

Issue date: December 2004, with amendments April 2007

Quick reference guide (amended)

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

Amendment of recommendations concerning venlafaxine: April 2007

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 revised sections are marked in italics on pages 6, 8 and 9 of this quick reference guide.

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.

*See

www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&useSecondary=true&ssDocName=CON2023843&ssTargetNodeId=389

Clinical Guideline 22 (amended)

Developed by the National Collaborating Centre for Primary Care

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.

Clinical Guideline 22

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 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. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

National Institute for Health and Clinical Excellence

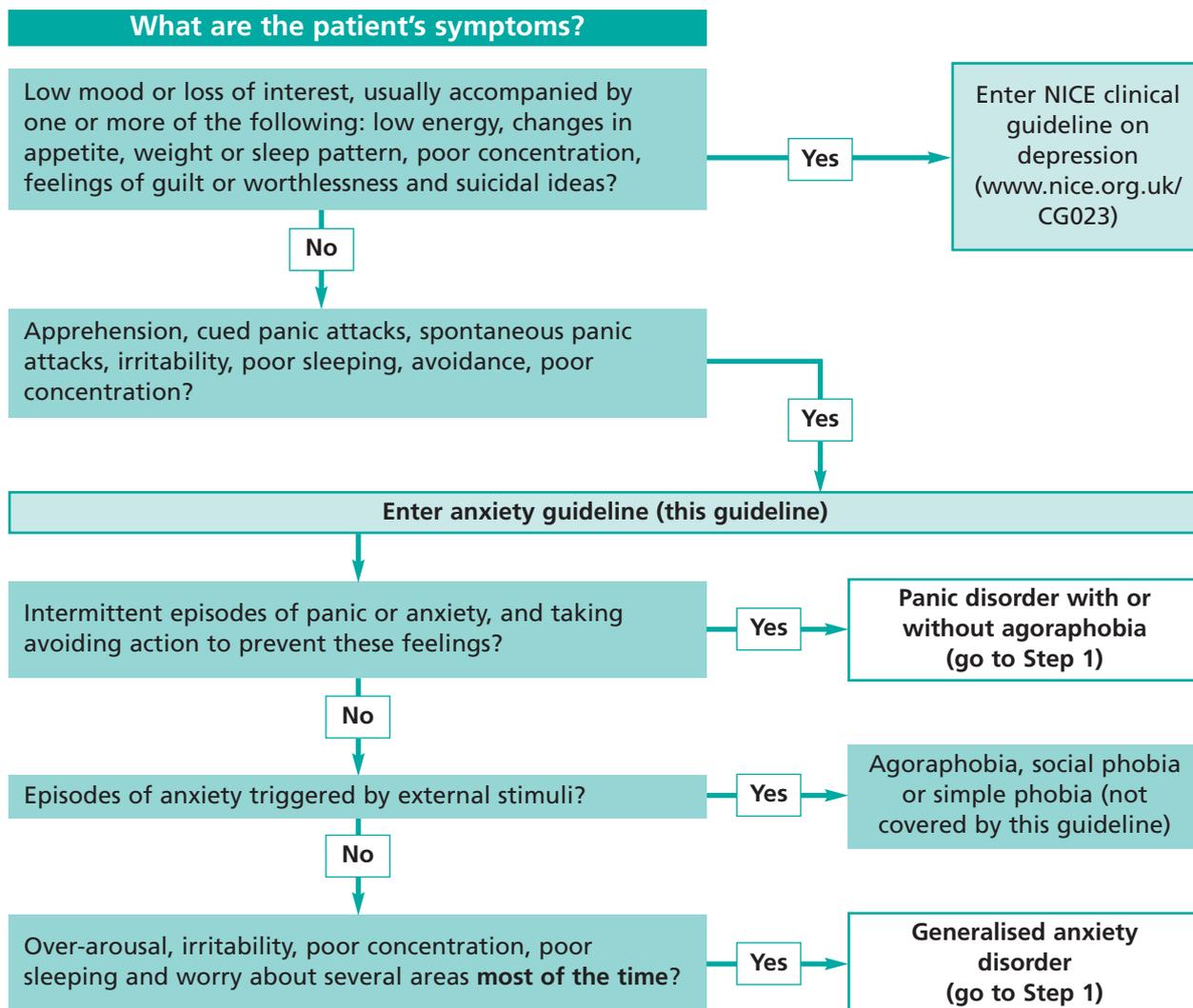
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Which NICE guideline?



Stepped approaches to care

The guideline provides recommendations for care at different stages of the patient journey, represented as different steps:

	Panic disorder See page:	Generalised anxiety disorder See page:
Step 1: Recognition and diagnosis	5	5
Step 2: Treatment in primary care	6–7	8–9
Step 3: Review and consideration of alternative treatments	6–7	8–9
Step 4: Review and referral to specialist mental health services	6–7	8–9
Step 5: Care in specialist mental health services	10	10

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 where 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 3.)

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: (a) psychological therapy (cognitive behavioural therapy [CBT]); (b) 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); (c) 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 should be taken into account. The interventions that have evidence for the longest duration of effect, in descending order, are: (a) psychological therapy (CBT); (b) pharmacological therapy (an SSRI licensed for generalised anxiety disorder); (c) 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 therapy, 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, reassessment of the individual, their environment and their 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.

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

For details of recommendation grading, see page 11.

General principles of care – all steps

Shared decision-making and information provision

- Shared decision-making between the individual and healthcare professionals should take place during diagnosis and all phases of care. **D**
- To facilitate shared decision-making:
 - provide evidence-based information about treatments **D**
 - provide information on the nature, course and treatment of panic disorder or generalised anxiety disorder, including the use and likely side-effect profile of medication **D**
 - discuss concerns about taking medication, such as fears of addiction **D**
 - consider patient preference and experience and outcome of previous treatments **D**
 - offer information about self-help groups and support groups for patients, families and carers **D**
 - encourage participation in self-help and support groups. **D**

Language

- Use everyday, jargon-free language, and explain any technical terms. **D**
- Where appropriate, provide written material in the language of the patient, and seek interpreters for people whose first language is not English. **D**
- Where available, consider providing psychotherapies in the patient's own language if this is not English. **D**

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

Consultation skills

- A high standard of consultation skills is needed so that a structured approach can be taken to the diagnosis and management plan^a. **D**

Diagnosis

- Ask about relevant information such as personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care. **D**

Comorbidities

- Be alert to comorbidity, which is common (particularly anxiety with depression and anxiety with substance abuse). **D**
- Identify the main problem(s) through discussion with the patient. **D**
- Clarify the sequence of the problems to determine the priorities of the comorbidities – drawing up a timeline to show when different problems developed can help with this. **D**
- If the patient has depression or anxiety with depression, follow the NICE guideline on management of depression (Clinical Guideline 23, see www.nice.org.uk/CG023). **D**

Presentation in A&E or other settings with a panic attack

- If a patient presents with a panic attack, he or she 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.

^a 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).

Management of panic disorder in primary care: Steps 2–4

Step 2: Offer treatment

Following discussion with patient and taking account of their preferences, offer one of the treatments listed in descending order of evidence for the long-term management of panic disorder:

- psychological therapy **A** or
- pharmacological therapy **A** or
- self-help **A**

The chosen treatment option should be available locally.

Psychological therapy

- CBT should be used **A**
 - It should be delivered by trained and supervised people, closely adhering to empirically grounded treatment protocols **A**
 - For most people, CBT should be in weekly sessions of 1–2 hours and be completed within 4 months **B**
 - The optimal range is 7–14 hours in total **A**
 - If offering briefer CBT, it should be about 7 hours, should be designed to integrate with structured self-help materials **D**, and should be supplemented with appropriate focused information and tasks **A**
 - Sometimes, more intensive CBT over a very short period might be appropriate **C**

Pharmacological therapy

Before prescribing, consider:

- age **D**
- previous treatment response **D**
- risks of deliberate self-harm or accidental overdose (*TCA*s are more dangerous in overdose than *SSRI*s) **D**
- tolerability **D**
- possible interactions with concomitant medications (check appendix 1 of the *BNF*) **D**
- the patient's preference **D**
- cost, where equal effectiveness **D**

When prescribing

- Offer an *SSRI* licensed for panic disorder
- If an *SSRI* is not suitable or there are contraindications, consider imipramine if appropriate
- Inform patients, at the time treatment is initiated, about:
 - potential side effects (including possible discontinuation/withdrawal)
 - delay in onset of effect **D**
 - time course of treatment **D**
 - need to take medication as prescribed in order to avoid relapse
- Written information appropriate to the patient's needs
- Side effects on initiation may be more noticeable than satisfactory therapeutic response
- Long-term treatment and doses should be discussed

• Benzodiazepines **A**, sedating antidepressants **A** are not recommended for the long-term treatment of panic disorder

^a Imipramine and clomipramine are not recommended for the long-term treatment of panic disorder as they are not effective in its management

Monitoring

- Assess progress according to process within the practice – determine the nature of the process on a case-by-case basis
- Use short, self-complete questionnaires to monitor outcomes wherever possible **D**

Monitoring

- Review efficacy and side effects within 2 weeks of starting treatment **D**
- Review at 8–12 week intervals if drug used for more than 12 weeks **D**
- Follow Summary of Product Characteristics for all drugs
- Use short, self-complete questionnaires to monitor outcomes wherever possible **D**

Is there improvement after a course of treatment?

Yes → If appropriate, continue care and monitoring

No → Step 3: Review

Has there been an improvement after 12 weeks of treatment?

Yes → Step 3: Review

No → Is this at least the second intervention tried?

Yes → Step 3: Review

No → Step 3: Review

Step 3: Review

Reassess the patient and consider trying another intervention **D**

If appropriate

Steps 2–4

Management in primary care

...ount of patient preference, offer (interventions with the longest duration of effect):

...promptly **D**

...panic disorder, unless otherwise indicated **A**
 ...there is no improvement after a 12-week course, and if further medication is not indicated, offer sertraline^a or clomipramine^a **A**
 ...when treatment is initiated, about:
 ...warning of a transient increase in anxiety at the start of treatment) **C**
 ...warning of withdrawal symptoms (see box on page 10) **C**

...not prescribed (this may be particularly important with short half-life drugs and discontinuation/withdrawal symptoms) **C**
 ...support for the patient's needs should be made available. **D**
 ...side effects should be minimised by starting at a low dose and slowly increasing the dose until a therapeutic effect is achieved **D**
 ...higher doses at the upper end of the indicated dose range may be necessary **B**

...antihistamines or antipsychotics **D** should not be prescribed for the

...not licensed for the treatment of panic disorder but have been shown to be

...at the start of treatment and again at 4, 6 and 8 weeks

...for more than 12 weeks **D**
 ...if other monitoring required **D**
 ...if monitoring or outcomes wherever possible **D**

Ongoing management

- Use with appropriate monitoring for 6 months after optimal dose reached: then dose can be tapered **D**
- When stopping, reduce the dose gradually over an extended period **C**

If appropriate, continue care and monitoring

Self-help

- Offer bibliotherapy based on CBT principles **A**
- Offer information about support groups, where available **D**
- Discuss the benefits of exercise as part of good general health **B**
- Computerised cognitive behaviour therapy may be of value, but a NICE technology appraisal^b found the evidence was an insufficient basis on which to recommend its general introduction into the NHS **N**

^b See www.nice.org.uk/TA051

Monitoring

- Offer contact with primary healthcare professionals to monitor progress and review; determine on a case-by-case basis but likely to be every 4–8 weeks **D**
- Use short, self-complete questionnaires to monitor outcomes wherever possible **D**

Is there improvement after a course of treatment?

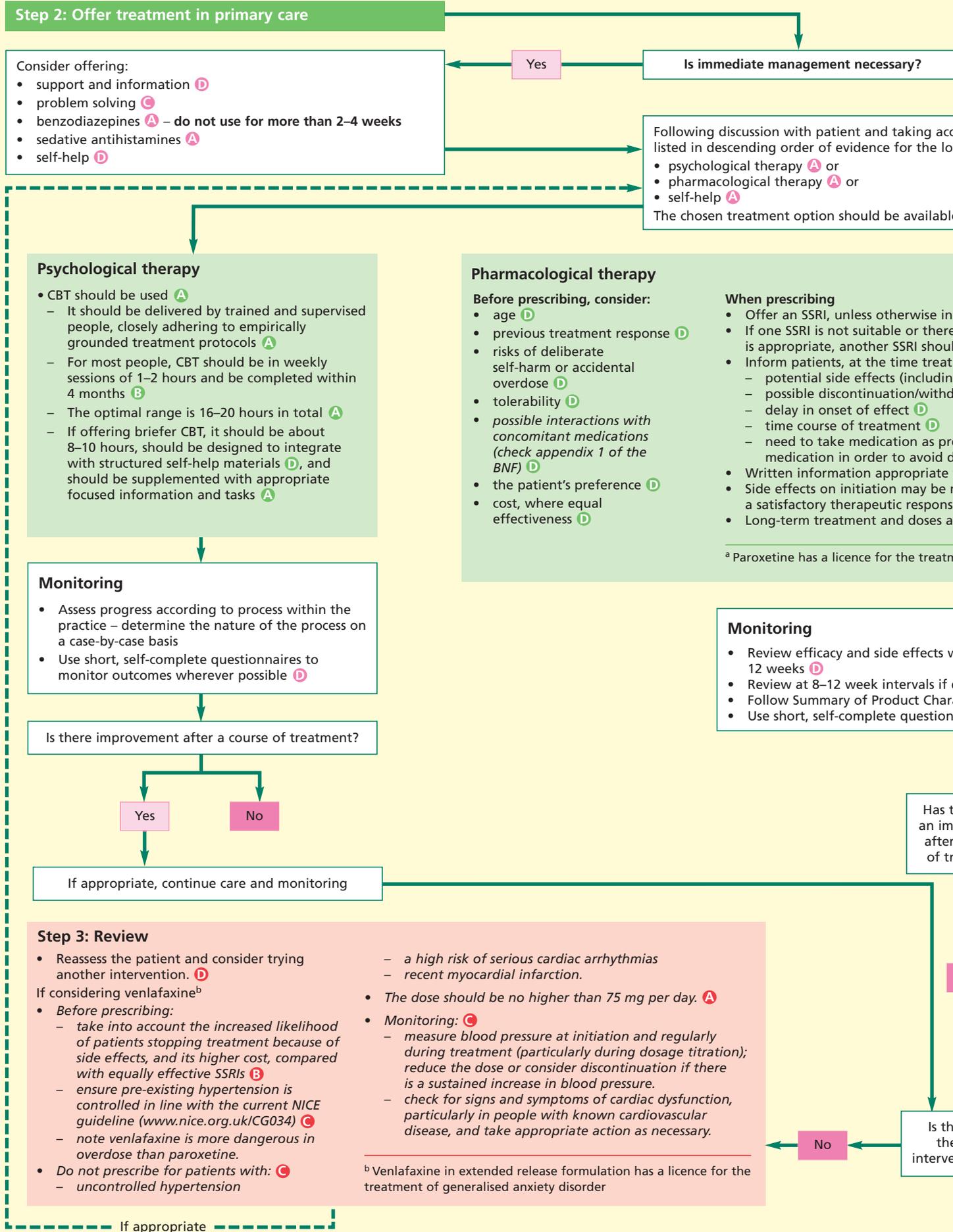
No

Yes

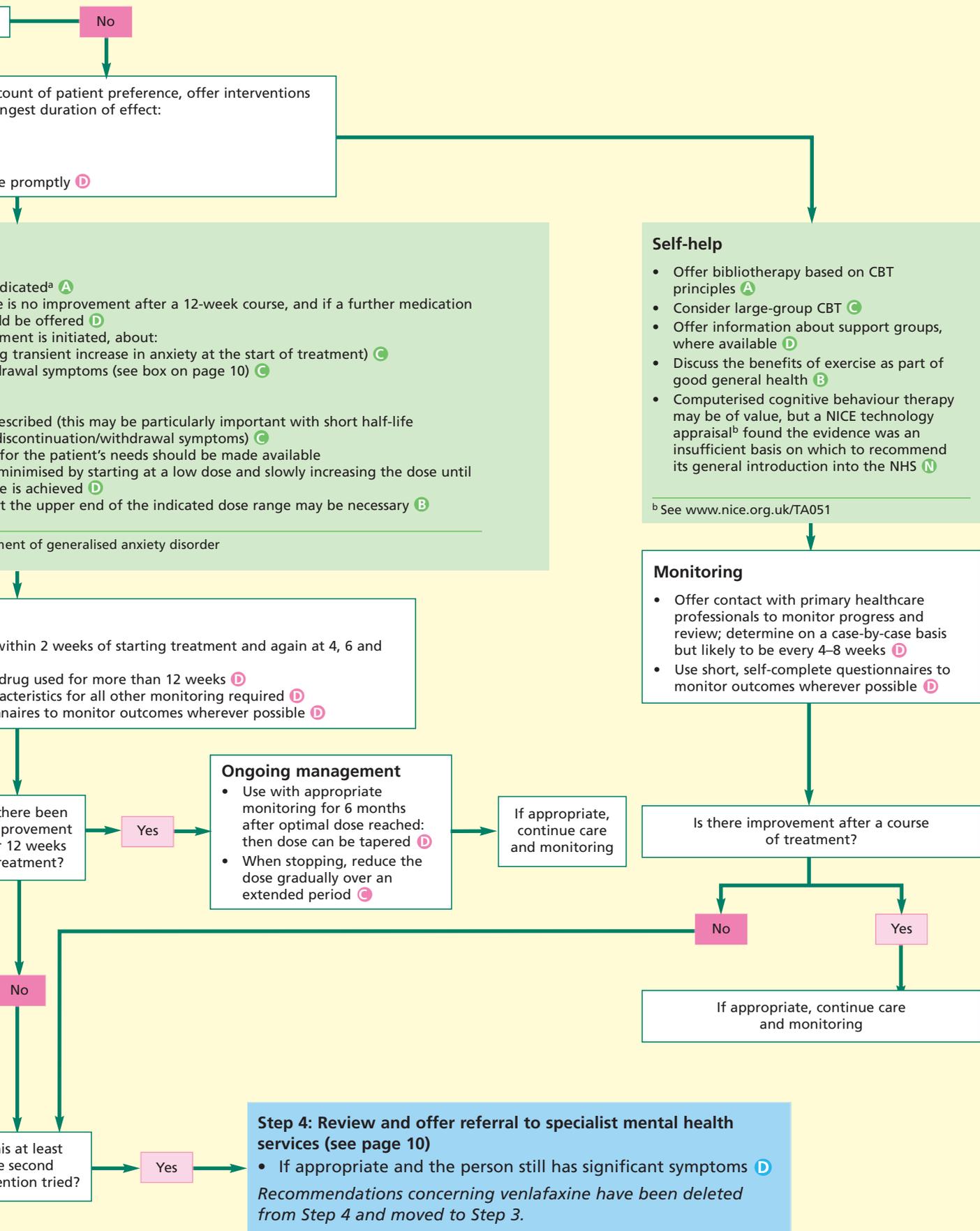
If appropriate, continue care and monitoring

Step 4: Review and offer referral to specialist mental health services (see page 10)
 If appropriate and the person still has significant symptoms **D**

Management of generalised anxiety disorder in p



Primary care: Steps 2–4



Step 5: Care for people with panic disorder and generalised anxiety disorder in specialist mental health services

- Reassess the patient, their environment and their social circumstances. Evaluate:
 - previous treatments, including effectiveness and concordance **D**
 - any substance use, including nicotine, alcohol, caffeine and recreational drugs **D**
 - comorbidities **D**
 - day-to-day functioning **D**
 - social networks **D**
 - continuing chronic stressors **D**
 - the role of agoraphobic and other avoidant symptoms. **D**
- Undertake a comprehensive risk assessment. **D**
- Develop an appropriate risk management plan. **D**

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

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

Ensure accurate and effective communication between all healthcare professionals – 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**

Antidepressant discontinuation/withdrawal symptoms

- Inform patients that:
 - although antidepressants 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**
 - 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**
 - they should seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms. **D**
- 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**
- Mild discontinuation/withdrawal symptoms: reassure the patient and monitor symptoms. **D**
- Severe discontinuation/withdrawal symptoms: consider reintroducing the antidepressant (or prescribing another from the same class that has a longer half-life) and gradually reducing the dose while monitoring symptoms. **D**

Grading of the recommendations

The recommendations on pages 5–10 are evidence-based. The grading system used is shown below. Further information on the grading of the recommendations and the evidence used to develop the guideline is presented in the full guideline (see the back cover for details).

- A** Based on category I evidence (meta-analysis of randomised controlled trials [RCTs] or at least one RCT)
- B** Directly based on category II evidence (at least one controlled study without randomisation or at least one other quasi-experimental study) or extrapolated from category I evidence
- C** Directly based on category III evidence (non-experimental descriptive studies) or extrapolated from category I or II evidence
- D** Directly based on category IV evidence (expert committee reports or opinions and/or clinical experience of respected authorities) or extrapolated from category I, II or III evidence
- N** Evidence from NICE technology appraisal guidance

See the NICE guideline for further information (www.nice.org.uk/CG022NICEguideline).

Implementation

Local health communities should review their existing practice for the care of individuals with panic disorder or generalised anxiety disorder against this guideline. The review should consider the resources required to implement the recommendations set out in Section 1 of the NICE guideline (www.nice.org.uk/CG022NICEguideline), 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 and protocols should be reviewed in the light of this guidance and revised accordingly.

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 http://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.cisp.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 is provided in the NICE guideline (www.nice.org.uk/CG022NICEguideline).

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

Further information

Distribution

The distribution list for this quick reference guide is available from www.nice.org.uk/CG022distributionlist

NICE guideline

The NICE guideline, '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).

The NICE guideline contains the following sections: Key priorities for implementation; 1 Guidance; 2 Notes on the scope of the guidance; 3 Implementation in the NHS; 4 Key research recommendations; 5 Other versions of this guideline; 6 Related NICE guidance; 7 Review date. It also gives details of the grading scheme for the evidence and recommendations, the Guideline Development Group, the Guideline Review Panel and technical detail on the criteria for audit.

Information for the public

NICE has produced a version of this guidance for people with people with panic disorder or generalised anxiety disorder, their carers and the public. The information is available, in English and Welsh, from the NICE website (www.nice.org.uk/CG022publicinfo). Printed versions are also available – see below for ordering information.

Full guideline

The full guideline includes the evidence on which the recommendations are based, in addition to

information in the NICE guideline. It is published by the National Collaborating Centre for Primary Care. It is available from www.rcgp.org.uk/nccpc, from www.nice.org.uk/CG022fullguideline and on the website of the National Library for Health (www.library.nhs.uk).

Related NICE guidance

For information about NICE guidance that has been issued or is in development, see the website (www.nice.org.uk).

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

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

Review date

NICE expects to make a decision on a full update of this guideline later in 2007.

Ordering information

Copies of this quick reference guide can be obtained from the NICE website at www.nice.org.uk/CG022quickrefguide or from the NHS Response Line by telephoning 0870 1555 455 and quoting reference number N1235. Information for the public is also available from the NICE website or from the NHS Response Line (quote reference number N1236).

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