



BZ USE AND MISUSE IN ADDICTION TREATMENT SETTINGS

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OUTLINE

- Role of Bzs in the Treatment of Anxiety
- Rates of Anxiety in Substance Using Populations
- Impact of Untreated Anxiety in Substance Users
- Impact of BZ Use in Substance Using Populations
- Under-use of non-medication alternatives for anxiety in substance users?

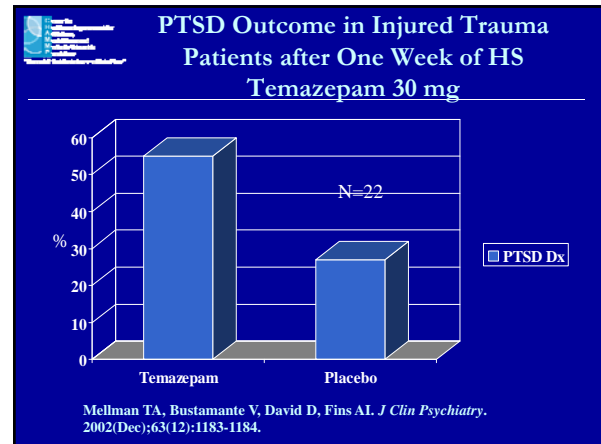
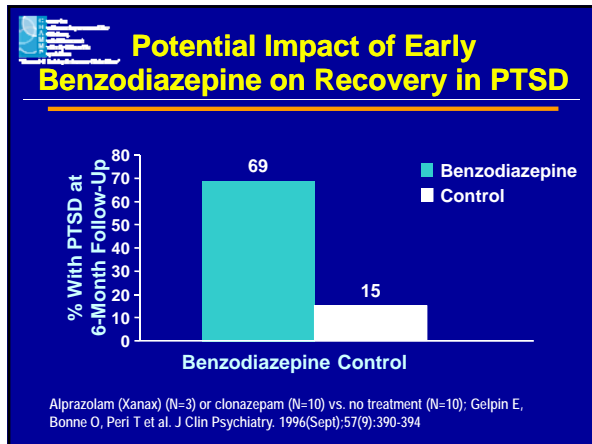


ROLE OF BZS IN THE TREATMENT OF ANXIETY



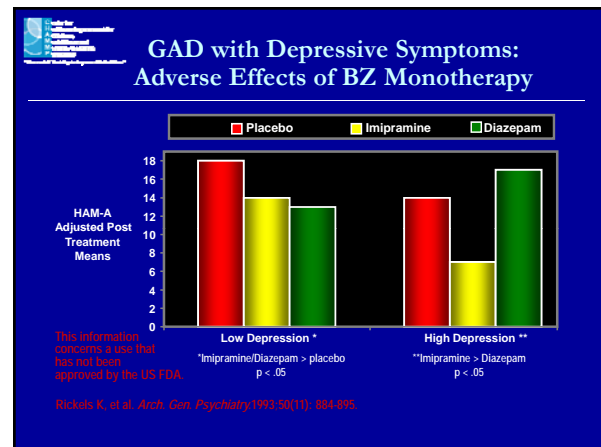
Bzs: Spectrum of Efficacy in the Anxiety Disorders

- Well-established short and longer term efficacy in: Panic Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder
- Efficacy in these disorders is COMPARABLE to antidepressants
- No efficacy for Obsessive Compulsive Disorder or PTSD (and could worsen outcome in PTSD)
- Thus, BZs not ALWAYS indicated or effective for "anxiety"—it depends on the source of anxiety!



Bzs: Efficacy in Major Depression

- BZs do not work as monotherapy for depression and could aggravate outcomes even in more depressed GAD patients
- BZs added to antidepressants provide greater symptom reduction on INITIAL treatment
- No studies to show value of adding BZs to depressed patients with residual anxiety symptoms (this is probably the most reasonable way to use)



Cognitive-Behavioral Treatment (CBT): An Alternative to Medication?

- Extremely effective for all five of the major anxiety disorders
- Also effective for depression
- COMPARABLE efficacy to medications (and greater for OCD and possibly PTSD)
- Underutilized due to limited availability of trained experts
- Therapist may say they are doing it but often many don't really do it i.e. they are providing nonspecific "relaxation" or other coping techniques

Anxiety Treatment Recommendations

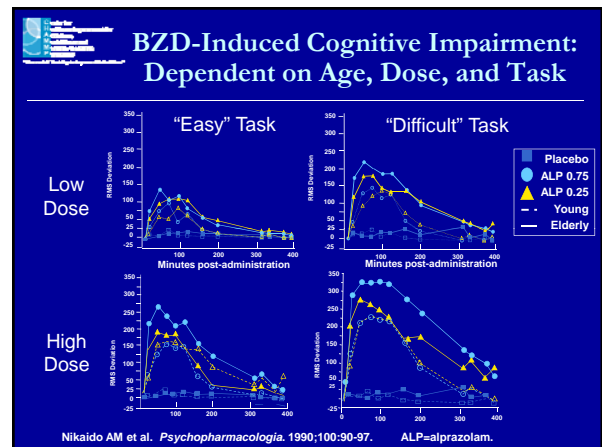
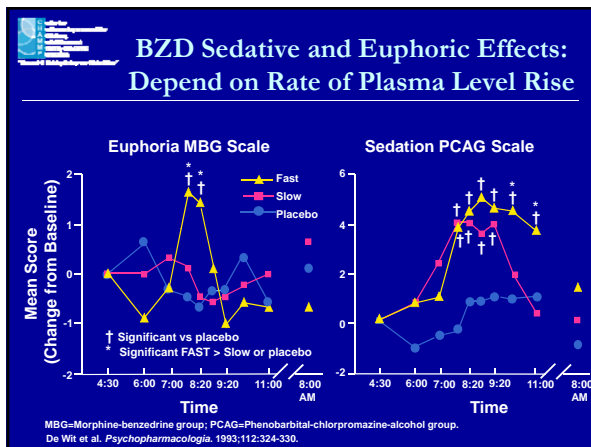
- Antidepressants are considered as primary/first-line treatments due to high depressive comorbidity and lower long term adverse risks. BZs are most often used as adjunctive agents added to AD
- It is likely that more adjunctive or singular use of CBT would substantially reduce use of BZs
- BZ risks, while not substantial, are greater on balance than risks of SSRIs

Benzodiazepines: Major Adverse Effects

- Abuse liability
- Sedation
- Psychomotor impairment
- Cognitive impairment (retrograde amnesia)
- Physiologic dependence/withdrawal
- Interference with Behavioral Therapy?

Benzodiazepines and Abuse

- Benzodiazepines abuse is rare (<1%) in anxious outpatients (Rifkin et al 1989; Garvey and Tollefson 1986)
- Benzodiazepine abusers usually (>90%) have a coexistent drug or alcohol abuse problem (Busto et al 1996; Wilkinson et al 1987)



Benzodiazepine: Risks of Fall in Elderly

- Increased with short half-life BZDs (but short half-life confounds potency with half-life)
- Increased with high dose
- Falls also increased with SSRIs for unclear reasons (odds ratio 1.8)¹
- SSRI fall rate close to that of BZDs in one study²

BZDs=benzodiazepines; SSRIs=selective serotonin reuptake inhibitors.
¹Thapa PB et al. *N Engl J Med*. 1998;339:875-882.
²Mendelson WB. *Sleep*. 1996;19:698-701.

BZ Dependence

- Not “addiction” but physiologic dependence similar to what occurs with other chronically administered medications
- More severe with higher dose, longer duration, more severe anxiety, panic disorder, anxious personality traits or personality disorder, and faster taper
- Slow careful tapers (over 3-6 months) along with CBT principles increases likelihood of success

Can BZs Adversely Impact the Efficacy of Behavioral Treatments?

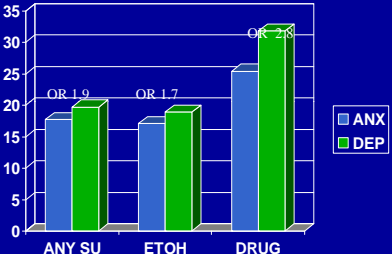
- Old literature suggests BZs may impair desensitization to specific phobias
- Uncontrolled studies suggest BZ use is associated with increased anxiety sensitivity since patients improve with BZ cessation (Fava et al 1994)
- Westra et al (2002) show prn BZ users have poorer CBT outcome than non-users or regular users
- As needed (prn) use of BZs is often employed in addition to regular dosing by users
- PRN use reduces self-efficacy (reinforces pill taking as a coping mechanism) and interferes with stress tolerance by linking anxiety contexts with BZ intake (Westra and Steward 2002)

RATES OF ANXIETY IN SUBSTANCE USING POPULATIONS

The Anxiety-Substance Use Link: Nonrandom Association

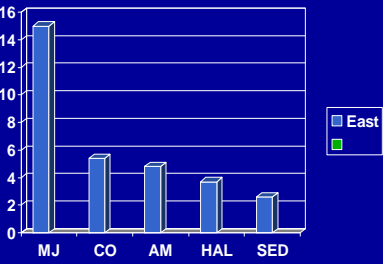


High 12 month Rates of Anxiety and Depression in Substance Use: NESARC



Grant et al Arch Gen Psych 61:807-816, 2004

Drug Use Disorders in Patients with Anxiety Disorders: NESARC




Conway et al: J Clin Psychiatry 67:247-257, 2006

Higher Rates of Anxiety and Depression in Clinic Patients


- Any Anxiety 80%
- Any Depression 63%
- Agoraphobia 48%
- Social Anxiety Disorder 52%
- Generalized Anxiety Disorder 22%
- PTSD 23%

Bakken et al: BMC Psychiatry 7:29, 2007




Substance Abuse and Anxiety: Which is the Primary Problem?

- “Self-medication” of anxiety (usually with alcohol, sedatives, or opiates) results in secondary substance abuse
- Primary substance abuse gradually results in secondary anxiety (most often with alcohol, stimulants, and perhaps hallucinogens)
- Many individuals with this comorbidity probably have elements of both




IMPACT OF UNTREATED ANXIETY IN SUBSTANCE USERS




Does Untreated Anxiety Have Adverse Effects in Substance Users?

- Anxiety disorder at baseline predicts relapse in alcoholics (Kushner et al 2005)
- GAD increases progression from first drink to dependence (Sartor et al 2007)
- SAD reduces treatment adherence and AA attendance (Book et al 2009; Terra et al 2006)
- Panic/Ag predicts readmission after alcohol detoxification in those with two or fewer prior admissions (Tomasson and Vaglum 1998)




Does Untreated Anxiety Have Adverse Effects in Substance Users?

- Anxiety sensitivity increases MJ use (Bonn-Miller et al 2007)
- Alcoholics with panic more likely to abuse Bzs and opiates (Jenson et al 1990)
- Paroxetine treatment of SAD does NOT improve drinking outcomes (Thomas et al 2008)




BOTTOM LINE

- There is some scattered evidence that untreated anxiety may have adverse effects on treatment adherence and/or outcome in substance users
- However, there is no clear evidence that anxiety treatment will improve these poor outcomes, though very few studies have been done




IMPACT OF BZ USE IN SUBSTANCE USING POPULATIONS



Impact of BZ Use in Dual Diagnosis Medicaid Patients

- 203 NH Medicaid followed 6 years
- 43% at least one Bz prescription
- Half had stopped Bz by study end
- 48% Sub Use Disorder remission in both Bz users and non-users
- Bz users had increased symptoms and more likely to develop Bz abuse (15% vs 6%)


Brunette et al, Psych Services 54: 1395-1401, 2003



BZ Prescription in SMI Medicaid: Effects of Substance Use Disorders


- Over 5 years, patients with co-morbid substance use disorder 8-17% higher rates of BZ use
- In addition, these patients had higher BZ doses
- Use of fast acting high potency BZs greater only for MDD and “other” psychiatric diagnosis (not Schiz/BP)

Clark et al, J Clin Psychiatry 65:151-155, 2004




BZ Use in Substance Using Populations: Older Data

- Pasternak and Mueller 2001—”There is little evidence to indicate that a history of substance abuse is a major risk factor for future BZ abuse or dependence. Furthermore, BZs do not appear to induce relapse of substance abuse in these patients”




BZ Use in Opiate Using Patients

- BZs enhance euphoric properties of opiates in animals and humans
- Surveys show that 50-90% of opiate addicted patients use BZs (Fatseas et al 2009)
- Methadone patients using BZs have higher methadone doses (Bramness and Korner 2007) and more opiate-positive urines (Brandds et al 2008)
- Patients can be sorted into “hedonic” and “therapeutic” motivations (Fatseas et al 2009)




BOTTOM LINE

- The risk of BZ use in recovering substance abusers, while clearly evident, is not overwhelmingly large
- It's possible risk may be much greater with use of certain substances (opiates)
- In the absence of more evidence, a reasonable conclusion would be to avoid whenever possible, but not to absolutely prohibit in select cases
- But keep in mind: BZs may retard the effects of CBT (and possibly other self-help or self-activation therapies) in some cases



Alternatives to BZs in Anxious Substance Use Patients Refractory to ADs

- CBT specific to the anxiety disorder
- Behavioral activation/exercise (emerging evidence these are anxiolytic)
- Mindfulness-based techniques (focus on acceptance?)
- Combination pharmacotherapy using non-BZ medications (second AD, atypical neuroleptic, anticonvulsant)?



FINAL THOUGHTS

- Our culture has come to believe there is a drug for everything
- We are increasingly less self-reliant and less prone to try to help ourselves or feel responsible for ourselves (the “cult of the victim”)
- There is a ceiling on the beneficial effects of self-reliance and self-activation, but many patients do not come close to this ceiling
- However, when a patient clearly has tried mightily, we should not withhold a potentially beneficial medication

