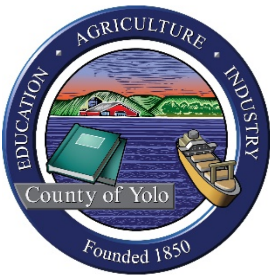

COUNTY OF YOLO

HEALTH AND HUMAN SERVICES AGENCY

POLICIES AND PROCEDURES

SECTION 5, CHAPTER 11, POLICY 002-E

ATTACHMENT E – PARAMETERS FOR THE USE OF ANXIOLYTIC MEDICATIONS

A. General Considerations

1. Anxiolytic medications referred to in these parameters include most benzodiazepines, buspirone, nefazodone, SSRIs, venlafaxine, isocarboxazid, tranylcypromine, pregabalin, and gabapentin. These medications have indications for treatment of one or more anxiety disorders.

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

   i. Adjustment disorders,

   ii. Anxiety disorders,

   iii. Mood disorders,

   iv. Sleep disorders,

   v. Select substance-induced mental disorders,

   vi. Mental disorders due to general medical conditions, and

   vii. Psychotic disorders.

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

   i. Antipsychotic medications: psychotic disorders and acute treatment of mania in bipolar disorders.

   ii. Antidepressant medications: depressive episodes occurring during mood disorders and psychotic disorders, panic disorder, social phobia, obsessive compulsive disorder, and symptoms of attention deficit hyperactivity disorder.

   iii. Mood stabilizing medications: manic episodes occurring during bipolar disorders and prophylaxis against mood episodes in bipolar disorders.

   iv. Psychostimulant medications: symptoms of attention deficit hyperactivity disorder.

4. 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:

    i. Brief cognitive and insight-oriented psychotherapies for adjustment disorders.

    ii. Behavioral psychotherapies for phobic disorders, obsessive-compulsive disorder, and generalized anxiety disorder.

5. Benzodiazepines should generally not be prescribed to individuals with mental disorders that are associated with abuse 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:

    i. Borderline personality disorder,

    ii. Antisocial personality disorder,

    iii. Somatazitation disorder, and

    iv. Substance use disorders.

6. Conditions in which benzodiazepines should generally NOT be prescribed:

    i. Benzodiazepines should generally NOT be prescribed to individuals with mental disorders that are associated with cognitive impairment (e.g., delirium, dementia, amnesic 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.

    ii. Benzodiazepines should generally NOT be prescribed to individuals in whom unimpaired cognitive and psychomotor function is critical (e.g., 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.

    iii. Benzodiazepines should generally NOT be prescribed to individuals who are taking other medications that may interfere with cognitive function or psychomotor performance (e.g., sedating antidepressant medications, sedating antipsychotic medications, sedating anticonvulsant medications).

7. 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. 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 be well documented. Examples include adjustment disorders and many sleep disorders.

8. Use of alprazolam should be avoided except for treatment of panic disorder due to a higher likelihood of developing substance dependence with this benzodiazepine.

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

B. 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. Clients should be maintained at the lowest effective dose, and efforts to ascertain the lower effective dose should be well documented in the medical record.

4. Generally, buspirone should not be prescribed at doses higher than 45 mg per day. The rationale and assessment of clients in whom higher doses are prescribed should be carefully documented in the medical record.

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

6. Generally, alprazolam should not be prescribed at doses exceeding 12 mg per day in panic disorder. The rationale and assessment of client in whom higher doses are prescribed should be carefully documented in the medical record.

7. Generally, clonazepam should not be prescribed at doses exceeding 8 mg per day in panic disorder. The rationale and assessment of clients in whom higher doses are prescribed should be carefully documented in the medical record.

C. Multiple Concurrent Anxiolytic Use

1. Only one anxiolytic medication should be used at any one time.

D. Use in Generalized Anxiety Disorder (GAD)

1. Buspirone or venlafaxine should generally be the drugs of first choice for treating GAD.

2. SSRIs and other newer antidepressant medications should be used when buspirone or venlafaxine are ineffective or contraindicated.

3. Benzodiazepines should be reserved for use in clients in whom other anxiolytics are ineffective or contraindicated. The reasons for long-term use of benzodiazepines should be carefully documented in the medical record.

4. Doses above 30 mg per day of diazepam should not be used without careful justification in the medical record.

5. Attempts to gradually decrease the dose of benzodiazepines at least every six (6) months should be documented.

6. Cognitive-behavioral psychotherapies, including biofeedback, should be additionally considered and should generally be part of treatment.

E. Use in Panic Disorder

1. Newer antidepressants (SSRIs, SNRIs) should generally be the medications of first choice for treatment of panic disorder.

2. Alprazolam or clonazepam should be used only when treatment with newer antidepressants is contraindicated, ineffective, or poorly tolerated.

3. Individuals 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 six (6) months should be documented.

5. Cognitive-behavioral psychotherapies, including systematic desensitization, should be considered for associated symptoms, including agoraphobia.

F. 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 medical record.

2. Benzodiazepines may be used as one component of treatment of insomnia due to other mental disorders, but should not be substituted for proper use of medications that are recognized as effective for specific mental disorders. Attempts to gradually decrease the dose of benzodiazepine should be frequent (generally, monthly) and well documented.

3. Benzodiazepines are a treatment option for primary insomnia, and should be part of a regimen that includes instruction in sleep hygiene. Attempts to gradually decrease the dose of benzodiazepine should occur at least every six (6) months and be well documented. Other hypnotic agents should be preferred in clients with primary insomnia in 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 medical 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 medical record.

G. 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 in the medical 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.

H. Laboratory Monitoring

1. 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 conditions, concurrent medications and laboratory monitoring of medication presence and level. Monitoring should be consistent with those in Attachment H – Parameters for General Health-related Monitoring and Interventions in Adults of this Policy.