National Institute for Health and Clinical Excellence

Amendments to recommendations concerning venlafaxine

On 31 May 2006 the MHRA issued revised prescribing advice for venlafaxine*. This amendment brings the guideline into line with the new advice but does not cover other areas where new evidence may be available. NICE expects to make a decision on a full update later in 2007.

The amendments to the recommendations to take account of the revised prescribing advice for venlafaxine were developed by the National Collaborating Centre for Mental Health.

Revised sections are in *italics.*

*See: http://www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&useSecondary=true&ssDocName=CON2023843&ssTargetNodeId=389)

Issue date: April 2007

Anxiety (amended)

Management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care

NICE clinical guideline 22 (amended)
Developed by the National Collaborating Centre for Primary Care

Clinical Guideline 22 (amended)
Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care

Issue date: April 2007

This document, which contains the Institute's full guidance on Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care, is available from the NICE website (www.nice.org.uk/CG022NICEguideline).

An abridged version of this guidance (a 'quick reference guide') is also available from the NICE website (www.nice.org.uk/CG022quickrefguide). Printed copies of the quick reference guide can be obtained from the NHS Response Line: telephone 0870 1555 455 and quote reference number N1235.

Information for the Public is available from the NICE website or from the NHS Response Line; quote reference number N1236 for a version in English. A version in Welsh is available from the NICE website (www.nice.org.uk/CG022).

This guidance is written in the following context:

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

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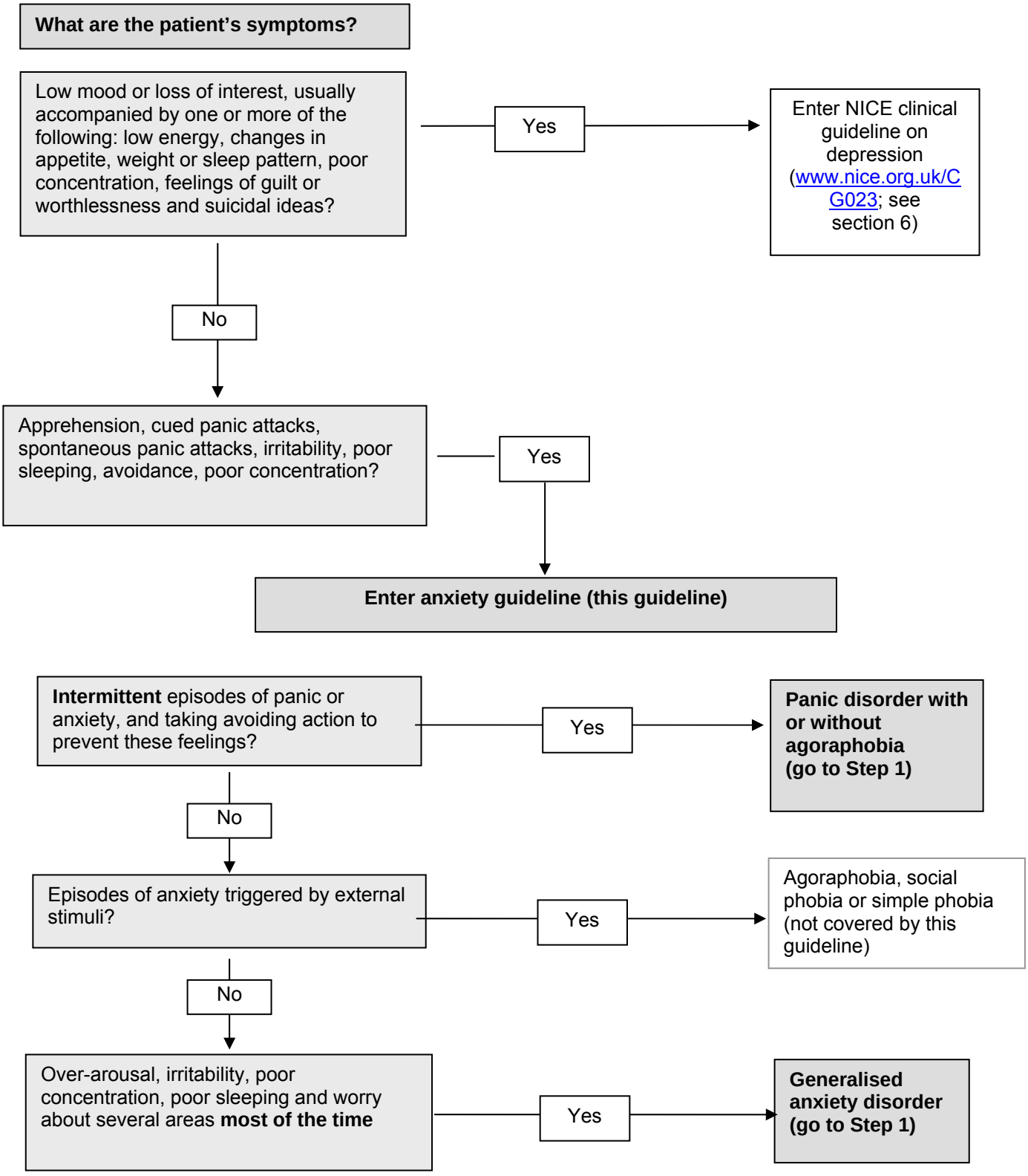
Contents

Which NICE guideline?



Key priorities for implementation

General management

- Shared decision-making between the individual and healthcare professionals should take place during the process of diagnosis and in all phases of care.

- Patients and, when appropriate, families and carers should be provided with information on the nature, course and treatment of panic disorder or generalised anxiety disorder, including information on the use and likely side-effect profile of medication.

- Patients, families and carers should be informed of self-help groups and support groups and be encouraged to participate in such programmes where appropriate.

- All patients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly.

Step 1: Recognition and diagnosis of panic disorder and generalised anxiety disorder

- The diagnostic process should elicit necessary relevant information such as personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care. (See also ‘Which NICE guideline?’, page 4.)

Step 2: Offer treatment in primary care

- There are positive advantages of services based in primary care practice (for example, lower drop-out rates) and these services are often preferred by patients.

- The treatment of choice should be available promptly.

Panic disorder

- Benzodiazepines are associated with a less good outcome in the long term and should not be prescribed for the treatment of individuals with panic disorder.

- Any of the following types of intervention should be offered and the preference of the person should be taken into account. The interventions that have evidence for the longest duration of effect, in descending order, are:

  - psychological therapy (cognitive behavioural therapy [CBT])
  - pharmacological therapy (a selective serotonin reuptake inhibitor [SSRI] licensed for panic disorder; or if an SSRI is unsuitable or there is no improvement, imipramine[a] or clomipramine[a] may be considered)
  - self-help (bibliotherapy – the use of written material to help people understand their psychological problems and learn ways to overcome them by changing their behaviour – based on CBT principles).

Generalised anxiety disorder

- Benzodiazepines should not usually be used beyond 2–4 weeks.

- In the longer-term care of individuals with generalised anxiety disorder, any of the following types of intervention should be offered and the preference of the person with generalised anxiety disorder

[a] Imipramine and clomipramine are not licensed for panic disorder but have been shown to be effective in its management.

should be taken into account. The interventions that have evidence for the longest duration of effect, in descending order, are

- psychological therapy (CBT)
- pharmacological therapy (an SSRI)
- self-help (bibliotherapy based on CBT principles).

Step 3: Review and offer alternative treatment

- If one type of intervention does not work, the patient should be reassessed and consideration given to trying one of the other types of intervention.

Step 4: Review and offer referral from primary care

- In most instances, if there have been two interventions provided (any combination of psychological intervention, medication, or bibliotherapy) and the person still has significant symptoms, then referral to specialist mental health services should be offered.

Step 5: Care in specialist mental health services

- Specialist mental health services should conduct a thorough, holistic, re-assessment of the individual, their environment and social circumstances.

Monitoring

- Short, self-complete questionnaires (such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder) should be used to monitor outcomes wherever possible.

Key messages about anxiety disorders

- Anxiety disorders are
    - common
    - chronic
    - the cause of considerable distress and disability
    - often unrecognised and untreated.
- If left untreated they are costly to both the individual and society.
- A range of effective interventions is available to treat anxiety disorders, including medication, psychological therapies and self-help.
- Individuals do get better and remain better.
- Involving individuals in an effective partnership with healthcare professionals, with all decision-making being shared, improves outcomes.
- Access to information, including support groups, is a valuable part of any package of care.

The following guidance is evidence based. The grading scheme used for the recommendations (A, B, C, D, NICE 2002) is described in appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline (see section 5).

1 Guidance

This guidance makes recommendations on the management of generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (aged 18 years and older) in primary, secondary and community care.

1.1 General management for both panic disorder and generalised anxiety disorder

People who have panic disorder or generalised anxiety disorder and their carers need comprehensive information, presented in clear and understandable language, about the nature of their condition and the treatment options available. Such information is essential for shared decision-making between patients and healthcare professionals, particularly when making choices between broadly equivalent treatments. In addition, given the emotional, social and economic costs that generalised anxiety disorder or panic disorder usually entail, patients and their families may need help in contacting support and self-help groups. Support groups can also promote understanding and collaboration between patients, their carers and healthcare professionals at all levels of primary and secondary care.

1.1.1 Shared decision-making and information provision

1.1.1.1 Shared decision-making should take place as it improves concordance and clinical outcomes. **C**

1.1.1.2 Shared decision-making between the individual and healthcare professionals should take place during the process of diagnosis and in all phases of care. **D**

1.1.1.3 Patients and, when appropriate, families and carers should be provided with information on the nature, course and treatment of panic disorder or generalised anxiety disorder, including information on the use and likely side-effect profile of medication. **D**

1.1.1.4 To facilitate shared decision-making, evidence-based information about treatments should be available and discussion of the possible options should take place. **D**

1.1.1.5 Patient preference and the experience and outcome of previous treatment(s) should be considered in determining the choice of treatment. **D**

1.1.1.6 Common concerns about taking medication, such as fears of addiction, should be addressed. **D**

1.1.1.7 In addition to being provided with high-quality information, patients, families and carers should be informed of self-help groups and support groups and be encouraged to participate in such programmes where appropriate. **D**

1.1.2 Language

1.1.2.1 When talking to patients and carers, healthcare professionals should use everyday, jargon-free language. If technical terms are used they should be explained to the patient. **D**

1.1.2.2 Where appropriate, all services should provide written material in the language of the patient, and appropriate interpreters should be sought for people whose preferred language is not English. **D**

1.1.2.3 Where available, consideration should be given to providing psychotherapies in the patient's own language if this is not English. **D**

Stepped approaches to care

The guideline provides recommendations for care at different stages of the patient journey, represented as different steps (sections 1.2 to 1.11):

Step 1 – recognition and diagnosis

Step 2 – treatment in primary care

Step 3 – review and consideration of alternative treatments

Step 4 – review and referral to specialist mental health services

Step 5 – care in specialist mental health services.

1.2 Step 1: Recognition and diagnosis of panic disorder and generalised anxiety disorder

1.2.1 Consultation skills

1.2.1.1 All healthcare professionals involved in diagnosis and management should have a demonstrably high standard of consultation skills so that a structured approach can be taken to the diagnosis and subsequent management plan for panic disorder and generalised anxiety disorder. The standards detailed in the video workbook 'Summative Assessment For General Practice Training: Assessment Of Consulting Skills – the MRCGP/Summative Assessment Single Route' (see www.rcgp.org.uk/exam) and required of the Membership of the Royal College of General Practitioners are a good example of standards for consulting skills. **D**

1.2.2 Diagnosis

The accurate diagnosis of panic disorder or generalised anxiety disorder is central to the effective management of these conditions. It is acknowledged that frequently there are other conditions present, such as depression, that can make the presentation and diagnosis confusing. An algorithm has been developed to aid the clinician in the diagnostic process, and to identify which guideline is most appropriate to support the clinician in the management of the individual patient (see page 4).

1.2.2.1 The diagnostic process should elicit necessary relevant information such as personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care. **D**

1.2.2.2 There is insufficient evidence on which to recommend a well-validated, self-reporting screening instrument to use in the diagnostic process, and so consultation skills should be relied upon to elicit all necessary information. **D**

1.2.3 Comorbidities

1.2.3.1 The clinician should be alert to the common clinical situation of comorbidity, in particular, anxiety with depression and anxiety with substance abuse. **D**

1.2.3.2 The main problem(s) to be treated should be identified through a process of discussion with the patient. In determining the priorities of the comorbidities, the sequencing of the problems should be clarified. This can be helped by drawing up a timeline to identify when the various problems developed. By understanding when the symptoms developed, a better understanding of the relative priorities of the comorbidities can be achieved, and there is a better opportunity of developing an effective intervention that fits the needs of the individual. **D**

1.2.3.3 When the patient has depression or anxiety with depression, the NICE guideline on management of depression should be followed (see section 6). **D**

1.2.4 Presentation in A&E with panic attacks

It is important to remember that a panic attack does not necessarily constitute a panic disorder and appropriate treatment of a panic attack may limit the development of panic disorder. For people who present with chest pain at A&E services, there appears to be a greater likelihood of the cause being panic disorder if coronary artery disease is not present or the patient is female or relatively young. Two other variables, atypical chest pain and self-reported anxiety, may also be associated with panic disorder presentations, but there is insufficient evidence to establish a relationship.

1.2.4.1 If a patient presents in A&E, or other settings, with a panic attack, they should: **D**

- be asked if they are already receiving treatment for panic disorder
- undergo the minimum investigations necessary to exclude acute physical problems
- not usually be admitted to a medical or psychiatric bed
- be referred to primary care for subsequent care, even if assessment has been undertaken in A&E
- be given appropriate written information about panic attacks and why they are being referred to primary care
- be offered appropriate written information about sources of support, including local and national voluntary and self-help groups.

Panic disorder – steps 2–5

1.3 Step 2 for people with panic disorder: offer treatment in primary care

The recommended treatment options have an evidence base: psychological therapy, medication and self-help have all been shown to be effective. The choice of treatment will be a consequence of the assessment process and shared decision-making.

There may be instances when the most effective intervention is not available (for example, cognitive behavioural therapy [CBT]) or is not the treatment option chosen by the patient. In these cases, the healthcare professional will need to consider, after discussion with the patient, whether it is acceptable to offer one of the other recommended treatments. If the preferred treatment option is currently unavailable, the healthcare professional will also have to consider whether it is likely to become available within a useful timeframe.

1.3.1 General

1.3.1.1 Benzodiazepines are associated with a less good outcome in the long term and should not be prescribed for the treatment of individuals with panic disorder. **A**

1.3.1.2 Sedating antihistamines or antipsychotics should not be prescribed for the treatment of panic disorder. **D**

1.3.1.3 In the care of individuals with panic disorder, any of the following types of intervention should be offered and the preference of the person should be taken into account. The interventions that have evidence for the longest duration of effect, in descending order, are: **A**

- psychological therapy (see section 1.3.2)
- pharmacological therapy (antidepressant medication) (see section 1.3.3)

- self-help (see section 1.3.4).

1.3.1.4 The treatment option of choice should be available promptly. **D**

1.3.1.5 There are positive advantages of services based in primary care (for example, lower rates of people who do not attend) and these services are often preferred by patients. **D**

1.3.2 Psychological interventions

1.3.2.1 Cognitive behavioural therapy (CBT) should be used. **A**

1.3.2.2 CBT should be delivered only by suitably trained and supervised people who can demonstrate that they adhere closely to empirically grounded treatment protocols. **A**

1.3.2.3 CBT in the optimal range of duration (7–14 hours in total) should be offered. **A**

1.3.2.4 For most people, CBT should take the form of weekly sessions of 1–2 hours and should be completed within a maximum of 4 months of commencement. **B**

1.3.2.5 Briefer CBT should be supplemented with appropriate focused information and tasks. **A**

1.3.2.6 Where briefer CBT is used, it should be around 7 hours and designed to integrate with structured self-help materials. **D**

1.3.2.7 For a few people, more intensive CBT over a very short period of time might be appropriate. **C**

1.3.3 Pharmacological interventions – antidepressant medication

Antidepressants should be the only pharmacological intervention used in the longer term management of panic disorder. The two classes of antidepressants that have an evidence base for effectiveness are the

selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants.

1.3.3.1 The following must be taken into account when deciding which medication to offer: **D**

- the age of the patient
- previous treatment response
- risks
  - the likelihood of accidental overdose by the person being treated and by other family members if appropriate
  - the likelihood of deliberate self-harm, by overdose or otherwise *(the highest risk is with TCAs)*
- tolerability
- *the possibility of interactions with concomitant medication (consult appendix 1 of the 'British National Formulary')*
- the preference of the person being treated
- cost, where equal effectiveness is demonstrated.

1.3.3.2 All patients who are prescribed antidepressants should be informed, at the time that treatment is initiated, of potential side effects (including transient increase in anxiety at the start of treatment) and of the risk of discontinuation/withdrawal symptoms if the treatment is stopped abruptly or in some instances if a dose is missed or, occasionally, on reducing the dose of the drug. **C**

1.3.3.3 Patients started on antidepressants should be informed about the delay in onset of effect, the time course of treatment, the need to take medication as prescribed, and possible discontinuation/withdrawal symptoms. Written information appropriate to the patient's needs should be made available. **D**

1.3.3.4 Unless otherwise indicated, an SSRI licensed for panic disorder should be offered. **A**

1.3.3.5 If an SSRI is not suitable or there is no improvement after a 12-week course and if a further medication is appropriate, imipramine[a] or clomipramine[a] may be considered. **A**

1.3.3.6 When prescribing an antidepressant, the healthcare professional should consider the following.

- Side effects on the initiation of antidepressants may be minimised by starting at a low dose and increasing the dose slowly until a satisfactory therapeutic response is achieved. **D**
- In some instances, doses at the upper end of the indicated dose range may be necessary and should be offered if needed. **B**
- Long-term treatment may be necessary for some people and should be offered if needed. **B**
- If the patient is showing improvement on treatment with an antidepressant, the medication should be continued for at least 6 months after the optimal dose is reached, after which the dose can be tapered. **D**

1.3.3.7 If there is no improvement after a 12-week course, an antidepressant from the alternative class (if another medication is appropriate) or another form of therapy (see 1.3.1.3) should be offered. **D**

1.3.3.8 Patients should be advised to take their medication as prescribed. This may be particularly important with short half-life medication in order to avoid discontinuation/withdrawal symptoms. **C**

1.3.3.9 Stopping antidepressants abruptly can cause discontinuation/withdrawal symptoms. To minimise the risk of

[a] Imipramine and clomipramine are not licensed for panic disorder but have been shown to be effective in its management.

discontinuation/withdrawal symptoms when stopping antidepressants, the dose should be reduced gradually over an extended period of time. **C**

1.3.3.10 All patients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly. **C**

1.3.3.11 Healthcare professionals should inform patients that the most commonly experienced discontinuation/withdrawal symptoms are dizziness, numbness and tingling, gastrointestinal disturbances (particularly nausea and vomiting), headache, sweating, anxiety and sleep disturbances. **D**

1.3.3.12 Healthcare professionals should inform patients that they should seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms. **D**

1.3.3.13 If discontinuation/withdrawal symptoms are mild, the practitioner should reassure the patient and monitor symptoms. If severe symptoms are experienced after discontinuing an antidepressant, the practitioner should consider reintroducing it (or prescribing another from the same class that has a longer half-life) and gradually reducing the dose while monitoring symptoms. **D**

1.3.4 Self-help

1.3.4.1 Bibliotherapy based on CBT principles should be offered. **A**

1.3.4.2 Information about support groups, where they are available, should be offered. (Support groups may provide face-to-face meetings, telephone conference support groups [which can be

based on CBT principles], or additional information on all aspects of anxiety disorders plus other sources of help.) **D**

1.3.4.3 The benefits of exercise as part of good general health should be discussed with all patients as appropriate. **B**

1.3.4.4 Current research suggests that the delivery of cognitive behavioural therapy via a computer interface (CCBT) may be of value in the management of anxiety and depressive disorders. This evidence is, however, an insufficient basis on which to recommend the general introduction of this technology into the NHS. **NICE 2002**

1.4 Step 3 for people with panic disorder: review and offer alternative treatment if appropriate

1.4.1.1 If, after a course of treatment, the clinician and patient agree that there has been no improvement with one type of intervention, the patient should be reassessed and consideration given to trying one of the other types of intervention. **D**

1.5 Step 4 for people with panic disorder: review and offer referral from primary care if appropriate

1.5.1.1 In most instances, if there have been two interventions provided (any combination of psychological intervention, medication, or bibliotherapy) and the person still has significant symptoms, then referral to specialist mental health services should be offered. **D**

1.6 Step 5 for people with panic disorder: care in specialist mental health services

1.6.1.1 Specialist mental health services should conduct a thorough, holistic reassessment of the individual, their environment and social circumstances. This reassessment should include evaluation of:

- previous treatments, including effectiveness and concordance
- any substance use, including nicotine, alcohol, caffeine and recreational drugs
- comorbidities
- day-to-day functioning
- social networks
- continuing chronic stressors
- the role of agoraphobic and other avoidant symptoms.

A comprehensive risk assessment should be undertaken and an appropriate risk management plan developed. **D**

1.6.1.2 To undertake these evaluations, and to develop and share a full formulation, more than one session may be required and should be available. **D**

1.6.1.3 Care and management should be based on the individual's circumstances and shared decisions made. Options include: **D**

- treatment of co-morbid conditions
- CBT with an experienced therapist if not offered already, including home-based CBT if attendance at clinic is difficult
- structured problem solving
- full exploration of pharmaco-therapy
- day support to relieve carers and family members
- referral for advice, assessment or management to tertiary centres.

1.6.1.4 There should be accurate and effective communication between all healthcare professionals involved in the care of any person with panic disorder, and particularly between primary care clinicians (GP and teams) and secondary care clinicians (community mental health teams) if there are existing physical health conditions that also require active management. **D**

Generalised anxiety disorder – steps 2–5

1.7 Step 2 for people with generalised anxiety disorder: offer treatment in primary care

The recommended treatment options have an evidence base: psychological therapy, medication and self-help have all been shown to be effective. The choice of treatment will be a consequence of the assessment process and shared decision-making.

There may be instances when the most effective intervention is not available (for example, cognitive behavioural therapy [CBT]) or is not the treatment option chosen by the patient. In these cases, the healthcare professional will need to consider, after discussion with the patient, whether it is acceptable to offer one of the other recommended treatments. If the preferred treatment option is currently unavailable, the healthcare professional will also have to consider whether it is likely to become available within a useful timeframe.

1.7.1 General

1.7.1.1 If immediate management of generalised anxiety disorder is necessary, any or all of the following should be considered:

- support and information **D**
- problem solving **C**
- benzodiazepines **A**
- sedating antihistamines **A**
- self-help. **D**

1.7.1.2 Benzodiazepines should not usually be used beyond 2–4 weeks. **B**

1.7.1.3 In the longer-term care of individuals with generalised anxiety disorder, any of the following types of intervention should be offered and the preference of the person with generalised anxiety disorder should be taken into account. The interventions which

have evidence for the longest duration of effect, in descending order, are:

- psychological therapy (see section 1.7.2) **A**
- pharmacological therapy (antidepressant medication) (see section 1.7.3) **A**
- self-help (see section 1.7.4). **A**

1.7.1.4 The treatment option of choice should be available promptly. **D**

1.7.1.5 There are positive advantages of services based in primary care (for example, lower rates of people who do not attend) and these services are often preferred by patients. **D**

1.7.2 Psychological interventions

1.7.2.1 CBT should be used. **A**

1.7.2.2 CBT should be delivered only by suitably trained and supervised people who can demonstrate that they adhere closely to empirically grounded treatment protocols. **A**

1.7.2.3 CBT in the optimal range of duration (16–20 hours in total) should be offered. **A**

1.7.2.4 For most people, CBT should take the form of weekly sessions of 1–2 hours and be complete within a maximum of 4 months from commencement. **B**

1.7.2.5 Briefer CBT should be supplemented with appropriate focused information and tasks. **A**

1.7.2.6 Where briefer CBT is used, it should be around 8–10 hours and be designed to integrate with structured self-help materials. **D**

1.7.3 Pharmacological interventions – antidepressant medication

Antidepressants should be the only pharmacological intervention used in the longer-term management of generalised anxiety disorder. There is an evidence base for the effectiveness of the SSRIs. Paroxetine, *and venlafaxine in extended release formulation (see step 3 for prescribing advice)*, have marketing authorisation for the treatment of generalised anxiety disorder.

1.7.3.1 The following must be taken into account when deciding which medication to offer:

- the age of the patient
- previous treatment response
- risks
  - the likelihood of accidental overdose by the person being treated and by other family members if appropriate *(venlafaxine is more dangerous in overdose than paroxetine)*
  - the likelihood of deliberate self-harm, by overdose or otherwise
- tolerability
- *the possibility of interactions with concomitant medication (consult appendix 1 of the 'British National Formulary')*
- the preference of the person being treated
- cost, where equal effectiveness is demonstrated. **D**

1.7.3.2 All patients who are prescribed antidepressants should be informed, at the time that treatment is initiated, of potential side effects (including transient increase in anxiety at the start of treatment) and of the risk of discontinuation/withdrawal symptoms if the treatment is stopped abruptly or in some instances if a dose is missed or, occasionally, on reducing the dose of the drug. **C**

1.7.3.3 Patients started on antidepressants should be informed about the delay in onset of effect, the time course of treatment and the need to take medication as prescribed, and possible discontinuation/withdrawal symptoms. Written information appropriate to the patient's needs should be made available. **D**

1.7.3.4 Unless otherwise indicated, an SSRI should be offered. **B**

1.7.3.5 If one SSRI is not suitable or there is no improvement after a 12-week course, and if a further medication is appropriate, another SSRI should be offered. **D**

1.7.3.6 When prescribing an antidepressant, the healthcare professional should consider the following.

- Side effects on the initiation of antidepressants may be minimised by starting at a low dose and increasing the dose slowly until a satisfactory therapeutic response is achieved. **D**
- In some instances, doses at the upper end of the indicated dose range may be necessary and should be offered if needed. **B**
- Long-term treatment may be necessary for some people and should be offered if needed. **B**
- If the patient is showing improvement on treatment with an antidepressant, the drug should be continued for at least 6 months after the optimal dose is reached, after which the dose can be tapered. **D**

1.7.3.7 If there is no improvement after a 12-week course, another SSRI (if another medication is appropriate) or another form of therapy (see 1.7.1.3) should be offered. **D**

1.7.3.8 Patients should be advised to take their medication as prescribed. This may be particularly important with short half-life medication to avoid discontinuation/withdrawal symptoms. **C**

1.7.3.9 Stopping antidepressants abruptly can cause discontinuation/withdrawal symptoms. To minimise the risk of discontinuation/withdrawal symptoms when stopping antidepressants, the dose should be reduced gradually over an extended period of time. **C**

1.7.3.10 All patients prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly. **C**

1.7.3.11 Healthcare professionals should inform patients that the most commonly experienced discontinuation/withdrawal symptoms are dizziness, numbness and tingling, gastrointestinal disturbances (particularly nausea and vomiting), headache, sweating, anxiety and sleep disturbances. **D**

1.7.3.12 Healthcare professionals should inform patients that they should seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms. **D**

1.7.3.13 If discontinuation/withdrawal symptoms are mild, the practitioner should reassure the patient and monitor symptoms. If severe symptoms are experienced after discontinuing an antidepressant, the practitioner should consider reintroducing it (or prescribing another from the same class that has a longer half-life) and gradually reducing the dose while monitoring symptoms. **D**

1.7.4 Self-help

1.7.4.1 Bibliotherapy based on CBT principles should be offered. **A**

1.7.4.2 Information about support groups, where they are available, should be offered. (Support groups may provide face-to-face meetings, telephone conference support groups [which can be based on CBT principles], or additional information on all aspects of anxiety disorders plus other sources of help.) **D**

1.7.4.3 Large-group CBT should be considered. **C**

1.7.4.4 The benefits of exercise as part of good general health should be discussed with all patients as appropriate. **B**

1.7.4.5 Current research suggests that the delivery of cognitive behavioural therapy via a computer interface (CCBT) may be of value in the management of anxiety and depressive disorders. This evidence is, however, an insufficient basis on which to recommend the general introduction of this technology into the NHS. **NICE 2002**

1.8 Step 3 for people with generalised anxiety disorder: review and offer alternative treatment if appropriate

1.8.1.1 If, following a course of treatment, the clinician and patient agree that there has been no improvement with one type of intervention, the patient should be reassessed and consideration given to trying one of the other types of intervention. **D**

1.8.2 If venlafaxine is being considered

1.8.2.1 Before prescribing venlafaxine, practitioners should take into account the increased likelihood of patients stopping treatment because of side effects, and its higher cost, compared with equally effective SSRIs. **B**

1.8.2.2 *Before prescribing venlafaxine, practitioners should ensure pre-existing hypertension is controlled in line with the current NICE guideline on hypertension (see www.nice.org.uk/CG034). Venlafaxine should not be prescribed for patients with uncontrolled hypertension.* **C**

1.8.2.3 *The dose of venlafaxine should be no higher than 75 mg per day.* **A**

1.8.2.4 *For patients prescribed venlafaxine, blood pressure should be checked on initiation and regularly during treatment, particularly during dosage titration. For patients who experience a sustained increase in blood pressure, the dose should be reduced or discontinuation considered.* **C**

1.8.2.5 *Practitioners should monitor patients prescribed venlafaxine for the signs and symptoms of cardiac dysfunction, particularly in those with known cardiovascular disease, and take appropriate action as necessary.* **C**

1.8.2.6 *Venlafaxine should not be prescribed for patients with a:*

- *high risk of serious cardiac arrhythmias*
- *recent myocardial infarction.* **C**

1.9 Step 4 for people with generalised anxiety disorder: review and offer referral to specialist mental health services

1.9.1 Referral from primary care

1.9.1.1 In most instances, if there have been two interventions provided (any combination of psychological intervention, medication, or bibliotherapy) and the person still has significant symptoms, then referral to specialist mental health services should be offered. **D**

[The recommendations on venlafaxine (1.9.2.1 to 1.9.2.4 in the guideline published in 2004) have been deleted from this section]

1.10 Step 5 for people with generalised anxiety disorder: care in specialist mental health services

1.10.1 Care in specialist mental health services

1.10.1.1 Specialist mental health services should conduct a thorough, holistic reassessment of the individual, their environment and social circumstances. This reassessment should include evaluation of:

- previous treatments, including effectiveness and concordance
- any substance use, including nicotine, alcohol, caffeine and recreational drugs
- comorbidities
- day-to-day functioning
- social networks
- continuing chronic stressors
- the role of agoraphobic and other avoidant symptoms.

A comprehensive risk assessment should be undertaken and an appropriate risk management plan developed. **D**

1.10.1.2 To undertake these evaluations, and to develop and share a full formulation, more than one session may be required and should be available. **D**

1.10.1.3 Care and management will be based on the individual's circumstances and shared decisions arrived at. Options include: **D**

- treatment of co-morbid conditions

- CBT with an experienced therapist if not offered already, including home-based CBT if attendance at clinic is problematic
- structured problem solving
- full exploration of pharmaco-therapy
- day support to relieve carers and family members
- referral for advice, assessment or management to tertiary centres.

1.10.1.4 There should be accurate and effective communication between all healthcare professionals involved in the care of any person with generalised anxiety disorder and particularly between primary care clinicians (GP and teams) and secondary care clinicians (community mental health teams) if there are existing physical health conditions that also require active management. **D**

1.11 Monitoring and follow-up (for individuals with panic disorder or generalised anxiety disorder)

1.11.1 Psychological interventions

1.11.1.1 There should be a process within each practice to assess the progress of a person undergoing CBT. The nature of that process should be determined on a case-by-case basis. **D**

1.11.2 Pharmacological interventions

1.11.2.1 When a new medication is started, the efficacy and side-effects should be reviewed within 2 weeks of starting treatment and again at 4, 6 and 12 weeks. Follow the Summary of Product Characteristics (SPC) with respect to all other monitoring required. **D**

1.11.2.2 At the end of 12 weeks, an assessment of the effectiveness of the treatment should be made, and a decision made as to whether to continue or consider an alternative intervention. **D**

1.11.2.3 If medication is to be continued beyond 12 weeks, the individual should be reviewed at 8- to 12-week intervals, depending on clinical progress and individual circumstances. **D**

1.11.3 Self-help

1.11.3.1 Individuals receiving self-help interventions should be offered contact with primary healthcare professionals, so that progress can be monitored and alternative interventions considered if appropriate. The frequency of such contact should be determined on a case-by-case basis, but is likely to be between every 4 and 8 weeks. **D**

1.11.4 Outcome measures

1.11.4.1 Short, self-complete questionnaires (such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder) should be used to monitor outcomes wherever possible. **D**

2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation; it is available from www.nice.org.uk/article.asp?a=30597

The guideline provides recommendations for all healthcare professionals in primary, secondary or community care who provide care for people who have panic disorder (with or without agoraphobia) or generalised anxiety disorder.

The scope of this guideline is the management of adults (aged 18 years or older) with a working diagnosis of panic disorder (with or without agoraphobia) or generalised anxiety disorder. The guideline does not cover the care of the following: children (people younger than 18 years); people with major depression; people with mixed anxiety and depression; people with bipolar depression; people with seasonal affective disorder (SAD); people with combat disorder; people with anxiety disorders associated with dementia; people with phobic disorders other than panic disorder with agoraphobia; people with organic brain disorders. The guideline also does not cover the care of people with post-traumatic stress disorder or obsessive–compulsive disorder, for which other NICE guidelines are being developed.

3 Implementation in the NHS

3.1 Resource implications

Local health communities should review their existing practice in the treatment and management of panic disorder and generalised anxiety disorder against this guideline. The review should consider the resources required to implement the recommendations set out in section 1, the people and processes involved and the timeline over which full implementation is envisaged. It is in the interests of patients that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

3.2 General

The implementation of this guideline will build on the National Service Frameworks for Mental Health in England and Wales and should form part of the service development plans for each local health community in England and Wales. The National Service Frameworks are available for England from www.dh.gov.uk/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598, and for Wales from www.wales.nhs.uk/sites/home.cfm?orgid=438.

The National Institute for Mental Health in England (NIMHE) is able to support the implementation of NICE guidelines through its regional development centres. More details can be found at www.nimhe.org.uk.

The introduction of the new general medical services (GMS) contract for primary care on 1 April 2004 provides a further opportunity to implement these guidelines. A draft quality and outcome framework (QOF) is provided as part of the Audit section (see section 3.2 and appendix D).

This guideline should be used in conjunction with the NICE guidance detailed in section 6.

3.3 Audit

Suggested audit criteria are listed in appendix D. These can be used as the basis for local clinical audit, at the discretion of those in practice.

As noted in 3.1, a draft quality and outcome framework is provided (see appendix D). This new framework is not part of the standard GMS contract, but could be used by Personal Medical Services practices if they wish.

4 Key research recommendations

The following research recommendations have been identified for this NICE guideline, not as the most important research recommendations, but as those that are most representative of the full range of recommendations. The Guideline Development Group's full set of research recommendations is detailed in the full guideline produced by the National Collaborating Centre for Primary Care (see section 5).

4.1 Assessment of the cost effectiveness of all interventions in panic disorder and generalised anxiety disorder.

4.2 Comparison of the cost effectiveness of medication with psychological therapies and with combination therapy in panic disorder and generalised anxiety disorder

4.3 Assessment of the cost effectiveness of various models of CBT, including consideration of:

- the number of sessions
- intervals between sessions
- the length of sessions
- substitution sessions CBT with increased homework.

4.4 Investigation of the duration of treatment with medication necessary in panic disorder and generalised anxiety disorder, to aid in making a decision that an adequate trial of therapy has been undertaken if medication is not proving effective.

4.5 Long-term follow-up studies for all therapies are also needed.

5 Other versions of this guideline

NICE commissioned the development of this guidance from the National Collaborating Centre for Primary Care. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The members of the Guideline Development Group are listed in appendix B. Information about the independent Guideline Review Panel is given in appendix C.

The booklet 'The Guideline Development Process – An Overview for Stakeholder, the Public and the NHS' has more information about the Institute's guideline development process. It is available from the Institute's website and copies can also be ordered by telephoning 0870 1555 455 and quoting reference number N1233).

In 2006, NICE commissioned the National Collaborating Centre for Mental Health to revise the recommendations on the use of venlafaxine in the light of the revised prescribing advice on the drug issued by the Medicines and Healthcare products Regulatory Agency. The Centre set up an independent working group to develop the revised recommendations (see appendix B). Information about the independent Guideline Review Panel is given in appendix C.

5.1 Full guideline

The full guideline, 'Clinical Guidelines for the Management of Panic Disorder and Generalised Anxiety Disorder', is published by the National Collaborating Centre for Primary Care; it is available on its website (www.rcgp.org.uk/nccpc), the NICE website (www.nice.org.uk) and on the website of the National Electronic Library for Health (www.nelh.nhs.uk).

5.2 Quick reference guide

A quick reference guide for healthcare professionals is also available from the NICE website (www.nice.org.uk/CG022quickrefguide) or from the NHS Response Line (0870 1555 455; quote reference number N1235).

5.3 Information for the public

A version of this guideline for people with generalised anxiety disorder or panic disorder and for the public is available from the NICE website (www.nice.org.uk/CG022publicinfo) or from the NHS Response Line (0870 1555 455; quote reference number N1236). This is a good starting point for explaining to patients the kind of care they can expect. A version in Welsh is available from the NICE website.

6 Related NICE guidance

Antenatal and postnatal mental health. NICE clinical guideline 45 (2007). Available from: www.nice.org.uk/CG045

Hypertension: management of hypertension in adults in primary care. NICE clinical guideline 34 (2006). Available from: www.nice.org.uk/CG034

Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005). Available from www.nice.org.uk/CG031

Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005). Available from www.nice.org.uk/CG026

Depression: management of depression in primary and secondary care. NICE clinical guideline 23 *(amended 2007)*. Available from www.nice.org.uk/CG023

Guidance on the use of computerised cognitive behavioural therapy for anxiety and depression. NICE technology appraisal guidance 51 (2002). Available from www.nice.org.uk/TA051

7 Review date

NICE expects to make a decision on a full update later in 2007. The updated guideline will be available within 2 years of the start of the review process.

Appendix A: Grading scheme

The grading scheme and hierarchy of evidence used in this guideline (see Table) is adapted from Eccles and Mason (2001).

Recommendation grade	**Evidence**
A	Directly based on category I evidence
B	Directly based on: • category II evidence, **or** • extrapolated recommendation from category I evidence
C	Directly based on: • category III evidence, **or** • extrapolated recommendation from category I or II evidence
D	Directly based on: • category IV evidence, **or** extrapolated recommendation from category I, II, or III evidence
NICE 2002	Evidence from NICE health technology appraisal
Evidence category	**Source**
I	Evidence from: • meta-analysis of randomised controlled trials, **or** • at least one randomised controlled trial
II	Evidence from: • at least one controlled study without randomisation, **or** • at least one other type of quasi-experimental study
III	Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case–control studies
IV	Evidence from expert committee reports or opinions and/or clinical experience of respected authorities

Adapted from Eccles M, Mason J (2001) How to develop cost-conscious guidelines. *Health Technology Assessment* 5(16)

Appendix B: The Guideline Development Group

Dr Alan Cohen (Chair)

Director of Primary Care, Sainsbury Centre for Mental Health, London

Karen Beck (in attendance)

PA, Section of Public Health, School of Health and Related Research (ScHARR), University of Sheffield

Paul Dennis

Nurse Practitioner in Mental Health, Meadows Health Centre, Nottingham

Revd John Eatock

Senior Counsellor, Bolton, Salford & Trafford Mental Health Partnership & Lead Advisor, British Association for Counselling and Psychotherapy

Lisa G Esmonde (December 2002–September 2003)

Research Associate, ScHARR, University of Sheffield

Celia Feetam

Clinical Psychiatric Pharmacist, Aston University and Birmingham and Solihull Mental Health Trust

Dr John Hague

General Practitioner and Mental Health Lead, Ipswich Primary Care Trust

Dr Ian Hughes

Consultant Clinical Psychologist, Cardiff & Vale NHS Trust

Julie Kelly

Patient Representative, National Phobics Society

Dr Nick Kosky

Consultant Psychiatrist and Clinical Director, North Dorset Primary Care Trust

Geraldine Lear

Community Psychiatric Nurse, Nottinghamshire Healthcare NHS Trust

Aileen McIntosh

Deputy Director, Sheffield Evidence Based Guidelines Programme, Public Health, ScHARR, University of Sheffield

Lilian Owens

Patient Representative, No Panic

Julie Ratcliffe

Health Economist, Sheffield Health Economics Group, ScHARR, University of Sheffield

Professor Paul Salkovskis

Clinical Director of the Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Trust, and Professor of Clinical Psychology and Applied Science, Institute of Psychiatry, King's College, London

Anthea Sutton (in attendance)

Information Officer, ScHARR, University of Sheffield

Nancy Turnbull (in attendance)

Chief Executive, National Collaborating Centre for Primary Care

Dr Allan Wailoo

Health Economist, Sheffield Health Economics Group, ScHARR, University of Sheffield (until January 2004)

Working group to consider amendments to the recommendations concerning venlafaxine

The working group was set up by the National Collaborating Centre for Mental Health

Dr Alan Cohen

Director of Primary Care, Sainsbury Centre for Mental Health, London

Professor Nicol Ferrier

Professor of Psychiatry, School of Neurology, Neurobiology and Psychiatry, Newcastle University

Professor Sir David Goldberg

Emeritus Professor of Psychiatry, Institute of Psychiatry, King's College, London

Dr John Hague

General Practitioner and Mental Health Lead, Ipswich Primary Care Trust

Mrs Carol Paton

Chief Pharmacist, Oxleas NHS Trust, south east London

National Collaborating Centre for Mental Health

Ms Rachel Burbeck, Lead Systematic Reviewer

Dr Catherine Pettinari, Senior Project Manager

Mr Stephen Pilling, Co-director

Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel *for the original guideline* were as follows.

Professor Mike Drummond
Director, Centre for Health Economics, University of York

Dr Kevork Hopayian
General Practitioner, Leiston

Mr Barry Stables
Patient Representative

Dr Imogen Stephens
Joint Director of Public Health, Western Sussex Primary Care Trust

Dr Robert Walker
Clinical Director, West Cumbria Primary Care Trust

The members of the Guideline Review Panel for the amended recommendations were as follows.

Professor Mike Drummond (Chair)

Professor of Health Economics, Centre for Health Economics, University of York

Dr Graham Archard
General Practitioner, Dorset

Mr Barry Stables
Lay Representative

Appendix D: Technical detail on the criteria for audit

Audit criteria

Criterion	Exception	Definition of terms
The patient shares decision-making with the healthcare professionals during the process of diagnosis and in all phases of care.	The patient with panic disorder or generalised anxiety disorder is unable to participate in an informed discussion with the clinician responsible for treatment at the time, and an advocate or carer is not available.	
The patient and, when appropriate, his or her family and carer(s) are offered appropriate information on the nature, course and treatment of panic disorder or generalised anxiety disorder, including information on the use and likely side-effect profile of medication.	None	
The patient and his or her family and carer(s) are informed of self-help groups and support groups and are encouraged to participate in programmes.	The patient with panic disorder or generalised anxiety disorder is unable to participate in self-help groups or support groups.	
All patients prescribed antidepressants are informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly.	None	
Necessary relevant information is elicited from	The patient with panic disorder or generalised	Necessary relevant information can be defined

the diagnostic process.	anxiety disorder is unable to participate in a discussion with the clinician responsible for treatment, and an advocate or carer is not available.	as personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care.
The treatment of choice is available promptly.	None	
Individuals with panic disorder are not prescribed benzodiazepines.	None	
A patient with panic disorder is offered any of the following types of intervention, and the person's preference is taken into account: • psychological therapy • pharmacological therapy • self-help.	None, providing that there are no known drug sensitivities	Psychological therapy is CBT. Pharmacological therapy refers to an SSRI licensed for panic disorder; or if an SSRI is unsuitable or there is no improvement imipramine or clomipramine are considered. Self-help includes bibliotherapy based on CBT principles.
A patient with generalised anxiety disorder is not prescribed benzodiazepines for longer than 2–4 weeks.	None	
A patient with longer-term generalised anxiety disorder is offered any of the following types of intervention, and the person's preference is taken into account • psychological therapy • pharmacological therapy • self help.	as above	Psychological therapy is CBT. Pharmacological therapy is an SSRI. Self-help includes bibliotherapy based on CBT principles.
A patient is reassessed if one type of intervention does not work, and consideration is given to trying one of the other types of intervention.	None	
A patient who still has significant symptoms after two interventions is offered referral to specialist	None	Two interventions can be defined as any combination of psychological intervention,

mental health services.		medication or bibliotherapy.
A thorough, holistic re-assessment of the individual, his or her environment and social circumstances is conducted by specialist mental health services.	None, unless the patient refused referral	
Outcomes are monitored using short, self-complete questionnaires.	The individual with panic disorder or generalised anxiety disorder is unable to participate in a discussion with the clinician responsible for treatment	A short self-complete questionnaire such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder.

Quality and outcome framework

The changes to the contractual arrangements for primary care services, and particularly for general practitioners, have provided an opportunity to consider different ways of auditing the care that is provided through implementing these guidelines.

The new contractual arrangements provide a system for practices to be financially rewarded for delivering specific clinical outcomes in a number of different clinical domains. Although these clinical domains and the financial rewards are carefully described for GMS (general medical services) practices, there exists the flexibility to develop new and innovative clinical domains for PMS (personal medical services) practices.

The Guideline Development Group has therefore produced such a draft framework. The structure of this section mirrors the structure of a standard quality and outcome domain, but does not allocate any points, because this will be up to the discretion of the commissioning Primary Care Trust (PCT), and then by negotiation with the personal medical services (PMS) practices.

It should be stressed that PCTs, and PMS practices, may wish to amend and alter this draft framework to make it more appropriate for local needs.

Details of the rationale, indicators and proposed methods of data collection and monitoring

Anxiety – rationale for inclusion of indicator set

Anxiety is a common and debilitating condition that affects large numbers of people. Effective treatments are available. Anxiety frequently co-exists with other conditions, both physical and mental, and influences the resolution of these other conditions. Effective treatment for anxiety disorders will also have a beneficial impact on these other co-existing conditions.

Indicator		Points*	Max threshold
Records			
A1a.	The practice can produce a register of people with generalised anxiety disorder		
A1b.	The practice can produce a register of people with panic disorder		
Treatment options			
A2a	The percentage of people with generalised anxiety disorder on the register offered CBT		No score
A2b.	The percentage of people with generalised anxiety disorder on the register offered medication		No score
A2c.	The percentage of people with generalised anxiety disorder on the register offered bibliotherapy		No score
A2	Total: the sum of the above		25–90%
A3a	The percentage of people with panic disorder on the register offered CBT		No score
A3b.	The percentage of people with panic disorder on the register offered medication *(a licensed SSRI, imipramine or clomipramine)*		No score
A3c.	The percentage of people with panic disorder on the register offered bibliotherapy		No score
A3	Total: the sum of the above		25–90%
Referral to secondary care			
A4.	The percentage of people on both registers who have been referred to secondary care services who have received two interventions in the last 12 months		25–70%

* To be agreed locally

Anxiety indicator 1

The practice can produce a register of either people with generalised anxiety disorder or panic disorder

Anxiety indicators 1a and 1b – rationale

To call and recall patients effectively in any disease category, and to be able to report on indicators, practices must be able to identify patients within the practice population who have either generalised anxiety disorder or panic disorder. Neither this quality and outcome framework nor the NICE guideline of which it is a part applies to people with mixed anxiety and depression, for which reference to the NICE depression guidelines should be made. This framework also does not apply to people who have a single panic attack, because they have not yet developed panic disorder.

Anxiety indicators 1a and 1b – preferred coding

Practices should record those with a current history of:

Generalised Anxiety Disorder Eu[X]41.1

Panic Disorder Eu[X]41.0.

Anxiety indicators 1a and 1b – reporting and validation

The practice reports the number of patients on both registers (for generalised anxiety disorder and panic disorder), and the number as a proportion of the total list size.

PCTs may compare the expected prevalence with the reported prevalence.

Anxiety indicators 2a, 2b, 2c and 2 Total

The number of patients with generalised anxiety disorder receiving either CBT, an approved medication, or self-help

Anxiety indicators 2a, 2b, 2c and 2 Total – rationale

This guideline provides the evidence for supporting shared decision-making in selecting treatments that are effective. These three indicators allow patient choice within the parameters of what is known to be effective. The sum of the total should account for all those on the generalised anxiety disorder register, to ensure that only effective interventions are offered.

Anxiety indicators 2a, 2b, 2c and 2 Total – preferred coding

Practices should record which medication, if any, is being prescribed.

Practices should record whether patients have been referred for CBT.

Practices should record whether patients have been referred for bibliotherapy.

Anxiety indicators 2a, 2b, 2c and 2 Total – reporting and validation

Practices should record the total percentage of patients on the generalised anxiety disorder register receiving an intervention.

PCTs should be able to scrutinise the computer print-out.

Anxiety indicators 3a, 3b, 3c and 3 Total

The number of patients with panic disorder receiving either CBT, an approved medication, or self-help

Anxiety indicators 3a, 3b, 3c and 3 Total – rationale

This guideline provides the evidence for supporting shared decision-making in selecting treatments that are effective. These three indicators allow patient choice within the parameters of what is known to be effective. The sum of the total should account for all those on the panic disorder register, to ensure that only effective interventions are offered.

Anxiety indicators 3a, 3b, 3c and 3 Total – preferred coding

Practices should record which medication, if any, is being prescribed.

Practices should record whether patients have been referred for CBT.

Practices should record whether patients have been referred for bibliotherapy.

Anxiety indicators 3a, 3b, 3c and 3 Total – reporting and validation

Practices should record the total percentage of patients on the panic disorder register receiving an intervention.

PCTs should be able to scrutinise the computer print-out.

Anxiety indicator 4

The number of patients referred to specialist mental health services who have had two effective interventions, but failed to improve

Anxiety indicator 4 – rationale

The majority of patients with generalised anxiety disorder or panic disorder can and should be cared for in primary care. It is appropriate to consider referral to specialist mental health services if two effective interventions have failed to produce an improvement for the patient. There will always be other reasons why referral may be necessary, which allows a slightly lower target than for the other indicators.

Anxiety indicator 4 – preferred coding

The practice should record which two interventions have been provided to patients who are referred.

Anxiety indicator 4 – reporting and verification

Practices should be able to produce a list of patients referred to specialist services for the management of generalised anxiety disorder or panic disorder, and for each patient, the number of effective interventions that patients had received.

PCTs should be able to scrutinise the list produced by the practice.

Appendix E: The algorithms

Management of panic disorder in primary care: Steps 2–4. *See the NICE website*

Management of generalised anxiety disorder in primary care: Steps 2–4. *See the NICE website*