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SUPPLEMENTARY MATERIAL

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 benzodiacepinas: un estudio cualitativo con pacientes y profesionales sanitarios

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Table. Barriers and enablers illustrated by themes, sub-themes and *verbatims*

Barriers
Social context of prescription
Pharmacological solution and intolerance of physical or emotional distress
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)
Alprazolam, everybody has heard of it, people treat it like candy (…) You'd be pushed to find a middle-aged person who hasn't been prescribed a benzodiazepine as part of their routine medication. (CMH practitioner)
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)
Positive viewpoints on treatment effectiveness
I could cope with it [work] perfectly well without lexatin, but I take it because I feel calmer and better that way. (PHC patient)
Benzodiazepines are very effective; it's the same as with anti-depressants, if they're prescribed properly, they're very effective. (CMH practitioner)
Socioeconomic conditions in the community
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 (…) with prolonged alprazolam treatment, at a dose not described in the specifications, i.e. a much higher dose and a posology that is probably unjustified if considered from a different perspective. (PHC practitioner)
In my opinion, and I have experience of the temporary contract issue, I think it 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 intern)

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Barriers
Institutional context and its organization
Time available for appointments
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, or you try to explain to them why they're feeling the way they are, or even set out the reasons for not stopping the prescription, you need time. (PHC practitioner)*
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; at least the first or second time we're seen, we should be heard out. (CMH patient)
Resources and treatment options: social prescription of health assets
Now I'm seeing a *young woman [psychologist, private practice]. I've had two sessions with her, early days yet, but unless you can afford it, or you can't cope any more (…) In the public health system, all you get is pills, but I need a psychologist. (CMH patient)*
I think that before doctors say to you "Take these anti-depressants", they should give you advice. Give you alternatives so you don't have to take drugs. Drugs are always going to be available, but try other natural and social remedies first. (PHC patient)
Deficit of knowledge and continuous training
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. It's an extra. (PH intern)*
I did Gestalt training for three years. It helped me know myself much better, and know other people, to not be scared off by other people's subjectivity … (PHC practitioner)
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)
In the majority of cases we don't have sufficient training; we have been trained in PH how to explain to patients the basic concepts of how to change their behaviour, in order, let's say, to reduce their anxiety. We're not prepared for this either. (PHC practitioner)
Physician-patient relational context
Distrust of and resistance to (de)prescription
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)*
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)
Patient expectations
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*)

Enablers
Social context of prescription
Socioeconomic conditions in the community
Here (*poor neighbourhood), we're starting to measure the rates of benzodiazepine prescription, right? And yes, we're quite a way above average, OK? It was one of the centres which most prescribed benzodiazepines. (PHC practitioner)*
A family GP has to be a good clinician, but ultimately they also need to have a social profile to practise medicine, don't they? We are family and community GPs. (PHC intern)
Institutional context and its organization
Resources and treatment options: social prescription of health assets
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 (PHC practitioner)* *My doctor is marvellous*; I wish there were more primary healthcare doctors like him. Because he's offered me a lot of resources, from books to things I can do for myself. (PHC patient)
Physician-patient relational context
Professional/patient attitudes: empathetic listening and therapeutic alliance
You have to *explain why to patients; you have to persuade them and build up a relationship of joint responsibility with patients (PHC practitioner)* *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).