Benzodiazepine Guidelines and Documentation

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Abstract

Background: Benzodiazepines present significant risks to clients if they are not safely and properly prescribed. Community Services Northwest is a community mental health agency that sought to improve its prescribing practices of these medications. Methods: Guidelines for the prescribing of benzodiazepines were created and disseminated among staff. A new documentation format was created to improve the documentation of prescribing decisions and the use of the format in new client intakes was tracked for two separate data periods. Qualitative interviews were done between periods to assess the ease and usefulness of the format. Results: The guidelines were approved by the Medical Director and will be used by the student PMHNP preceptor to train new students. Use of the documentation format did not meet expectations during data collection periods but was felt to be useful by the majority of the LMP's. Conclusions: The prescribing of benzodiazepines in the United States is under increasing pressure to be reduced and it is difficult to change provider prescribing practices, but improving documentation of practice decisions can be a way to initiate small changes that lead to improved practice.

Benzodiazepine Guidelines and Documentation

Benzodiazepines are one of the most commonly prescribed psychiatric medications in the United States and many other parts of the world (Kurko et al., 2015). Despite long standing concerns in the psychiatric community (Lader & Russell, 1993) about the effectiveness and safety of the long-term use of these medications, their widespread use persists. Although effective in treating anxiety in the short term, their ability to treat it in the long-term is still debated (Otto et al., 2010). There are additional concerns about their safety, including risks associated with tolerance, abuse, dependence, psychomotor impairment, cognitive decline, and the development of dementia (Kurko et al., 2015; Lader, 2011). Since diazepam was the most prescribed drug in the United States (1968 to 1982) (Lader, 2011), there has been increasing concern about the risks of long-term usage of this class of medications despite them continuing to be prescribed at high rates (Olfson, King, & Schoenbaum, 2015). The psychiatric community has long been concerned about these medications and many current professional organizations recommend only the short term use of these medications for a maximum of four weeks (Kurko et al., 2015).

While users can develop tolerance to some of the side effects that increase risk of harm, like sedation, other side effects such as impaired coordination, learning, and memory do not remit via the development of tolerance (Lader, 2011). There is also increasing concern that long-term use of these medications increases the risk of developing dementia (Zhong, Wang, Zhang, & Zhao, 2015). Other recent research has found associations between benzodiazepine use and increased mortality (Kripke, Langer & Kline, 2012). Thus, there is increasingly more evidence that the long-held concerns about the long-term use of this class of medications are justified.

At the Medical Services Department (MSD) of Community Services Northwest (CSNW) there has been concern expressed by providers and the medical director that the current policies and documentation of benzodiazepine prescriptions need to be reassessed. Many current benzodiazepine prescriptions need to be reassessed yet many attempts to change benzodiazepine prescriptions have been met with resistance from many clients. However, simpler quality improvement initiatives need to be done before attempting to implement massive changes in current policies. Since the MSD has not engaged in any quality improvement in the past it was necessary to start with the very basics for this project in the attempt to introduce improvement concepts without generating resistance. The goal of the project was to generate prescribing guidelines tailored for the agency and then improve documentation of benzodiazepine prescribing decisions so the agency can then assess if they want to develop additional initiatives to improve provider prescribing.

Thus, the initial part of the project will be to develop agency specific guidelines based on a review of the literature which can be used as a reference for LMP's. The second part the project will be to improve documentation of clinical decision making when prescribing benzodiazepines with clear clinician rationale and plan for future use. In much of the current documentation it is not known what the providers rationale is, and before changes can be made to improve this rationale it must be established how decisions are made. The use of this new documentation format will be tracked and data gathered to assess clinician compliance with the new format and provide baseline data for improving clinical decision-making and developing feedback for the LMPs.

Methods

This project was conducted at CSNW located in Vancouver, Washington. CSNW is one of the two main community mental health agencies for adult clients with Medicaid insurance in Clark County, Washington. The agency has a variety of chemical dependency, mental health therapy, case management, and psychiatric services. The MSD provides pharmacotherapy to over 650 clients of the agency and is staffed by the medical director (a psychiatrist), two full time psychiatric mental health nurse practitioners (PMHNP), two part time PMHNPs, three registered nurses and currently three student PMHNPs. The department has very few strict policies regarding documentation or prescribing that all providers need to follow. Instead the medical director allows each provider to practice and document based on their own style and philosophy as long as it is within community and professional standards, but there is a general agreement that the department needs to improve the prescribing practice for benzodiazepines.

Intervention

The first phase of the project was the development of the guidelines for prescribing of benzodiazepines. The development of guidelines is a common method used to influence LMP practice and prescribing (Smith, 2000; Grimshaw et al., 2004). The guidelines can then be used to assess LMP behavior as the agency develops new policies as well as to train new staff. The CSNW guidelines were developed based on an already existing document used by Lifeworks Northwest (2016). The format of this document was used as a template but expanded and specialized for use at CSNW. Extensive literature searches were done to ensure evidence based decisions and recommendations from several international professional organizations guidelines for the treatment of anxiety disorders were utilized.

The second phase of the project asked all the LMP's to change their documentation in the initial psychiatric evaluation for all intakes that are prescribed benzodiazepines. Each LMP was

provided with a notecard with documentation changes to put on their desk to remind them to use the new format. Reminders are a frequently used and studied tool to implement changes in practice (Grimshaw et al., 2004). At the end of each LMP note there was a list of problems that have an attached comment and plan. In the problem section the client's benzodiazepine use was described in one of three ways: short term benzodiazepine use less than 6 months, long-term benzodiazepine use less than 2 years, or chronic benzodiazepine use greater than 2 years. In the comment section the LMP documented the client's (1) rationale for use, preferably based on diagnosis, (2) concerns about specific risks, and (3) client's thoughts/feelings about their use. In the plan section the LMP documented the (1) rationale for starting, increasing, decreasing, or not changing the current benzodiazepine dose or type, (2) as specific as possible description of the long-term plan for use, and (3) any additional resources offered to, or to be done by, the client to assist in reduction of benzodiazepine use. This created seven data points per note that were collected and analyzed over two separate time periods. The first was from February 28th to March 20th comprising 15 working days and the second was from April 2nd to April 20th comprising another 15 working days. The LMP notes of all clients who completed intakes during those time periods were reviewed to see if a benzodiazepine was prescribed and if the LMP complied with the new documentation requirements. In between these time periods each LMP was interviewed to assess their thoughts about the process and possible changes or improvements.

The data that was collected from reviews of the client electronic charts and no client data was recorded or assessed. Data from all intakes documented during the collection period was grouped together and converted to an aggregate score of percentage of intakes where the guidelines were used (charts with guidelines used/total charts reviewed), the total percentage of

intakes with 100% documentation (charts with 100% documentation/total charts reviewed), and percentage of documentation compliance for all charts (total number of correct documentation points/(number of charts review * 7)). The initial goals for the project, for each LMP and the entire department were 40% of intakes with 100% of data points documented and 60% of all data points documented in all selected charts. It was also hoped that there would be an improvement in documentation compliance between the two data collection periods.

Results

The benzodiazepine prescribing guidelines were completed and approved by the medical director. The dissemination of educational information on its own has rarely been show to significantly affect LMP behavior (Grimshaw et al., 2001) and the literature that specifically looks at changing prescribing practices of benzodiazepines has found similar results (Pimilott et al., 2003; Zermansky et al., 2001; Berings, Blondeel & Habraken, 1994). However, due to the culture of this agency and its providers, attempting to provide feedback on prescribing behavior using an audit and feedback method (Ivers et al., 2012) (Obrien et al., 2007) would have generated significant resistance at this time. Thus, the document will serve as a guide for LMPs and a useful resource for students training at the agency and any newly hired LMP's. Below is a brief summary of the guidelines.

Benzodiazepine Guidelines

For all clients taking benzodiazepines the MSD has a set list of expectations. They should be actively engaged with their therapist with few no shows to appointments, do not appear to be overly sedated or cognitively impaired due to their benzodiazepine, do not request early refills, do not obtain benzodiazepines from another LMP, let the CSNW LMP know about all other medications they are taking, and agree to random UDS's if requested by their LMP.

The agency decided that the approved short term indications, for less than one month, are largely based on standard practice in the community such as brief situational anxiety (ex. dental work or flying) and agitation due to psychosis or mania. Additional reasons with more empirical validation are severe distress during the initiation of a SSRI or SNRI (Canadian Psychiatric Association, 2006), brief insomnia (Sateia, Buysse, Krystal, Neubauer, & Heald, 2017); (American Academy of Sleep Medicine, 2017), and catatonia (Penland, Weder, & Tampi, 2006).

The approved indications based on a review of several international guidelines on the treatments of anxiety based diagnoses for the long term use, greater than one month, were for the diagnosis of panic disorder with or without agoraphobia (American Psychiatric Association, 2009); (Canadian Psychiatric Association, 2006); (Royal Australian and New Zealand College of Psychiatrists, 2003), treatment resistant generalized anxiety disorder with severe distress (Canadian Psychiatric Association, 2006); (National Institute for Health and Care Excellence, 2011), treatment resistant social anxiety disorder with severe distress (Canadian Psychiatric Association, 2006); (National Institute for Health and Care Excellence, 2013b), or akathisia (Resende Lima, Soares-Weiser, Bacaltchuk, & Barnes, 2002).

Strong contraindications for the use benzodiazepines are clients who are pregnant or breast feeding (The Royal Australian College of General Practitioners, 2015), those who are actively abusing substances (Posternak & Mueller, 2001); (Jones & McAninch, 2015); (The Royal Australian College of General Practitioners, 2015), or those with acute PTSD (National Institute for Health and Care Excellence, 2005); (Guina, Rossetter, DeRhodes, Nahhas, and Welton, 2015).

The guidelines also include a section addressing special situations where the prescribing of benzodiazepines needs modification, additional caution, client education, or monitoring. This

includes when the client was undergoing methadone (Chou et al., 2014), buprenorphine treatment (Renner, Levounis & LaRose, 2018), or if they are using prescription opioids for the long term or short term (Dowell, Haegerich, & Chou, 2016); (Park, T. W., Saitz, R., Ganoczy, D., Ilgen, M. A., & Bohnert, 2015); (Sun et al., 2017); (Yarborough et al., 2016). Concurrent use of benzodiazepines and psychostimulants is generally contraindicated (A. Burt, personal communication, February 2nd, 2018); (G. MeCouch, personal communication, January 17th, 2018). Additional attention and consideration is also encouraged for clients with a history of substance use disorder in remission (Wolitsky-Taylor, Operskalski, Ries, Craske & Roy-Byrne, 2011); (Ciraulo & Nace, 2000); (McHugh, 2015), clients over the age of 65 years old (The Royal Australian College of General Practitioners, 2015), or with a history of a traumatic brain injury Rothschild, Shindul-Rothschild, Vihuera, Murray, & Brewster, 2000).

These guidelines are not intended to be a complete reference document for the LMP's but two additional elements were added to the document to assist in appropriate prescribing of benzodiazepines: a benzodiazepine equivalency table and a summary of guidelines for the treatment of diagnosis where benzodiazepines are often used. The treatment of psychiatric illness encompasses a variety of interventions and while nurse practitioners have variable amounts of training in psychotherapy they are expected to be knowledgeable about treatment options other than medications. It is often just as important to decide not to prescribe a medication, as it is to prescribe one. Most nurse practitioners in community mental health are expected to exclusively provide medication services and not engage in therapy with clients (Stein, 2012). This is the expectation at CSNW and the state requires all clients who we prescribe medications have access to, and attend, regular therapy. It is important for the LMP's to encourage therapy and know when that is the best treatment option for the client rather than medications. Thus, the summation

was included at the end of the guidelines on recommended psychotherapies and pharmacotherapies for the treatment for panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, social phobia, post traumatic stress disorder, and specific phobia. This information was taken from professional guidelines from the United States, the United Kingdom, Canada, and Australia and New Zealand.

Benzodiazepine Documentation

The second phase of the project was the change in documentation of initial benzodiazepine prescriptions during psychiatric intakes. This phase of the plan was presented in a treatment team meeting and each of the LMP's and students at the agency were provided with 3x5 inch reminder cards that concisely listed the new documentation expectations. In total there were one full time psychiatrist, one full time PMHNP, two part time PMHNP's, and three NP students that had the potential to use the new documentation format when doing intakes on new clients. While the expectation for the project was to have the LMP use the documentation only on new client's some of the participants used it on established clients, however this was not tracked as part of this data gathering period but was reflected in some of the follow up interviews after this first round of data collection.

During the period of February 28th through March 20th all intakes were analyzed to see if the client was prescribed a benzodiazepine and if the LMP used the new format. During this time period, which was 15 working days, there were a total of 35 intakes completed with four clients started on benzodiazepines. Of the four intakes only one (25%) had 100% compliance with the new documentation protocol. For the three main areas of documentation the compliance varied. For the Problem area there was 2 of 4 (50%) data points completed, for Comment there was 7 of 12 (58.3%) data points completed, and for Plan there was 5 of 12 (41.7%) data points completed.

For all data points for the four charts there was a cumulative 14 of 28 (50%) data points completed. The goals for completed documentation were not met during this first round. Only 25% of the intakes had 100% documentation, which did not meet the goal of 40%. For all data points there were 50% completed which fell short of the goal of 60%.

Five people were interviewed after the first round of data was collected about the documentation process, the medical director with more than 20 years of experience, full time PMHNP with over 20 years of experience, one part time PMHNP with less than a year of experience and three students. Since the documentation was started and continued outside of the specific data tracking time, more LMP's had experience with using the new documentation format that was officially captured in the data, thus everyone had experience using the new format.

Of the three people who did use the format on a new client they agreed that the format was easy to use and did not feel that the extra documentation was repetitive or added a significant increase in typing or time compared to normal documentation. One participant said "it was simple…it didn't add anymore to what I was doing." All of these people had the provided documentation outline card taped to their computer monitor so they would remember to use the format. For the LMP that did not use the format at all, they said the reason they failed was that although the card was on their desk they forgot to use it because they are in a hurry to finish their documentation.

When asked about the format in general and if it was helpful there was a notable difference between the responses of the experienced providers and the new LMP's. The two experienced providers said they already think through all of these steps when starting or continuing a benzodiazepine prescription and the format did not improve or assist in their

thought process. Conversely all the new LMP's felt that it was helpful and improved how they thought about the issues surrounding the prescribing of these medications and presenting them to the client. One said it was helpful "organizing my thoughts about what my decision was" while another said it "helped guide my thoughts about what I wanted and needed to say."

When asked if this new format adds any value to there was consensus about the improved value. The medical director said it would not be beneficial to him in any way but felt that it would be if someone else took over care of one of his clients. The other experience provider expressed similar thoughts but added that experienced providers "often don't document all their thinking and even sometimes struggle to even verbalize why their making their decisions," and that this would then be more helpful to someone else who was following up with the client rather than for herself because she knows her internal thought process. Similarly, the less experienced providers felt that the greatest value this added to the charting was the increased detail and improved communication provided to an LMP who would follow up with the client. They emphasized the value of having the extra details of if the short and long-term plan, or additional resources, were discussed with the client, as well as knowing what the client's previous thoughts about their use of benzodiazepines were.

When asked if this new documentation process would improve patient care most of the LMP's felt that it would. The medical director again reiterated that it would only be beneficial if an LMP other than the client's main provider was reading the chart and seeing the client. The other experience LMP stated that she thought this documentation was "significantly relevant to our practice" but was not sure if it would improve client care. All of the less experienced practitioners felt that it would improve patient care primarily by making sure this level of detailed conversation about benzodiazepines was occurring at the initial and future visits.

At this point in the project it appear that the majority of the LMP's felt that the documentation change was beneficial despite documentation of all data points being done by only one person. Despite this, after an interview none of them felt that they had any difficulty doing the documentation or that it was to onerous for them to complete, with the exception of the medical director who made a plan to improve his documentation by placing the documentation reminder card in front of his computer.

During the second period of April 2nd through April 20th all intakes were analyzed to see if the client was prescribed a benzodiazepine and if the LMP used the new format. During this time period, which was 15 working days, there were a total of 33 intakes completed with two clients started on benzodiazepines. Of the two intakes 0 had 100% compliance with the new documentation protocol. For the three main areas of documentation the compliance varied. For the Problem area there was 1 of 2 (50%) data points completed, for Comment there was 4 of 6 (66.7%) data points completed, and for Plan there was 2 of 6 (33.3%) data points completed. For all data points for the four charts there was a cumulative 7 of 14 (50%) data points completed.

The goals for completed documentation were not met during the second round. None of the intakes had 100% documentation, which did not meet the goal of 40%. For all data points there were 50% completed which fell short of the goal of 60%. Thus, there was no quantitative improvement in the documentation data from round one to two, with a decline in compliance of charts that had 100% documentation. The second round of data collection had less clients prescribed benzodiazepines and they were both done by the senior staff members. The psychiatrist and senior PMHNP both started one client on the benzodiazepine. The psychiatrist started one client in the first round of data collection and did not use any aspect of the new format. For the client in the second round he only included the rationale and the client's thoughts

in the Comment section of the documentation. The senior PMHNP completed 71% of the data points in both the first and second rounds.

Discussion

This goal of this project was to improve the documentation of benzodiazepines at a community mental health agency as part of a broader goal of improving the prescribing practices of these medications. All of the LMPs agreed to participate in the project and initially agreed that it was worthwhile to change the documentation standards. Unfortunately, there was limited data collected during either of the two periods due to the infrequency of the prescribing of these medications. What data was able to be gathered showed moderate compliance with the new documentation standards and no objective improvement from one period to the next.

However, from a qualitative improvement perspective the project was successfully because the majority of the LMPs genuinely attempted to use the new standards, expressed agreement that it would improve practice, and began to expand the use of the format outside of the parameters being tracked for the project. The senior PMHNP and her students changed the documentation of benzodiazepines for existing clients and not just new clients to the agency. While this didn't show up in the objective data, it does give confirmation of the staff's stated interest in the value of the project.

Going forward the LMP's have decided to modify and continue to use the new documentation format on all current and future notes for clients being prescribed benzodiazepines. The new format is currently being used for 22% of all clients that are prescribed benzodiazepines and this will slowly increase as its use is expanded to existing clients. Also, because clients frequently request refills on medication instead of, or prior to an existing appointment, additional information on the refill recommendations the LMP wants the

nursing staff to follow will be added to the plan section of the documentation to ensure good communication and proper usage of these medications.

The benzodiazepine prescribing guidelines that were developed were initially meant to be implemented by the LMPs and then compared to their practice. This did not happen and would have been difficult to study because improving the clarity of documentation was a primary first step and even in the completed new documentation a clear rationale wasn't always included. However, going forward the senior LMP who embraced the project stated that she would use the guidelines as an educational tool for her students and thus it may guide practice decisions in the future.

This project was limited by the amount of objective data collected and the lack of data that showed improvement in the amount of compliance with the documentation data points. Benzodiazepines were only prescribed for 8.8% of intakes done at the agency during the data collection periods, even though approximately 23% of the agencies clients are currently prescribed benzodiazepines. This small number gave a small sample pool in which to measure improvement from one period to the next. A better design would have been to initially collect baseline data on old benzodiazepine prescriptions against the data points of the new format and then compare these to the data points documented after the LMPs were asked to use the new format to see if there was an increase in the concepts of proper documentation.

In the initial conceptualization stages of the project the goals was to find a way to change the prescribing practices of the LMPs of the agency and this quickly proved to be an unrealistic goal. However, at the end of the project the senior PMHNP's desire to use the developed guidelines in the future training of her students provides a more realistic way to improve LMP prescribing of benzodiazepines. This would provide the opportunity in the future to use the

developed guidelines and documentation to educate students and track their compliance with the agency standards. Student knowledge could be assessed prior to staring the clinical rotation and then reassessed afterwards to see if there is an increase in knowledge and confidence in prescribing this potentially dangerous class of medications.

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Appendix A

Community Services Northwest Benzodiazepine Prescribing Guidelines

Community Services Northwest Benzodiazepine Treatment Guidelines

Despite benzodiazepines being one of the most commonly prescribed medications in the United States and the world, considerable controversy remains on when, how, and to whom they should be prescribed. While they are very effective anxiolytics there is significant concern about their safety in specific populations and in combinations with other medications. In order to minimize the risks to our clients, the Medical Department at CSNW, has developed these guidelines to promote safe and responsible prescribing practices.

These guidelines primarily apply to the use of benzodiazepines as an anxiolytic agent. Benzodiazepine use as a hypnotic, for agitation in clients with psychosis, or behavioral control for clients with intellectual disabilities may follow some but likely not all of these recommendations.

Requirements for all clients taking Benzodiazepines

Be actively engaged with a therapist with a minimal amount of no shows.
Client should not demonstrate signs of sedation or cognitive impairment during sessions.
Client does not request early refills. Lost medication or prescriptions will not be replaced.
Client will not obtain benzodiazepines from another LMP.
Client will let their LMP know about the use of any other medications they are taking.
Client will agree to random UDS as requested by their LMP.

Psychiatric Indications for Short Term Use (less than 1 month)

Situational anxiety – dental work, MRIs, flying on planes, etc.
Severe distress during the initiation of treatment with SSRI's or SNRI's
Insomnia, in conjunction with sleep hygiene education
Agitation due to psychosis or mania
Catatonia

Psychiatric Indications for Long Term Use (greater than 1 month)

Panic Disorder, with and without agoraphobia
Treatment resistant generalized anxiety disorder with severe distress
Treatment resistant social anxiety disorder with severe distress
Movement Disorders (akathisia)

Contraindications for Benzodiazepine Use

Clients who are pregnant or breast-feeding.
Clients with active substance abuse, including alcohol.
Acute PTSD and generally are not indicated for chronic PTSD.

Special Considerations and Recommendations

Methadone Treatment – Concurrent use of benzodiazepines and methadone is very strongly contraindicated.[14] If necessary, benzodiazepines should be prescribed and monitored by the LMP that prescribes the client's opiates. LMP's at CSNW will not prescribe benzodiazepines for any client receiving methadone.

Buprenorphine Treatment - Concurrent use of benzodiazepines and buprenorphine is very strongly contraindicated.[13] If necessary, benzodiazepines should be prescribed and monitored by the LMP that prescribes the client's opiates. LMP's at CSNW will not prescribe benzodiazepines for any client receiving buprenorphine.

Long-term Opioid Use - Concurrent use of prescription opiates and benzodiazepines increases a person's risk of intentional and unintentional overdose, emergency department visits, and death.[10, 11] In 2016 the FDA started placing boxed warnings on all opiates and benzodiazepines warning of the serious risks of taking these medications at the same time.[15] The two medications can be used together but this should be done with extreme caution. Client's showing signs of sedation or cognitive impairment will have their use of these medications re-evaluated. The client needs to have an active release of information for the LMP prescribing them opiates.

Short-term opioid Use - Concurrent use of prescription opiates and benzodiazepines increases a person's risk of intentional and unintentional overdose, emergency department visits, and death.[10, 11] In 2016 the FDA started placing boxed warnings on all opiates and benzodiazepines warning of the serious risks of taking these medications at the same time.[15] If the client needs opioid medications for acute pain they need to let their LMP at CSNW know at their next appointment. Depending on the circumstances the client may need to sign a release of information for the LMP prescribing the opioids.

Psychostimulant Treatment – CAUTION. Concurrent use of psychostimulants and benzodiazepines is contraindicated due to the potential for their intended actions to counteract each other.

History of Substance Use Disorder – EXTREME CAUTION. The client should be in full-sustained sobriety for 12 months and their primary diagnoses verified after 6 months sobriety. The client should exhibit active engagement with primary providers, with few no shows or treatment concerns for 6 months. First-line, non-benzodiazepine pharmacological therapies should first be attempted during a period of sobriety.

Client Over 65 Years Old – CAUTION, due to risk of cognitive impairment, falls, and motor vehicle accidents. Because of reduced metabolism and risk of side effects doses should be lower than those used in younger adults.

Traumatic Brain Injury - CAUTION, due to risk of disinhibition and cognitive impairment.

Benzodiazepine Equivalents and Recommended Doses

Generic Name	Equivalent Doses[8,9]	Potency[9]	Usual Range of TDD[9]	High Range of TDD[9]
Alprazolam	0.5mg	High	0.5-4mg/day	4mg/day
Clonazepam	0.5mg	High	1mg/day	4mg/day
Diazepam	10mg	Medium	4-40mg/day[12]	40mg/day
Lorazepam	1mg	High	2-6mg/day	10mg/day
Temazepam	20mg	Low	7.5-30mg/day	30mg/day[12]
Triazolam	0.5mg	High	0.125-0.25/day	0.5mg/day[12]

Summary of Professional Guidelines for Pharmacological Treatment of Specific Anxiety Disorders

Panic Disorder, with or without agoraphobia

General Recommendations - NICE (2011) states that therapy should be used first for most clients.[2] Benzodiazepines are associated with worse outcomes in the long term and should not be prescribed for the treatment of individuals with panic disorder.[2]

Psychotherapy –The RANZCP (2003) guidelines feel that there is no difference in outcomes between TCA's and BZD's and that TCA's are as effective as CBT. They do not offer any specific recommendations for CBT treatment.[4]

Pharmacotherapy

First Line – NICE (2011) states that antidepressants and specifically SSRI's first, should be the only pharmacological intervention used in the long term management of panic disorder.[2] The Canadian Psychiatric Association (2006) guidelines recommend citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, venlafaxine XR or escitalopram.[1] If no response, switch to another first line agent or a second-line medications.[1]

In contrast, the American Psychiatric Association states that SSRI's, SNRI's, TCA's and BZD's all have comparable efficacy in the treatment of panic disorder.[3] However, SSRI's and SNRI's are generally first line due to less side effects than TCA's. With co-occurring depression SSRI's, SNRI's, and TCA's are preferable because they can treat that disorder as well.[3] All six SSRI's are equally effective for panic disorder, but only fluoxetine, sertraline, and paroxetine are FDA approved for panic.[3] Benzodiazepines may be especially useful for clients with very distressing or impairing symptoms who need quick relief. Several studies show that short-term (4-6 weeks) augmentation with benzodiazepines while titrating antidepressants produces a more rapid therapeutic response.[3] For choice of benzodiazepine they recommend alprazolam or clonazepam.[3]

In the RANZCP (2003) guidelines they feel that there is no difference in outcomes between TCA's and BZD's and that TCA's are as effective as CBT.[4] They recommended imipramine and clomipramine as first line treatments and feel that the evidence supporting use of SSRI's is conflicting with no notable differences between fluvoxamine, fluoxetine, paroxetine, sertraline, and citalopram.[4]

They indicated that some research has shown that benzodiazepines have had small to moderate effect sizes in studies and have often been found to have similar efficacy to TCA's, but in their own meta-analysis they were less effective.[4] Benzodiazepines are frequently better tolerated than TCA's but they carry the risk of iatrogenic dependence, difficult withdrawal, impaired attention, impaired concentration, impaired short-term memory, and industrial and road accidents.[4]

Second Line - NICE (2011) says that if no improvement in 12 weeks on an SSRI to use imipramine or clomipramine.[2] The CPA's (2006) second line medications are clomipramine, imipramine, and mirtazapine.[1] They feel that benzodiazepines can be used at any time if agitation or anxiety is severe and that a SSRI plus a benzodiazepine can lead to more rapid response, but the benzodiazepine should be used short term.[1] Specifically, the benzodiazepines alprazolam, clonazepam, lorazepam and diazepam have shown effectiveness.[1]

Third Line - Depakote, gabapentin, phenelzine, SGA's, pindolol, and moclobemide.[1]

Not Recommended - Sedating antihistamines or antipsychotics should not be prescribed for the treatment of panic disorder.[2] Buspirone, trazodone, propranolol, and carbamazepine. Desipramine.[4] Buspirone, beta blockers, bupropion, flurazepam, temazepam, and triazolam are ineffective. [4] Insufficient evidence for nefazodone, moclobemide, and venlafaxine. [4]
No role for conventional antipsychotics or clonidine.[4]

Generalized Anxiety Disorder

Psychotherapy –The NICE (2011) guidelines on the treatment of GAD recommend first line interventions of individual non-facilitated self help, individual guided self-help, or psychoeducation groups.[2] When the client is experiencing functional impairment they recommend high intensity psychological interventions such as CBT, applied relaxation, or pharmacotherapy.[2]

The CPA (2006) guidelines offer more specific advice for the treatment of GAD.[1] They recommend both group and individual CBT as a first line therapy that has similar effectiveness as antidepressants.[1]

Pharmacotherapy

First Line – The NICE (2011) recommend pharmacotherapy only for more severe forms of GAD and feel that any SSRI or SNRI can be effective but to not offer a benzodiazepine for treatment of GAD except as a short-term measure during crises.[2] The CPA (2006) recommends escitalopram, paroxetine, sertraline, or venlafaxine XR because antidepressants treat the key feature of GAD, ruminative worry, much more effectively than benzodiazepines.[1]

Second Line – The NICE (2011) say if SSRI's or SNRI's are not successful they recommended a trail of pregabalin.[2] The CPA (2006) says that if several trials of SSRI's or SNRI's are not effective then their second line medications are alprazolam, bromazepam, lorazepam, diazepam, bupropion XL, buspirone, imipramine, and pregabalin. Benzodiazepines can be used at any time if agitation or anxiety is severe, but their use should be short term.[1] Despite rapid relief from anxiety, evidence suggests that their effect may not be significantly different from placebo at 4-6 weeks of treatment.[1]

Third Line – Augmentation with olanzapine, risperidone, hydroxyzine, mirtazapine or trazodone. [1]

Not Recommended – Propranolol.[1]

Social Anxiety Disorder (Social Phobia)

Psychotherapy – The NICE (2013) guidelines on the treatment of social anxiety disorder recommend specific individual CBT therapy based on the Clark and Wells model or the Heimberg model as the most effective intervention.[6] Their recommended second line intervention is CBT based self-help.[6] They do not recommend mindfulness based interventions or supportive therapy.

The CPA guidelines (2006) differ slightly in that while they feel that CBT and pharmacotherapy have similar effectiveness for the treatment of acute SAD but they recommend CBT first because treatment gains with therapy have consistently been found to last longer than drug therapy.[1]

Pharmacotherapy

First Line – The NICE (2013) consider medications a third line intervention overall, but if chosen they recommend a SSRI (escitalopram or sertraline).[6] If not tolerated or no response, offer alternative SSRI (fluvoxamine or paroxetine) or a SNRI (venlafaxine).[6] The CPA (2006) recommends escitalopram, fluvoxamine, paroxetine, sertraline, or venlafaxine XR.[1] Two different first line agents should be tried before going to second line medications

Second Line – The NICE (2013) says if no response to SSRI or SNRI, offer a MAOI (phenelzine or moclobemide). [6] The CPA (2006) recommends clonazepam, alprazolam, bromazepam, gabapentin, pregabalin, citalopram, and phenelzine as second line medications.[1] They also state that benzodiazepines can be used at any time if agitation or anxiety is severe, but their use should be short term and all are second line due to risks of withdrawal, tolerance, and addiction.[1] While the combination of a benzodiazepine and a SSRI or SNRI is widely used in practice they do not feel it is supported by research literature.[1]

Third Line – The CPA (2006) says the following medications can be considered as adjunctive or monotherapy: fluoxetine, bupropion, mirtazapine, moclobemide, divalproex, topiramate, levetiracetam, olanzapine, quetiapine, selegiline, and clomipramine

Not Recommended - The NICE (2013) guidelines say to not routinely offer anticonvulsants, TCA's, benzodiazepines, antipsychotic medication, St. John's Wort or other over the counter medications. [6]

Post-Traumatic Stress Disorder

Psychotherapy – The NICE (2005) recommendations on the treatment of PTSD vary depending on the time that has past since the traumatic event.[5] When symptoms emerge within 3 months of trauma pharmacotherapy should not be offered except to assist with sleep disturbances.[5] Instead trauma-focused CBT should be offered and not relaxation or non-directive therapy.[5] When symptoms have been present for more than 3 months after the trauma pharmacotherapy is not a first line intervention and every client should be offered trauma-focused CBT or EMDR regardless of the time that has elapsed since the trauma.[5] Non-trauma focused interventions such as relaxation or non-directive therapy that do not address traumatic memories should not be routinely offered to people with chronic PTSD. [5] If there is minimal improvement in symptoms then an alternative trauma focused therapy can be tried or augment therapy with pharmacotherapy.[5]

The CPA (2006) guidelines for the treatment of PTSD vary significantly from the NICE guidelines.[1] They do recommend trauma focused CBT but caution that meta-analysis has shown

that only 44-54% of clients respond.[1] They consider EMDR to be controversial but agree that supportive therapy is not helpful.[1]

Pharmacotherapy
First Line – The NICE (2005) feels the evidence for pharmacotherapy for PTSD is limited, but there is some evidence of benefit from mirtazapine, amitriptyline, or phenelezine as well as paroxetine. If sleep is a major problem, hypnotic medication can be used in the short-term.[5] If not responsive to therapy or initial drug treatment: increase dose, try different class of antidepressant, or use olanzapine adjunctively.[5] The CPA's (2006) first line medications are fluoxetine, paroxetine, sertraline, venlafaxine XR.[1]
Second Line – The CPA's (2006) lists monotherapy with fluvoxamine, mirtazapine, moclobemide, phenelzine; or augmentation with risperidone or olanzapine as second line options.[1]
Third Line – The CPA (2006) lists monotherapy with amitriptyline, imipramine, escitalopram; or augmenttation with carbamazepine, gabapentin, lamotrigine, valproate, tiagabine, topiramate, quetiapine, clonidine, trazodone, buspirone, bupropion, prazosin, citalopram, fluphenazine, or naltrexone all as third line options. [1]
Not Recommended - The CPA (2006) doesn't recommend desipramine, cyproheptadine; or monotherapy with alprazolam, clonazepam, or olanzapine.[1]

Obsessive Compulsive Disorder

Psychotherapy - The CPA (2006) guidelines also recommend exposure with response prevention behavioral therapy as effective and with some debate, cognitive therapy; however traditional insight oriented psychotherapy has not been shown to be helpful. The NICE (2013) guidelines for OCD recommend low intensity psychological treatments for clients with mild impairment and if not effective offer intensive CBT. For clients with moderate or severe impairment they recommend offering intensive CBT.

Pharmacotherapy
First Line – The CPA (2006) recommends fluoxetine, fluvoxamine, paroxetine, or sertraline.[1] In the NICE (2013) guidelines for OCD the first line pharmacotherapy recommendations are fluoxetine, fluvoxamine, paroxetine, sertraline or citalopram.[7] Clomipramine should be considered if no response to an SSRI.[7]
Second Line – The CPA (2006) recommends clomipramine as a second line medication due to the risk of side effects, but acknowledges that it can be very effective.[1] Other second line medications are mirtazapine, venlafaxine XR or citalopram; or augment with risperidone or mirtazapine.[1]
The NICE (2013) guidelines for OCD say if there is no response to first line interventions then they recommend adding an antipsychotic to an SSRI, monotherapy with clomipramine, or combining clomipramine and citalopram.[7]
Third Line – The CPA's (2006) third line medications are olanzapine, quetiapine, haloperidol, gabapentin, topiramate, tramadol, riluzole, phenelzine, St. John's Wort, and pindolol which have shown some effectiveness and could be considered as augmentation agents. [1]
Not Recommended - The CPA (2006) does not recommend clonazepam, desipramine, bupropion, clonidine, naltrexone, buspirone, and lithium.[1] The NICE (2013) guidelines for OCD

say to not use these drugs routinely without co-morbid psychiatric issues: TCA's other than clomipramine, SNRI's, MAOIs, benzodiazepines, antipsychotic monotherapy. [7]

Specific Phobia

According to the CPA (2006) the primary treatment for specific phobia is exposure-based which can provide the client with relatively quick symptom resolution.[1]

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