COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

3.4 PARAMETERS FOR THE USE OF ANXIOLYTIC MEDICATIONS

October 2014

I. GENERAL CONSIDERATIONS

A. Definition:

Anxiolytic medications referred to in this parameter include most benzodiazepines (excluding midazolam), buspirone, SSRIs/SNRIs, isocarboxazid, tranylcypromine, pregabalin, and gabapentin. These medications have indications for treatment of one or more anxiety disorders.

B. Optional Use as One Component of Treatment:

Anxiolytic medications may be tried as one component of treatment of clinically significant anxiety in a wide variety of mental disorders, including:

1. Adjustment disorders
2. Anxiety disorders
3. Depressive and bipolar disorders
4. Sleep disorders
5. Select substance-induced mental disorders
6. Mental disorders due to general medical conditions
7. Psychotic disorders

C. Caution Regarding Substitution in place of other medications:

1. Anxiolytic medications should not be substituted for proper use of medications that are generally recognized as effective treatments of first choice for specific mental disorders. Examples include:

    a. Antipsychotic medications: Psychotic disorders and acute treatment of mania in bipolar disorders

    b. Antidepressant medications: Depressive episodes occurring during mood disorders and psychotic disorders, panic disorder, social anxiety disorder obsessive compulsive disorder, symptoms of attention deficit hyperactivity disorder

    c. Mood stabilizing medications: Manic episodes occurring during bipolar disorders and prophylaxis against mood episodes in bipolar disorders

    d. Psychostimulant medication: Symptoms of attention deficit hyperactivity disorder

2. Anxiolytic medications should not be substituted for proper use of other forms of psychotherapies that are recognized as effective for specific mental disorders. Examples include:

a. Brief cognitive and insight-oriented psychotherapies for adjustment disorders, and

b. Cognitive and behavioral psychotherapies: phobic disorders, obsessive-compulsive disorder, generalized anxiety disorder.

D. Caution re Use in Individuals with Mental Disorders Associated With Excessive Use of Medications:

Benzodiazepines should generally not be prescribed to individuals with mental disorders that are associated with excessive use of medications. When prescribing anxiolytic medication for such individuals, quantities should be limited and follow up examination should be frequent and well documented. Examples of such disorders include:

1. Borderline personality disorder
2. Antisocial personality disorder
3. Somatization disorder
4. Substance use disorders

E. Conditions in which Benzodiazepines Should Generally NOT Be Prescribed:

1. Cognitive Impairment: Benzodiazepines should generally **not** be prescribed to individuals with mental disorders that are associated with cognitive impairment. Examples include delirium, dementia, amnesiac disorder, and intoxication with alcohol and sedative-hypnotic medications. When prescribing anxiolytic medications for such individuals, assessment of cognitive function should be frequent and well documented.

2. Individuals in whom unimpaired cognitive and psychomotor function is critical: Benzodiazepines should generally **not** be prescribed to individuals in whom unimpaired cognitive and psychomotor function is critical. Examples include individuals who may be expected to be operating motor vehicles or other heavy machinery. When prescribing anxiolytic medications for such individuals, assessment of cognitive and psychomotor performance should be frequent and well documented.

3. Individuals who are taking other medications that may interfere with cognitive function or psychomotor performance. Benzodiazepines should generally **not** be prescribed to individuals who are taking other medications that may interfere with cognitive function or psychomotor performance. Examples include sedating antidepressant medications, sedating antipsychotic medications, and sedating anticonvulsant medications.

F. Other Cautions:

1. Caution should be exercised when prescribing anxiolytic medications for prolonged periods to individuals with mental disorders that are usually time-limited or usually respond to treatment reasonably quickly (e.g., adjustment disorders and sleep disorders). Such individuals should be assessed for

signs of substance dependence and the assessment should be well documented. Attempts to gradually withdraw the anxiolytic medication should likewise be well documented.

2. Use of alprazolam should be avoided except for treatment of panic disorder that does not respond to antidepressant treatment.

3. Use of gabapentin should be avoided except when all other anxiolytics documented as ineffective or contraindicated, as clinical data on efficacy are limited.

4. Benzodiazepines should be prescribed to older adults only after examination and only in the absence of any significant cognitive impairment and in the absence of significant risk for falls.

II. ANXIOLYTIC MEDICATION DOSAGES

1. Dosage schedules of anxiolytic medications should be determined by clinical situation.

2. Trials of anxiolytic medications should be at dosages generally recognized as effective, unless untoward effects prevent this. In such cases, the individual should be switched to a different anxiolytic medication.

3. Patients should be maintained at the lowest effective dose, and efforts to ascertain the lowest effective dose should be well documented in the clinical record.

4. Buspirone should not be prescribed at doses higher than 60 mg. per day. The rationale and assessment of patients in whom higher doses are prescribed should be carefully documented in the clinical record.

5. Benzodiazepines should not be prescribed at doses higher than 30 mg. per day of diazepam, or the equivalent. The rationale and assessment of patients in whom higher doses are prescribed should be carefully documented in the clinical record.

6. Alprazolam should not be prescribed at doses exceeding 8 mg. per day in panic disorder. The rationale and assessment of patients in whom higher doses are prescribed should be documented carefully in the clinical record.

7. Clonazepam should not be prescribed at doses exceeding 8 mg. per day in panic disorder. The rationale and assessment of patients in whom higher doses are prescribed should be carefully documented in the clinical record.

III. MULTIPLE CONCURRENT ANXIOLYTIC USE

Only one anxiolytic medication from any single class should be used at any one time.

IV. USE IN GENERALIZED ANXIETY DISORDER

1. Buspirone or SSRIs/SNRIs should generally be the drugs of first choice for treating generalized anxiety disorder.

2. Benzodiazepines should be reserved for use with patients for whom other anxiolytics are ineffective or contraindicated. The reasons for long-term use of benzodiazepines should be carefully documented in the clinical record.

3. Doses above 30 mg. of diazepam or the equivalent should not be used without careful justification in the clinical record.

4. Attempts to gradually decrease the dose of benzodiazepines at least every 6 months should be documented in the clinical record.

5. Evidence-based psychotherapies, especially cognitive-behavioral psychotherapies and biofeedback, should be additionally considered and should generally be part of treatment.

V. USE IN PANIC DISORDER

1. SSRIs/SNRIs should generally be the medications of first choice for treatment of panic disorder.

2. Benzodiazepines should be used only when treatment with SSRIs/SNRIs is contraindicated, not effective, or poorly tolerated.

3. Individuals being treated with benzodiazepines should be assessed for symptoms of withdrawal that may occur between doses and the dosage schedule should be adjusted accordingly.

4. Attempts to gradually decrease the dose of benzodiazepines at least every 6 months should be documented in the clinical record.

5. Evidence-based psychotherapies, especially cognitive-behavioral psychotherapies such as systematic desensitization, should be considered for symptoms associated with panic disorder and agoraphobia.

VI. USE OF ANXIOLYTICS IN SLEEP DISORDERS

1. Individuals with complaints of difficulty initiating or maintaining sleep, or poor quality of sleep should be carefully assessed for the presence of a variety of dyssomnias, including breathing-related sleep disorders and substance-induced insomnia. This assessment should be well documented in the clinical record.

2. Benzodiazepines may be used as one component of treatment of insomnia due to other mental disorders, but should not be substituted for instruction about sleep hygiene coupled with the proper use of medications that are recognized as effective for specific mental disorders that may be the cause of the insomnia. Attempts to gradually decrease the dose of benzodiazepine should be frequent and well documented in the clinical record.

3. Benzodiazepines may be used to treat primary insomnia only as a part of a regimen that includes instruction in sleep hygiene. Attempts to gradually decrease the dose of benzodiazepine should occur at least every 6 months and be well documented in the clinical record. Non-benzodiazepines with hypnotic properties and minimal addictive potential should be preferentially used for patients with primary insomnia for whom benzodiazepines are contraindicated due to general medical conditions or increased potential for misuse.

4. Benzodiazepines may be a component of treatment for a number of other sleep disorders, including circadian rhythm sleep disorders and night terror. Response to benzodiazepine in these disorders should be carefully documented in the clinical record.

5. Benzodiazepines are contraindicated in the presence of breathing related sleep disorders. They should be prescribed with caution in individuals with risk factors for these disorders, and only after careful assessment that is well documented in the clinical record.

VII. USE OF ANXIOLYTIC MEDICATIONS IN OTHER DISORDERS

1. Benzodiazepines may be used to treat severe anxiety during acute psychotic episodes and during manic episodes.

2. Benzodiazepines may be used to treat severe anxiety during intoxication with amphetamines, cocaine, and hallucinogens.

3. Benzodiazepines should generally be avoided when treating individuals intoxicated with alcohol, opioids, or sedative hypnotics. When benzodiazepines are prescribed in such

cases, careful documentation of the rationale and assessment should be placed in the clinical record.

4. Benzodiazepines may be used to treat clinically significant anxiety and insomnia that occur during withdrawal from a variety of substances, including alcohol, benzodiazepines, cocaine, amphetamines, and opioids.

5. Benzodiazepines are contraindicated for treatment of PTSD, due to the associated high potential for misuse and the lack of evidence for efficacy.

6. Benzodiazepines may be used to treat clinically significant anxiety associated with depressive and bipolar disorders, if antidepressant treatment is not effective in reducing anxiety.

VIII. LABORATORY MONITORING

Laboratory monitoring of individuals taking anxiolytic medications should be determined by the clinical situation, including type of medication, health risk factors, duration of treatment, concurrent general medical condition, concurrent medications, and laboratory monitoring of medication presence and levels. Monitoring should be consistent with the 3.7 Parameters for General Health-Related Monitoring and Interventions in Adults