

ARTÍCULOS ORIGINALES

Identifying barriers and enablers for benzodiazepine (de)prescription: a qualitative study with patients and healthcare professionals

Identificación de barreras y facilitadores para la (des)prescripción de benzodiazepinas: un estudio cualitativo con pacientes y profesionales sanitarios

A. Marquina-Márquez^{1,2}, A. Olry-de Labry-Lima^{3,4,5}, C. Bermúdez-Tamayo^{3,4,5}, I. Ferrer López⁶, J. Marcos-Marcos⁷

ABSTRACT

Background. There has been a steadily growing trend in prescribing benzodiazepines over last decade. Spain is one of the countries where this class of drugs is most extensively prescribed by primary healthcare physicians. The aim of this study is to identify factors that might be acting as barriers and enablers for benzodiazepine (de)prescription from patient and professional perspectives.

Methods. Qualitative study through semi-structured interviews with medical practitioners (n=17) and patients (n=27), and a nominal group with medical practitioners (n=19). Interviews were audio-recorded, transcribed and analyzed using thematic analysis.

Results. The analysis revealed key themes and was organized around barriers and enablers connected to three interrelated dimensions: the social and community context of prescription; the structure, organization and/or management of the health system, and the doctor-patient relationship. The excessive workload of professionals was widely cited as influencing over-prescription. (De)prescription of benzodiazepine was facilitated by encouraging the social prescription of health assets or developing strategies to therapeutic alliance processes and better doctor-patient communication.

Conclusion. Our findings suggest that there is a role for the salutogenic approach and the health asset model in the development of a more person-centred clinical care. This study considers the importance of encouraging the use of non-pharmacological methods and techniques in the health system and promoting the creation of multidisciplinary teams, therapeutic alliance processes and better doctor-patient communication by giving professionals training in psychosocial skills.

Keywords. Prescription drugs. Benzodiazepines. Primary health care. Qualitative research.

RESUMEN

Fundamento. La tendencia en la prescripción de benzodiazepinas ha crecido en la última década. España está entre los países donde este tipo de fármacos es el más prescrito por profesionales en Atención Primaria. El propósito de este estudio es identificar factores que podrían estar actuando como barreras y facilitadores en la (des)prescripción de benzodiazepinas desde la perspectiva de pacientes y profesionales sanitarios.

Material y métodos. Estudio cualitativo a través de entrevistas semi-estructuradas con profesionales sanitarios (n=17) y pacientes (n=27), y un grupo nominal con profesionales sanitarios (n=19). Las entrevistas fueron transcritas y analizadas utilizando un análisis temático.

Resultados. El análisis reveló temas claves organizados como barreras y facilitadores conectados a tres dimensiones interrelacionadas: el contexto comunitario y social de la prescripción; la estructura, organización y/o gestión del sistema sanitaria, y la relación médico-paciente. La excesiva carga laboral de los profesionales fue ampliamente citada como influyente en la prescripción excesiva. Acciones como promover la prescripción social de activos en salud o desarrollar estrategias para facilitar la alianza terapéutica y mejorar la comunicación médico-paciente, fueron vistos como facilitadores.

Conclusiones. Los hallazgos sugieren el rol que el enfoque salutogénico y el modelo de activos en salud pueden jugar en el desarrollo de una atención clínica centrada en la persona. El estudio considera la importancia de promover métodos y técnicas de intervención no farmacológicos, la promoción de equipos multidisciplinares y la formación en habilidades psicosociales.

Palabras clave. Prescripción de fármacos. Benzodiazepinas. Atención Primaria. Investigación Cualitativa.

1. Department of Sociology and Social Work. University of Valladolid. Valladolid. Spain.
2. Applied Sociocultural Studies Research Group (SEJ208). University of Granada. Granada. Spain.
3. Andalusian School of Public Health (Spanish acronym EASP). Granada. Spain.
4. Health Research Institute of Granada (ibs.GRANADA). Granada. Spain.
5. Biomedical Research Center Network of Epidemiology and Public Health (CIBERESP). Madrid. Spain.
6. Seville Primary Care Pharmacy Clinical Management Unit. Sevilla. Spain.
7. Department of Health Psychology. University of Alicante. Spain.

Corresponding author:

Jorge Marcos-Marcos
Universidad de Alicante
Departamento de Psicología de la Salud
Edificio de Ciencias Sociales
Campus de San Vicente del Raspeig, Ap.99
03080 Alicante
Spain
E-mail: jorge.marcosmarcos@ua.es

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INTRODUCTION

Benzodiazepine type drugs (BZD) are the most commonly prescribed anxiolytics and hypnotics. Europe is the region with the highest average consumption of BZD in the world^{1,2}, and has shown an increase in BZD prescription since the beginning of the COVID-19 pandemic³. Spain is one of the countries with the highest consumption^{1,2}, and BZD were the third most frequently sold medication in the country in 2019⁴. According to the Spanish Agency of Medicines and Sanitary Devices (AEMPS), the prescription of BZD in primary healthcare (PHC) doubled in 2010-2018⁵. Moreover, Novak et al (2016) also identified Spain as being one of the countries with the highest rate of self-medicated BZD⁶. Two studies published in 2021 reported an increase in the consumption of BZD in Spain^{7,8}.

Therapeutic guidelines recommend the short-term use of BZD for rapid relief of severe anxiety or insomnia when symptoms are incapacitating. *Circular No. 3/2000* from AEMPS stipulated for products whose composition is a BZD or an analogue (zolpidem, zopiclone), that their information sheet should state that the recommended duration of treatment should be as short as possible, not exceeding four weeks for insomnia and eight to twelve weeks for anxiety, including the time necessary to gradually withdraw the medication⁹. Likewise, clinical recommendations such as the *Choosing Wisely initiative* highlight the fact that they are useful for short-term alleviation of symptoms but they should only be used for limited periods¹⁰. This recommendation is shared by the Spanish Society of Family and Community Medicine (semFYC), in its project *DON'T DO practices*, which were subjected to a national scientific debate and took into account the GRADE (Grading of recommendations assessment, development and evaluation) methodology for their development.

The chronic use of BZD causes tolerance and dependence after a few weeks¹¹. Other safety issues were observed: increased risk of mortality (four more deaths per 100 patients in 7-8 years)¹², double the risk of traffic accidents (from 2 to 5-9 accidents per 1,000 people and year of exposure)¹³, and an increased relative risk of pneumonia¹⁴, falls and fractures¹⁵. The use of BZD increases cognitive impairment¹⁶ and dementia¹⁷, and may also be a predictive factor for the development of Alzheimer's disease¹⁸.

Studies carried out in PHC with poly-medicated patients showed that the use of long half-life BZD is the second most frequent cause of inappropriate prescribing in Spain¹⁹, and also flagged up the high frequency of adverse effects identified¹⁸; excessive rates of consumption of many treatments with these psychoactive drugs are inappropriate in terms of indication and/or duration²⁰.

PHC professionals play a fundamental role in the use of BZD, being responsible for 45-76% of prescriptions²¹. The literature on the opinions of professionals in this respect is limited, and few studies have been carried out to holistically explore the behaviors of prescribers and consumers. Literature reviews on the experiences and perceptions of professionals and patients demonstrated how beliefs and attitudes influence decision-making as regards BZD consumption and prescription^{22,23}. Similarly, studies that focused on drug de-prescription emphasized the importance of promoting *social prescribing* linked to a salutogenic approach and a health assets model, in which professionals are encouraged to refer patients to non-medical sources of support in the third sector²⁴, such as social support networks and community, environmental, or human resources²⁵. On the other hand, Smith et al (2019) pointed out the relevance of a person-centered approach (feelings valued and recognized through empathy, communication and respect) in (de)prescription²⁶. Both social prescription and person-centered care have the potential to improve the relational aspects of medical treatment. This indicates that further research is needed to increase knowledge about the best ways for de-prescription, which needs to be conducted in collaboration with patients.

Given the gaps identified and the lack of qualitative research, this study was designed to improve understanding of (de)prescription and consumption of BZD. Specifically, the aim of this article is to identify factors among professionals and patients regarding the consumption and (de)prescription of BZD, and contribute to identify their barriers and enablers.

METHODS

Design and context

A descriptive qualitative study was conducted to provide in-depth data that lead to a better understanding of benzodiazepine (de)prescription

and consumption. The study was carried out just before the pandemic in the city of Granada and its metropolitan area, one of the health districts with the highest consumption rate of benzodiazepines in Andalusia (southern Spain).

The research was carried out sequentially in three complementary stages; the first and the second were performed in parallel by two researchers in the form of semi-structured interviews with patients and healthcare professionals, and the third stage consisted of putting together a nominal group of professionals working in the Andalusian Public Health System.

Participants and procedure

Participants were selected through purposive non-probability sampling given that is a technique widely used in qualitative research for the identification and selection of information-rich cases, identifying and selecting individuals that are experienced with a phenomenon of interest²⁷. To give higher external validity to the process, we tried to minimize any potential selection bias by using independent networks of professionals not linked to the project.

In the first stage, 17 interviews were held with professionals recruited from 10 community primary mental health care (CMH) and PHC units in the Granada health district (Table 1). Professionals were purposely identified by using the following inclusion criteria: experience with BZD prescription and working in community healthcare. Snowball sampling was subsequently used for participants at the start of the study, and they were asked to publicize the study in their professional network.

In the second stage, 27 semi-structured interviews were held with patients (Table 1). The general inclusion criterion was that participants had taken some class of BZD for at least six consecutive months according to their medical records provided by their doctors. We chose to use a temporal criterion because there is no universally accepted definition of high-dose BZD dependence and the risk of dependence is considered to increase over an extended period of three months. The participants were recruited from among patients attending PHC centers in the Granada health district. The research team contacted potential participants in person, identified beforehand by medical professionals according to the criterion of extended pe-

riod of use. In order to increase sample heterogeneity, variables such as level of education, marital status and work situation were taken into account.

Stage three was launched once preliminary analysis of the previous stages had been completed. A nominal group of 19 professionals from different fields: pharmacists (1), hospital managers (3), PHC managers (2), regional health department managers (4), nurses (3), PHC doctors (3), and hospital care doctors (3), was set up. We gave participants a list of statements regarding factors in BZD prescription and consumption in terms of the barriers and enablers identified in previous stages. This technique was implemented in order to compare and contrast the main results from stages 1 and 2, as well as those arising from the literature review carried out beforehand. It followed the logic of a triangulation of sources which endorsed the trustworthiness of research team analysis and led to discussion of results in terms of barriers and enablers, and also their assessment on the basis of relevance and feasibility criteria. The triangulation of sources is a key strategy that include different groups of stakeholder to ensure the credibility of the results²⁸.

The data saturation model was used to determine the quantity of data to be collated because, rather than theoretical saturation, it seems to center on informational redundancy: new data tend to be redundant of data already collected²⁹. For the interviews with professionals this was determined in interview number 12, and for patient interviews in interview number 18. However, in order to enhance the reliability of the procedure, a further five interviews were held with professionals and nine with patients.

The topic guide used as the protocol for interviews was drawn up jointly by two members of the team following a literature review of previous research and current policy. The first two interviews with professionals and patients served as a pilot test. The interviews were facilitated using semi-structured interview guides that consisted of preplanned questions to assist in reminding the data collectors (Table 2). Separate guides were developed for professionals and patients to accommodate their perspective. The interviews lasted between 50 and 90 minutes and took place in healthcare or other settings chosen by participants. All of the interviews in both stages were recorded and then transcribed *verbatim* by staff not linked to the research project; later, they were completed with the interviewer field notes.

Table 1. Characteristics of healthcare professionals and patients

Healthcare professionals (n=17)		Patients (n=27)	
Variables	N (%)	Variables	N (%)
Sex/gender		Sex/gender	
Male	8 (47.1)	Male	20 (74.1)
Female	9 (52.9)	Female	7 (25.9)
Age		Age	
< 30	5 (29.4)	< 30	2 (7.4)
30-45	3 (17.6)	30-39	9 (33.3)
46-60	8 (47.1)	40-49	6 (22.2)
> 60	1 (5.9)	50-60	7 (25.9)
		> 60	3 (11.1)
Practitioner profile		Level of education	
<i>Family Medicine</i>	7 (41.1)	Primary	10 (37.0)
Resident FM practitioner	4 (23.5)	Secondary	9 (33.3)
Psychiatry. Community	3 (17.6)	University	8 (29.6)
<i>Mental Health</i>	2 (11.8)	Work situation	
Resident CMH practitioners	1 (5.9)	Not working/unemployed	10 (37.0)
Community Nursing	1 (5.9)	Working	17 (63.0)
Work Area		Marital status	
Primary Healthcare	12 (70.6)	Single	9 (33.3)
Community Mental Health	5 (29.4)	Married / partner	17 (63.0)
		Widow / widower	1 (3.7)
Area		Residence	
Granada city	7 (41.1)	Granada city	12 (44.4)
Metropolitan area	10 (58.8)	Metropolitan area	15 (55.6)
Years of healthcare experience		Reason for appointment	
< 10	6 (35.3)	Psychological/psychiatric ¹	8 (29.6)
> 10	11 (64.7)	Psycho-social ²	18 (66.7)
		Physical ³	1 (3.7)

Reason for appointment. 1: sleep disorders, anxiety, panic attacks, bulimia, depression, introspective personality (shyness), obsessive-compulsive disorder, fear of public spaces, etc.; 2: unemployment, drug dependency, workplace stress, violent outbursts, cultural expectations (gender roles, achievement/effort ethics), relationship problems, widowhood; 3: chronic illnesses (arthritis, fibromyalgia, multiple sclerosis, etc.), motor disability, etc.

Table 2. Topic guide for interviews

Interview schedule for patients
<ul style="list-style-type: none"> • <i>Experience with anxiety/insomnia problems</i>: How and when you came to perceive anxiety problems. Causes that could have led to discomfort. Coping capacity. Consequences in daily life. • <i>Managing anxiety and insomnia (self-care strategies)</i>: Self-care strategies (pharmacological and non-pharmacological). Reasons for self-care strategies instead of going to the doctor. • <i>Seeking healthcare</i>: Reasons for seeking healthcare. Treatment options for anxiety, insomnia, depression, stress, etc. Time spent attending the health centre. Type of information offered at the health centre to respond to anxiety, insomnia, depression, stress, etc. Remembering the first-time benzodiazepine was prescribed. Prior knowledge of benzodiazepines. Experiences with benzodiazepine consumption. Physical, emotional, social consequences of consumption. Demanding benzodiazepines. Acceptance of other alternatives to consumption. Perception of dependency. Type of therapeutic relationship with the doctor/s. • <i>Beliefs and attitudes about benzodiazepine use</i>: Risk perception. Self-control perception. Opinion on dependency. • <i>Proposals and recommendations for the improvement of care</i>: Opinion on improvements in healthcare with benzodiazepines. A suggestion of models of care.
Interview schedule for practitioners
<ul style="list-style-type: none"> • <i>Prescription of benzodiazepines</i>: Experience in benzodiazepine prescription. Profile of people attending the health centre. Changes in profile in recent years. Prescription frequency. Patient demand. Information provided on consumption. Over-prescription. • <i>Treatment options</i>: Diagnostic criteria for the prescription. Prescription suitability options for benzodiazepines. Alternative options to benzodiazepine prescription. Barriers when considering other therapeutic alternatives. Offering patient treatment options to replace the prescription of benzodiazepines. • <i>Healthcare model and professional practices</i>: Recommendations for improving the quality of benzodiazepine prescription. Knowledge of guidelines for benzodiazepine prescription recommendations. Knowledge of alternative treatments offered in the Public Health Services. • <i>Proposals and recommendations for the improvement of care</i>: Proposals for modification of interventions to improve benzodiazepine prescription. An ideal model of healthcare for people suffering from anxiety, insomnia, stress, etc. Recommendations and strategies to address (de)prescription.

Data analysis

QSR NVivo 11 software was used for the analysis. Thematic analysis was selected as a method of data analysis for the next steps: listening to interview recordings, reading interview transcriptions several times and generating codes, categories and themes³⁰. During the first step of analysis, two members of the team read a portion of the transcribed material and then, in a subsequent step, read the transcripts in full and drew up an initial list of codes. This initial free coding (inductive analysis) was complemented in order to integrate the inductive emergent codes with related terms identified in the literature (deductive analysis). This preliminary comparison of codes served for discussing and agreeing on the coding guide and then interviews were coded and categorized by topic. This categorization was followed by the identification of final themes and sub-themes. After this analytical process, the most relevant analysis units identified as factors relating to BZD (de)prescription and consumption processes were extracted in

verbatim form, and interrelationships between the final topics were identified. This process enabled us to enhance the reliability and inter-code agreement of the analytical process.

Ethical considerations

This research was subject to the ethical standards set out in the Declaration of Helsinki. Given the nature of the study (no risks of harm, no hazards or discomforts) no specific approval from the ethics committee was needed. Thus, the current study follows the internationally accepted ethics in research with human participants of the American Psychological Association³¹. Pursuant to prevailing Spanish legislation (Organic Law 3/2018), all participants involved in the study received information about the study objectives, the institutions responsible and the funding body. All participants voluntarily agreed to participate and informed consent to their participation was signed beforehand. For data anonymization, pseudonyms were used in addition to coding direct identifiers of person information.

RESULTS

Initially, fifteen codes were identified and then categorized by topic. A thematic framework was produced through discussion and negotiation, and the analysis produced a set of nine sub-themes which were organized within three themes: social

context of prescription, the institutional context and its organization, and the physician-patient relational context (Table 3) This framework, in turn, was linked to barriers and enablers identified in the analysis and illustrated by *verbatim* ([supplementary material](#)).

Table 3. Summary of themes and sub-themes identified from interviews

<i>Social context of (de)prescription: biomedical versus socio-economic factors</i>
<ul style="list-style-type: none"> • Pharmacological solution and intolerance of physical or emotional distress • Positive viewpoints on treatment effectiveness • Socioeconomic conditions in the community
<i>Institutional context: structural, organizational and/or management factors</i>
<ul style="list-style-type: none"> • Time available for appointments • Resources and treatment options: social prescription of health assets • Deficit of knowledge and continuous training
<i>Physician-patient relational context: psychosocial and behavioural factors</i>
<ul style="list-style-type: none"> • Distrust of and resistance to (de)prescription • Patient expectations • Professional/patient attitudes: empathetic listening and therapeutic alliance

The social context of (de)prescription: biomedical versus socio-economic factors

Pharmacological solution and intolerance of physical or emotional distress

An opinion shared by professionals and their patients alike, and posited by professionals to justify high prescription levels, was intolerance of physical or emotional distress. Professionals repeatedly referred to increasingly low tolerance thresholds among patients for physical or emotional distress caused, for example, by work or relationship problems, death of a family member, or poor body image. Patients also acknowledged that BZD was easy to get as a quick pharmacological solution. These excerpts below illustrate this view:

People are quick to go to medical practitioners as soon as something in their life bothers them; it's as if we were living in a society where... suffering is also pathologised. (CMH practitioner-10)

It's really easy to get hold of valium or lexatin here. You just tell them your nerves are playing up, and they prescribe it. (PHC patient-7)

Positive viewpoints on treatment effectiveness

The general practitioners (GP) interviewed agreed that BZD should be viewed as a short-term pharmacological solution. Their comments tended to focus on treatment effectiveness and, in the majority of cases, adverse effects were overlooked. There was a clear connection with what patients themselves held to be true. For example, these drugs are effective for treating problems such as insomnia and anxiety, and are also relatively safe. In this respect, the rapid action of BZD emerged as a key consideration when analyzing prescription patterns among medical professionals. The following patient excerpt is also a good example of this point of view:

I could cope with it [work] perfectly well without lexatin, but I take it because I feel calmer and better that way. (PHC patient-3)

So I took a diazepam to relax, to at least fall asleep. You understand? I wake up and I feel just as tired. But diazepam helps me, helps me through the worst times. (PHC patient-11)

Socioeconomic conditions in the community

Although professionals agreed that there is plenty of room for improvement in prescription of BDZ in PHC, they also referred to the need to take into account the social and community setting of clinical practice.

A family GP has to be a good clinician, but ultimately they also need to have a social profile to practice medicine, don't they? We are family and community GPs in a context with social and economic problems. (PHC intern-11)

The idea of medical practice based on experience, rather than formal clinical practice guidelines, was repeatedly remarked on by medical professionals working in neighborhoods with a severe degree of socioeconomic privation, where prescription of BZD is considered a social containment mechanism. One interviewee referred to this as follows:

We are using benzodiazepines as a containment mechanism. I acknowledge this. As a containment mechanism when people are in a situation that causes them stress or anxiety, to stop them from stealing or from going on to other types of drugs. (PHC practitioner-5)

The institutional context: structural, organizational and/or management factors

Time available for appointments

A fundamental point made by professionals was the patient quota and number of appointments they are expected to cover daily, and their increased administrative workload. Excessive workload was directly linked to opting for prescription.

What every patient needs is, on the day they go to the appointment, is that we don't just get asked four questions and given five minutes, but for it to happen like we're doing here and now, less than fifteen minutes for a person who comes to talk about a problem. (CMH patient-17)

I don't believe you can do your job when you have five minutes per patient, it's practically impossible. If someone comes in and says "Hi, I want you to prescribe me X", "OK, here's X", you've

dealt with it in a minute. If you try to find out why they want this medication, you need time. (PHC practitioner-4)

The time available for (de)prescription processes and therapeutic effort was also flagged up in relation to the increase in temporary contracts; professionals have temporary and/or locum contracts that oblige them to regularly move to different catchment areas. Similarly, the majority of patients mentioned the time they are given as an important factor in their experience of the healthcare system, and the effect this has on quality of care.

In my opinion, and I have experience of the temporary contract issue, I think it is necessary to have permanent healthcare staff. When you run a surgery and have been there for fifteen years, and someone comes to see you, or their child, you know perfectly well how to... you know the whole package, don't you? Over time, the package of the family problems and personal problems that they have. (PHC temporary contract practitioner-13)

What any patient would need is that on the day you go there, you don't just limit yourself to four questions and five minutes, but to do something like we are doing here now, less than fifteen so that the person who goes there with a problem, but at least the first or second time, the first and second time you go there, that they listen to you, that they attend to you. (PHC patient-4)

Resources and treatment options: social prescription of health assets

Although some professionals did refer to the use of alternative forms of intervention, many of them said that they were not particularly familiar with other approaches, or mentioned the limited body of proof supporting the effectiveness of non-pharmacological interventions.

GRUSE [PHC socio-educational program] groups have been run occasionally by the social worker, but it was more a case of ticking the box, a target for the health center, and it wasn't that effective. (PHC practitioner-1)

So we also have a certain difficulty in having access to this. And then how to apply it is another key, that is to say, we don't have as much preparation for a social approach because we have never been prepared for it, and then when we have this theoretical knowledge we don't know how to apply it well in the consultations and in the times we have in the consultations. (PHC practitioner-9)

Improvement of the care process was associated with ideas about promoting the social prescription of health assets, creating inter-disciplinary teams and increasing the involvement of social workers, considered a key element in the approach for patients with clinical symptoms requiring prescription of BZD.

The system needs teams which support each other and communicate with each other more, with mental health, with nursing, with social workers (...) Social workers shouldn't be there just to sort out paperwork, but to tell us what associations there are, to see which patients can benefit from these associations and to report on the attitudes and preferences of each patient. (PHC practitioner-6)

For example, to improve this service, that the doctor is not only there for a pill or if you need to fix a paper for the system, but also to tell you that there are these associations, to see which patients can benefit from this association, to relate and inform you about the attitudes and tastes of each one. For example, the typical person who likes hiking, likes to walk, to hike. "There is this association, it will distract you, it will help you to let go of the economic and social problems that you are responsible for". So this kind of training is not given much in the clinics. (PHC patient-18)

I think that before the doctor tells you, "Take these antidepressant pills", the professional should advise you. "Try to do this, change your lifestyle, go to this association or take up these social habits". Before saying, "Take the pills", give you alternatives to avoid the drug. If you can't avoid the drug it will always be there, but try other natural and social solutions first. (PHC patient-6)

There was a generalized perception of the limited quantity of other non-pharmacological treat-

ment options offered by the health system. This view was backed by patients who said that they had asked for other alternatives:

Because other people prescribe pills, my doctor will listen to me, he will hear me and he will give me other resources and not pills. And when I went to the psychiatrist, he didn't even make eye contact, he just wrote... (PHC patient-9)

He's marvelous, and I wish there were many more primary care doctors like him. Because he's given me so many resources, from books, things like associations, to recommending a psychologist. There are a lot of alternatives and I like that. (PHC patient-15)

Deficit of knowledge and continuous training

Professionals also mentioned the need to attend continuous training courses in order to improve their knowledge, particularly as regards de-prescription for poly-medicated patients, alternative therapies and psychosocial skills.

In the majority of cases we don't have sufficient training; we have been trained in PH on how to explain to patients the basic concepts of how to change their behavior, in order, let's say, to reduce their anxiety. We're not trained in this either. (PHC practitioner-12)

In this respect, in view of the limited time they have for attending classroom courses, GPs mentioned increasing the options for acquiring new knowledge via virtual means, and the importance of receiving more training which would equip them better to manage the community dimension of health.

Before we were talking about non-pharmacological alternatives, more psychosocial. In most cases, we do not have training or resources of this type. (PHC practitioner-17)

Going on a continuous training course, that's outside your working day. So yes, there are courses, but most of them, ninety-something percent of them, that's a load on top of your care workload. (PHC temporary contract practitioner-9)

They similarly referred to the importance of knowing how to handle emotions and having tools

for better understanding of “what lies behind the reason for the appointment”. This led some professionals to find out about Gestalt therapy or gender perspective, which was decisive in their becoming aware of the need for a change of focus and finding new treatment alternatives:

I did Gestalt training for three years. It helped me know myself much better, and know other people, not to be scared off by other people's subjectivity... (PHC practitioner-3)

When I started my training in feminism and mental health, the first thing I learnt was the idea of distress as a way of being able to explain women's health problems; this made me reconsider the area of pharmacological prescription. (CMH practitioner-10)

The physician-patient relational context: psychosocial and behavioral factors

Distrust of and resistance to (de)prescription

Professional and patient perspectives also revealed attitudes such as questioning the authority and competence of the doctor, playing down adverse effects or requesting a change of GP. Professionals and patients referred to these areas in terms of power relationships.

It's also about a power struggle with me; getting what they want. Sometimes because they need to maintain the role of sick person for themselves and their environment, because it might benefit them in some way (PHC practitioner-15)

A patient cannot feel inferior, even among doctors; particularly older people who have grown up in the culture of the doctor as all-powerful, you see? (PHC patient-24)

Patient expectations

Many patients mentioned their distress if they went to see their doctor and were not offered a pharmacological solution, as stated earlier. In the opinion of professionals, and as can be seen in the excerpt from an interview below, patient expectations combined with increasing concern for their

satisfaction are clear determinants of the demand, and also of the healing process itself.

Today I saw a particular case in my clinic that made me think: an unresolved conflict leads to somatization, which is the reason for making the appointment and asking for medication, but patient expectations are what dictate the symptom being reinforced or successfully dealt with. (PHC practitioner-8)

In many cases it is true, it is the belief they have: “Well, I have an insomnia problem, an anxiety problem, I know that there are treatments for this and I know that it will solve the problem”. So, effectively, in many cases, they come to you to prescribe something for them and to prescribe them enough so that they don't feel those peaks of panic or those peaks of anxiety that later, it's true, can affect them in their day-to-day life, that can harm them, right? But it is true that they often come directly looking for drugs. (PHC practitioner-14)

Professional/patient attitudes: empathetic listening and therapeutic alliance

Relational aspects of medical treatment, negotiation, empathy and active listening skills were areas that are highly valued by professionals. Similarly, professionals and patients alike had these aspects in mind when talking about the importance of being able to negotiate treatment aims.

If patient mentalities don't change, practitioners aren't going to change much either, because it's a two-way thing, practitioner and patient; we need to work together to find the solution to a problem that affects both of us. (PHC patient-12)

Because if the mentality of the patients does not change, the professionals are not going to change much, because there are always two of us, the professional and the patient, neither one more nor the other less, the two have to be united to solve a common problem. (PHC patient-19)

DISCUSSION

This qualitative study was designed to identify factors that may act as barriers and enablers for the processes of (de)prescription and consumption

of BZD. The analysis reveals barriers and enablers connected to three interrelated dimensions.

Our results highlight how prescription processes for this type of drugs are closely linked to factors beyond purely clinical ones. Previous studies found social determinants of health, such as unemployment or income level, to be key areas when analyzing the behavior of doctors' prescriptions and patients requesting prescriptions at an appointment^{32,33}. This situation causes unease among medical professionals who are aware that they are contributing to the creation of dependency situations, in addition to feeling out of their depth when having to deal with psychosocial issues³⁴.

The organizational context is another structural factor of key importance in care quality. We found professional dissatisfaction caused by excessive workload and lack of time, factors which promote prescription as a treatment option²¹. Patients also considered lack of time related to the quality of care. It connects to inadequate communication between doctors and patients that is linked to false expectations about the benefits and to choosing treatments that might not have been chosen if better information had been available³⁵.

However, our results also reveal significant differences in clinical practice among professionals, not only in terms of their perceptions of adverse effects, but also in terms of their psychosocial skills for active listening, empathy or negotiation, aspects considered by professionals and patients to play a fundamental role in (de)prescription processes.

Similarly, we found that some professionals have implemented alternative forms of psychosocial intervention and social prescription of community assets, highly valued by patients, as shown in the *verbatim*. This finding clearly suggests that the doctor-patient relationship is also mediated by knowledge of and attitudes towards non-pharmacological alternatives among professionals³⁶. This suggests that, when designing interventions, community PHC professionals ought to consider an *asset approach* to health by referring patients to non-medical sources of support in the community^{24,37}. Within the organizational context, our results also highlight the need for integrating medical and social healthcare in inter-disciplinary teams or those forms found to give consistent outcomes in the UK and Australia³⁸. Indeed, interventions tailored to

patient situation give the best de-prescription outcomes, because they reduce the therapeutic burden. This underlines the importance of designing interventions which take into account the characteristics and living conditions of patients.

Our patients gave great value to occasions when clinical practice takes into account the psychosocial areas accompanying the somatization of problems such as insomnia or anxiety. Developing PHC interventions to complement and/or replace pharmacological solutions^{39,40} are endorsed by multifaceted interventions being three times more effective in stopping BZD treatment than no intervention⁴¹, and the effectiveness of psychosocial interventions to treat excessive or chronic BZD consumption^{40,42}.

Our results show that continuous professional training in health education and community development was a significant topic, but it also highlights that the organizational structure and management of the health system leave little room for it. In recent literature there are recommendations for promoting training of medical professionals through Internet-based resources⁴³.

The majority of the patients who took part in our study mentioned the importance of feeling that they are being listened to. This suggests the importance of a therapeutic relationship between patients and their PHC professionals and the development of shared decision-making tools. The available evidence shows that this kind of tool can help patients to feel that they have a say in decisions regarding their diagnosis or treatment⁴⁴. This connects with the idea of therapeutic alliance and person-centered care as regards the relational aspects of medical treatment, which both professionals and patients had in mind when talking about the importance of being able to negotiate treatment aims⁴⁵. Interventions should therefore have multiple components such as counseling, communication, or continuous support.

This study has revealed a set of factors relating to the (de)prescription and consumption of BZD which go beyond purely clinical criteria, shedding light on a series of barriers and enablers for (de)prescription processes in the PHC context studied. It highlights the need to address the processes of (de)prescription, taking into account a wide range of social determinants of health, going beyond aspects relating to the individual responsibility of patients and professionals. Our findings also point to the role that the salutogenic approach and the

health asset model can play in the development of more person-centered clinical care.

In this qualitative study, a thematic framework was produced and linked to barriers and enablers relating to BZD (de)prescription and consumption processes. This framework was organized within nine sub-themes inside three key themes: social context of prescription, the institutional context and its organization, and the physician-patient relational context. The excessive workload of professionals was widely cited as influencing over-prescription. (De)prescription of benzodiazepines were facilitated by encouraging the social prescription of health assets or developing strategies for therapeutic alliance processes and better doctor-patient communication.

Knowledge of relevant barriers and enablers can be used to assist in the development and implementation of programs and policies designed for (de)prescribing BZD. This study encourages the use of non-pharmacological methods and techniques in the health system by a) considering unemployment and income levels of a community when analyzing consumption and prescription processes; b) drafting clinical practice guidelines that more closely match the social reality experienced by professionals; c) promoting the creation of multidisciplinary teams that can implement proposals to connect the clinical practice with salutogenic approaches, and d) developing strategies to facilitate therapeutic alliance processes and better doctor-patient communication. Special attention must be paid over the next few years to the possible impact of COVID-19 on the use of BZD

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Declaration of Competing Interest

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Ethical statement

This research followed the Declaration of Helsinki and the American Psychological Association standards. Approval from the ethics committee was waived. All participants voluntarily agreed to participate and signed informed consent beforehand. Data were anonymized by using pseudonyms and coding direct identifiers of person information.

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