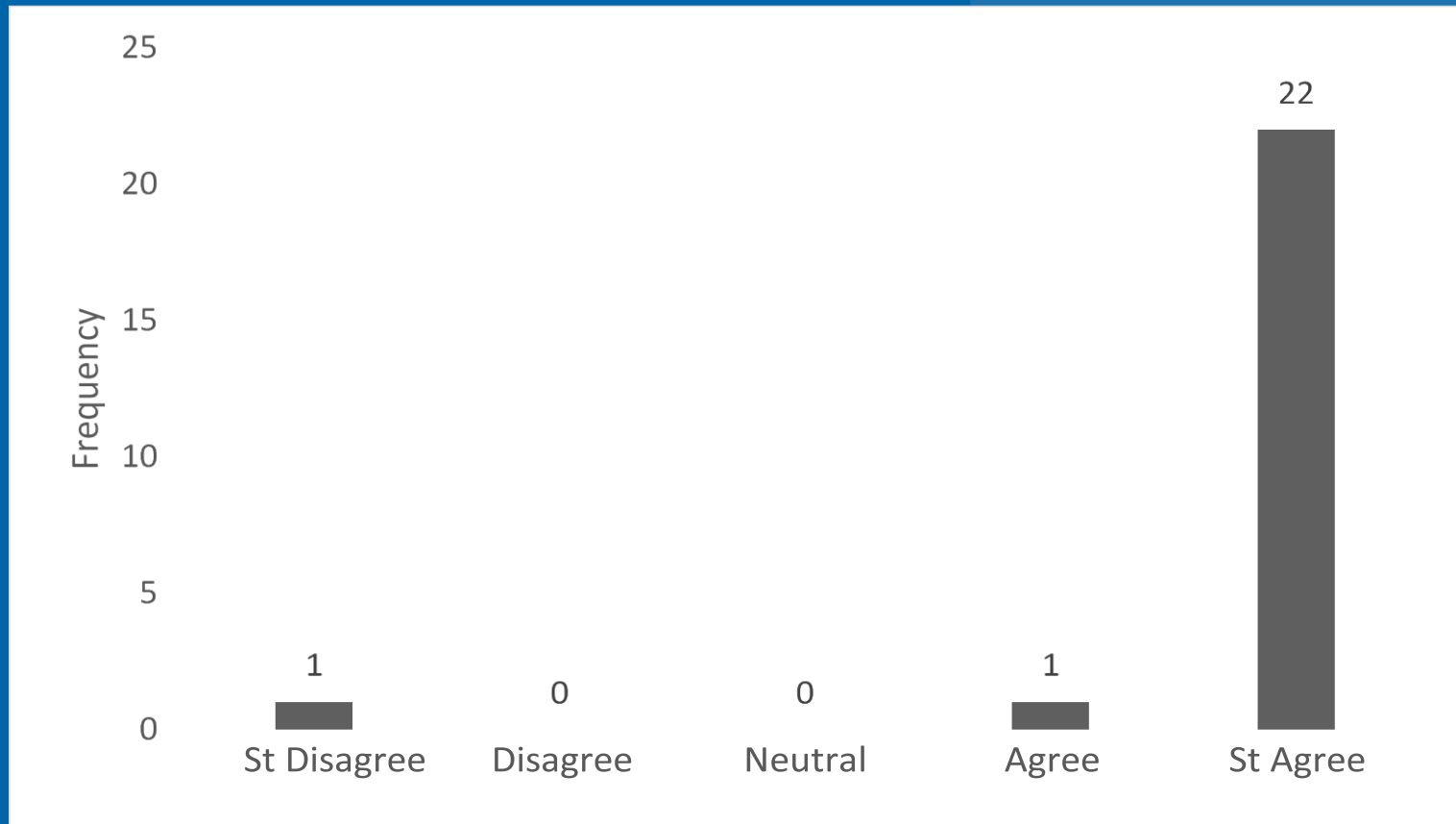
Effectiveness: client interviews

- *"My counsellor does goal-setting, monitors progress on reduction ... [is] very empathetic and supportive, reminds me of the commitment I have made, understands me. [I am] confident in the counsellors... give counsellor 10/10."*
(Participant 25)
- *"[I'm] functioning the way I am because of [the service]. [It's] improved my quality of life."* (Participant 21)
- *"I received the results I wanted can't speak highly enough of them"* (Participant 23)

Appropriateness: Client ratings, have confidence in counsellors' knowledge and skills, (n= 23)



Appropriateness: client ratings, felt respected by the counsellor, (n= 24)



Appropriateness: client interviews

- Tapering well supported and the use of the Ashton method was seen as helpful
- Community-based programs were also well supported:
“Community model keeps you in the community with your supports around you” (Participant 23)
- Substitution of longer acting BZD (Diazepam) in the taper process perceived as problematic e.g., *“I objected to taking Valium”, “... they squeeze people into a treatment model”*

Safety and Accessibility, client interviews

- Service was perceived as safe e.g., *"I always felt extremely comfortable"* (Participant 22)
- Client's noted the service was warm and welcoming, felt secure
- Issues with after-hours accessibility
 - need for after-hours counselling appointments
 - Need for after-hours specialist telephone support and information line (cf. Lifeline & Beyond Blue)
- Volunteers noted helpline increased access, but Face to Face BZD counsellors only available in limited metro locations

Continuity of Care, client interviews

- Coordination of withdrawal between the BZD Counsellors and GPs/psychiatrists/public mental health services/others) not straightforward (*“Need psychiatrists who will work in conjunction with the withdrawal counsellors”*)
- Co-ordination of the taper hindered by logistical (e.g., billing) & professional collaboration issues
- Clients perceived prescribing doctors did not share information about side-effects & withdrawal processes

Continuity of Care, volunteer focus groups

Volunteers contributed to continuity in care in a number of important ways

- **Validation and acceptance**

“By the time they [clients] get here, they are just so angry and they feel so abandoned and mistreated so just to have a system here to tell them that what they’re experiencing is real and not imagined, it changes everything for them I think and they really appreciate the service for that.” (FG1-P1)

Continuity of Care, volunteer focus groups

- **Encouragement and reassurance**

“Sometimes just encouraging them, reassuring them, giving them or retelling them the same information they already know, sometimes that’s all they’re calling for”. (FG4-P3)

- **Social support**

Volunteers’ roles in providing appraisal, informational, instrumental and emotional support (e.g., Faulkner & Davies, 2005) leading to better engagement with treatment

Efficiency, staff interviews

Evidence-based delivery:

- gradual **tapering** and use of a reduction schedule in collaboration with clients (Ashton, 2002, 2013; Psychotropic Expert Group, 2013)
- **Psycho-social support , psycho-education and CBT** (Darker et al., 2015)
- **Client-centred.** *“Certainly, at the very core of the organisation that culture of being very client-centred is just inherent”*
- **trauma informed**
- Strong culture of **regular supervision and PD**

Key themes from the evaluation

- Flexible, client-centred support
- Client control
- Choice
- Information, reassurance and well-qualified staff
- Co-ordinated service delivery & supportive social networks