

THE BASICS ON SUBSTANCE USE AND SERIOUS MENTAL ILLNESS

BENZODIAZEPINES AND OTHER SEDATIVE HYPNOTICS

PART 1: BASIC FACTS

Description: Sedative-hypnotic agents include barbiturates, benzodiazepines (lorazepam, diazepam, clonazepam, alprazolam), nonbenzodiazepine hypnotics (eszopiclone, zolpidem, and zaleplon), and orexin receptor antagonists (suvorexant, lemborexant, and daridorexant). Benzodiazepines are commonly used in the acute management of stimulant or hallucinogen withdrawal, management of anxiety and sleep, and to manage alcohol withdrawal. Sedative-hypnotics may also be used off-label as adjunctive treatments for mood and psychotic disorders (including catatonia) and other conditions. In addition to being obtained legitimately by prescription, these medications may be sold on the street. Street alprazolam for example is relatively common and may have a variety of “street names” including zannies, Z-bars, bricks, bars, and zanbars. Illicit alprazolam and other substances now may contain fentanyl or its other potent opioid analogues that exacerbate the risk of unintentional potentially fatal overdose.¹

Prevalence: Similar to other substance use, sedative (most commonly benzodiazepine) misuse is more common among individuals with SMI compared to the general population.² Benzodiazepines are commonly prescribed for anxiety and insomnia among the general population and those with SMI. The population with SMI, for reasons below, may misuse their benzodiazepine prescriptions, as evidenced by taking medication inconsistently, overusing medication, and sharing medication with friends or relatives. Individuals with SMI may also develop a dependency to sedatives/benzodiazepines, either as a preferred drug or in combination with other addictive substances; however, this is less common than prescription misuse in this population.

Reasons for use: These medications can be helpful in relieving anxiety and sleep difficulty. Misuse of these medications may be due to the temporary relief of various psychiatric symptoms in the short-term.

Problems related to use in people with SMI:

- ⦿ **Effect on the brain and body:** Benzodiazepines or sedatives provide relief through their interaction with various receptors in the brain (i.e., gamma-aminobutyric acid (GABA) and orexin receptors). Most individuals exposed to prescribed benzodiazepines regularly, and for prolonged periods, will develop some degree of physical dependence. All patients that are physically dependent on benzodiazepines or sedatives will develop benzodiazepine withdrawal symptoms if they were to stop after prolonged exposure. For instance, if an individual with SMI has anxiety and receives benzodiazepines long-term, and then stops or runs out of the medication or significantly reduces the dosage, that person may experience benzodiazepine withdrawal symptoms. Withdrawal from benzodiazepines presents similarly to alcohol withdrawal symptoms, and is commonly associated with increased anxiety, shakiness, and other related discomfort. As with alcohol withdrawal, individuals who are withdrawn from prolonged use of relatively high doses of benzodiazepines carry risk for seizure and delirium tremens (DTs), which can be fatal if not properly treated. These risks are greater in elderly patients.
- ⦿ **Effects on symptoms:** Individuals with SMI may be prescribed benzodiazepines and other sedatives to alleviate psychiatric symptoms. Under medical supervision and monitoring, these can offer relief and be helpful.

- ⦿ **Effects on medications:** Combining benzodiazepines with certain psychiatric medications can result in patients being overly sedated (and carry risk for overdose if used with opioids as well). A side effect of benzodiazepines and sedatives may include impaired concentration and memory, disinhibition, and can result in confusion in some instances. Safety discussions should be held around risks for falls and fractures in elderly patients, and increased risk for motor vehicle accidents if operating while taking sedatives, particularly in those with other CNS depressants.
- ⦿ **Effects on substance use disorders:** Individuals with SMI are at greater risk for developing substance use disorders (SUDs) generally, including sedative use disorders, and comprehensive substance use screening is necessary. Other substance use (i.e., opioids) with benzodiazepine or other sedative misuse can lead to further destabilization and carry risks of overdose through respiratory depression. Individuals who misuse sedatives such as benzodiazepines are at greater risk of misusing or becoming addicted to other substances. In addition, although some individuals with stable substance use disorders can use prescribed benzodiazepines safely, others find that even small amounts of benzodiazepines trigger enough euphoria that they are more likely to relapse into use of other substances as well. Therefore, benzodiazepine prescription in individuals with substance use disorders should be only initiated after very careful consideration, and always monitored closely for evidence of co-occurring substance use.

PART 2: SCREENING AND INTERVENTION

For individuals with SMI, it is important to not only identify whether the person is using substances, but also to describe the pattern of substance use, whether the substance use is causing harm, and the degree to which the individual is in control of the substance use. Some individuals will have patterns of harmful use that are “in control” and do not meet criteria for the diagnosis of SUD. For individuals with a chronic psychiatric disability, any persistent substance use is likely to be harmful, even if there is no obvious intoxication or lack of control, as the substance use can interfere with the person’s fragile brain equilibrium. Other individuals may have patterns of “out of control” substance use that are consistent with moderate to severe SUD. These require different levels of intervention. **Once substance use is identified, the assessment should inquire –for each type of substance - about the pattern of use: experiences and perceptions of harm because of that use pattern and the degree to which the individual experiences control – or lack of control – over that use.**

| Brief Guide to Screening:

- A. Screening requires practice.** Developing a “welcoming” style to facilitate screening takes practice. It is a common concern that the person you are interviewing will not want to talk about their substance use, and that they might not tell the truth. In fact, most people who use substances talk about their substance use all the time; they just don’t think it’s a good idea to talk to you! How can you convey to the person you are screening that you would be a good person with whom to talk to about their substance use? The key is in the concept of welcoming. If you are genuinely open when the person shares their substance use with you (rather than disapproving or disappointed) they will be much less likely to conceal information. But it takes practice to do that, and to balance the fact that you don’t recommend that they use substances with welcoming the opportunity to discuss their substance use openly. Remember that you can’t help them make better choices if they don’t discuss their choices at all.
- B. Screening works best when it is integrated into the person’s story.** Pulling out a “screening tool” and asking questions one after the other often feels less personal and reinforces the person’s natural inclination to say “no” to all the questions, just to get the painful process over with. Using a tool is helpful for the interviewer to remember things to ask about, (and not to forget what to ask), but the art of doing this is to work the questions into the flow of the story so that the person can progressively feel more comfortable sharing (and that areas where the person is uncomfortable sharing can be more clearly identified). Some clients may feel more comfortable answering questions on a screening form, rather than face to face, but many will not.

- C. Screening for sedative use, including misuse of prescribed sedatives such as benzodiazepines, should be routine in all services delivering care to those with SMI.** Sedative misuse screening is always embedded in a broader approach to substance use screening. Remember, SUDs are more prevalent among the population with SMI compared to the general population, and misuse of multiple substances is common.^{2,3} See [this resource](#) for various screening tools and processes that include screening for benzodiazepine.

| Brief Guide to Intervention:

How you talk to people who indicate they are misusing benzodiazepines and other sedatives is always based in a framework of welcoming, empathic, hopeful partnership and needs to be matched to the individual's stage of change for sedative use as well as their personal goals for a happy, meaningful life (recovery goals).⁴

For instance, if an individual is in the precontemplation stage about benzodiazepine or other sedative misuse, the focus is on helping them move into the contemplation stage, that is to develop enough trust to engage in discussions about their substance use, so they can work in partnership with the team over time (often months) to make better decisions. The most important thing you can do is to maintain a welcoming strength-based relationship, which increases their ability to eventually discuss their substance use more freely. If the person is in the contemplation stage (or beyond this stage), then it is helpful to provide a recommendation of elimination of all substance misuse (without struggling with the person), and while indicating that the most important goal is to help the person make the best decisions for themselves), maintain the option of making progress in tiny steps (as opposed to abstinence being the only goal) and providing awareness of treatment options including how the mental health team can provide support for making even small steps of change. Note that when the person with SMI is misusing prescribed medications that are controlled substances such as benzodiazepines or combining the prescribed medications inappropriately with other substances like alcohol, the option of continuing the prescription can be contingent on working hard to take the medication only as prescribed, and without combining it with other substances. This allows the team to work in partnership with the person to help them continue the medication safely if that is an important goal. Conversely, if the person demonstrates that they are unable to use the medication safely, then the goal of the team is to work collaboratively with the person to slowly taper the medication safely. The more information the person has about how the team can help support efforts to change, the more prepared they can be when they are ready to make a change to their substance use. More information is available [here](#) about Stages of Change and matching interventions with each stage.

Example vignette: Meeting of the mental health care team and a person with SMI misusing prescribed benzodiazepines. The team is taking an approach with consideration of stages of change and using a motivational interviewing approach.

Case: This individual is diagnosed with schizoaffective disorder and marijuana use disorder in remission. She has persistent auditory hallucinations on her current dose of antipsychotics. She was prescribed Klonopin 0.5 mg three times daily for anxiety about one year ago. At first, she seemed to be taking the medication as prescribed, reporting that it helped her. Recently, she came to the clinic twice saying she ran out of her prescription early. She stated she "needed" the Klonopin, and is asking for early refills, and a higher dose. The team engages her in a conversation about it, as follows:

Mental health professional (MHP) or any team member: *Hi, it's great to see you. I understand that you came in today again because you ran out of your Klonopin early. What's going on?*

Individual: *It's not working like it used to. I probably took a little extra, and I ran out. I mean it's no big deal, right. Why don't you just give me more?*

MHP: *I totally understand. We know how hard you've been working to manage your voices, and to not use marijuana. You've been doing a fantastic job. This is such hard work for you.*

Individual: *Yeah, so I've earned more Klonopin, right?*

MHP: *I don't know whether more Klonopin is right for you, or not. The mental health team who is working with you to reach your goals gets super concerned about you (or anyone) who takes more Klonopin than they are prescribed, or who starts to feel like the prescription isn't working like it used to. Do you know why we're worried?*

Individual: *Because you think I'm an addict, right?*

MHP: *No. We are concerned because we care about you, and we don't want you to be doing anything with any medication that might make your situation worse. Here's the deal, you have a history of marijuana use. That dependency is still sitting in your brain, so you are at risk of losing control of any addictive substance. Also, Klonopin will make your anxiety better for a while, and then when it wears off, your anxiety may start to get worse. Then, you take more, and the cycle can repeat, and then trigger your craving for other substances. Given that your brain is already having a hard time being stabilized, we don't want anything to happen that will make your brain worse.*

Individual: *I don't know. I think it helps me. I think I just need more of it. Don't make me suffer!!!*

MHP: *We absolutely do not want you to suffer! You're already having a hard time. We also don't want to do anything that might create a problem for you. I have a thought you may want to consider, are you interested?*

Individual: *Sure.*

MHP: *First, I know the doctor will not change your medication when you have been misusing it. When you are on a potentially addictive substance and you want a change in dose, it's especially important that you take it exactly as prescribed and discuss with the doctor whether a change is needed. Does that make sense?*

Individual: *Well, yeah, but I'm scared to talk to the doctor. What if she says no?*

MHP: *We will help you talk to her, but if she says no, then, you and she (and the team) need to keep working with you till we find strategies that help, both medications and non-medication strategies. We are right there with you. Do you want part 2 of the thought to consider?*

Individual: *Okay.*

MHP: *Let's get you back on track with your existing dose and help you to keep track of your anxiety on a daily basis. We can help you keep a log for a week, so we really understand what you are going through. Then, we can discuss this with the doctor and see what she wants to do. That way, we help you to be clear about what you are experiencing, and she is more likely to have a plan to help. We can also work with you on skills to manage anxiety without overusing your prescriptions. Does that make sense?*

Individual: *Yeah, but it sounds like hard work. Can't you just give me more pills? Don't you care about me?*

MHP: *If we didn't care about you, we would give you any old thing you asked for and we wouldn't care if it hurt you. It's because we care that we want to take the time to help you with this. And as a reminder, as the doctor told you last time, if you keep misusing the Klonopin, or if you start getting high on top of it, she will have to start to taper it, and we don't want you to have to go through that. This way, you keep the dose, AND we come up with the best plan to help you with your anxiety.*

Individual: *Thanks. I kind of know you're right. I appreciate that you guys do care and are willing to work with me.*

PART 3: TREATMENT OPTIONS

Note that if an individual were to have severe benzodiazepine use disorder, it would be appropriate to discuss what options are available to help, including medications and psychotherapy. The options below are presented in professional language. In presenting these options to an individual, you would tailor the language.

There are currently no FDA-approved **medications** for sedative use disorder. Rather, treatment must include careful consideration of the patient's readiness to change and plan for reducing use and/or cessation. Benzodiazepine withdrawal syndrome can be seriously risky, and in rare instances life threatening, just like alcohol withdrawal and each person undergoing withdrawal should be evaluated for what's most clinically appropriate in regard to the person's level of control, the speed of the dose reduction, use of longer-acting benzodiazepines in taper plans, and level of care (inpatient versus outpatient) based on risks of benzodiazepine withdrawal and medical comorbidities.

Behavioral Therapies are a form of psychosocial interventions that assists an individual with building self-management skills for managing triggers, cravings, and risky situations, as well as skills for creating a support system (professionals, family/friends, peers) and using that support system by regularly asking for help.

Recovery Support Programs are peer led programs that provide extra support to individuals who are ready for change and looking to practice abstinence from the use of substances. These programs are typically delivered through community and faith-based groups by way of mutual support meetings.

SUD Treatment Groups or Programs are professional supervised programs within outpatient, inpatient, and residential settings. These could be referred to individuals that may benefit from professional stage-matched group interventions.

Comprehensive Integrated Care is often indicated since individuals with SMI and comorbid substance use often have poorer medical outcomes and require care coordination for management of mental health, substance use and medical illnesses. Treatment plans should be individualized to each individual's unique needs and may include medication, counseling or therapies, mutual support groups, and additional psychosocial interventions.

References

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