NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Anxiety

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 1 July 2013

Contents

Introduction

This briefing paper presents a structured overview of potential quality improvement areas for a NICE quality standard on anxiety. It provides the Committee with a basis for discussion when prioritising quality improvement areas for developing quality statements and measures, which will be drafted for public consultation.

Structure

The structure of this paper includes a brief overview of the topic followed by a summary of each of the suggested quality improvement areas.

Where relevant, guideline recommendations selected from the key development sources are presented to aid the Committee when considering detail of which statements and measures should be developed.

Development source

Unless otherwise stated, the key development sources referenced in this briefing paper are presented below, by order of publication date with most recent first.

NICE Clinical Guideline	Population covered
Social anxiety disorder: recognition, assessment and treatment. NICE clinical guideline 159 (May 2013).	Children, young people and adults
Common mental health disorders: identification and pathways to care. NICE clinical guideline 123 (2011)[1].	Adults
Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline 113 (2011).	Adults
Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).	Children, young people and adults
Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005).	Children , young people and adults

Where relevant, guideline recommendations from the above sources are presented alongside each of the suggested areas for quality improvement within the main body of the report.

[1] **The common mental health disorder (for adults) guideline brings together advice from existing guidelines and combines it with new recommendations on access to care, assessment and developing local care pathways for common mental health disorders. Common mental health disorders include depression, generalised anxiety disorder (GAD), panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety disorder.**

1 Overview

1.1 Focus of quality standard

The focus of this quality standard is the identification and management of anxiety disorders in primary, secondary and community care.

1.2 Definition

Common mental health problems

Anxiety disorders are examples of **common mental health disorders**.

They include depression and anxiety disorders such as generalised anxiety disorder (GAD), panic disorder, obsessive-compulsive disorder (called OCD for short) and post-traumatic stress disorder (called PTSD for short).

These mental health problems are called 'common' because combined they affect more people than other mental health problems (up to 15% of people at any one time in the UK). However, many individuals do not seek treatment and common mental health disorders often go unrecognised.

Some people may have more than one mental health problem (such as depression and anxiety).

Generalised anxiety disorder (GAD)

Generalised anxiety disorder is a common disorder, of which the central feature is excessive worry about a number of different events associated with heightened tension. A person with generalised anxiety disorder may also feel irritable and have physical symptoms such as restlessness, feeling easily tired, and having tense muscles. They may also have trouble concentrating or sleeping.

A formal diagnosis is made using the DSM-IV classification system. Symptoms should be present for at least 6 months and should cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Panic disorder

Panic disorder can be characterised by the presence of recurring, unforeseen panic attacks followed by at least 1 month of persistent worry about having another panic attack and concern about the consequences of a panic attack,

or a significant change in behaviour related to the attacks[2]. At least two unexpected panic attacks are necessary for diagnosis and the attacks should not be accounted for by the use of a substance, a general medical condition or another psychological problem.

Obsessive–compulsive disorder (OCD)

Obsessive-compulsive disorder is characterised by the presence of either obsessions or compulsions, but commonly both. The symptoms can cause significant functional impairment and/or distress. An obsession is defined as an unwanted intrusive thought, image or urge that repeatedly enters the person's mind. Compulsions are repetitive behaviours or mental acts that the person feels driven to perform.

Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder can develop following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. PTSD does not therefore develop following those upsetting situations that are described as 'traumatic' in everyday language, for example, divorce, loss of job, or failing an exam.

Social anxiety disorder (previously known as 'social phobia')

Social anxiety disorder (previously known as 'social phobia'), also known as social phobia is persistent fear of or anxiety about one or more social situations that involve interaction, observation and performance that is out of proportion to the actual threat posed by the social situation. It is one of the most common of the anxiety disorders.

There is considerable variation in the severity of common mental health disorders, but all can be associated with significant long-term disability and people with severe mental illnesses die on average 20 years earlier than the general population. Mental health problems can be distressing to individuals, their families, friends and carers, and affect their local communities.

There is also an association with poorer socio-economic outcomes, as people with mental health problems often have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes, are more likely to be homeless or insecurely housed, and are more likely to live in areas of high social deprivation[3].

Anxiety disorders can have a lifelong course of relapse and remission.

[2] American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders (fourth edition, text revision). Washington DC: American Psychiatric Association.

[3] HM Government (2011) No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.

1.3 Incidence and prevalence

The 1-week prevalence rates from the Office of National Statistics 2007 national survey[4] were 4.4% for GAD, 1.1% for panic disorder, 3.0% for PTSD, 1.1% for OCD and 1.4% for phobias.

The development of anxiety symptoms and syndromes is likely to have started by adolescence. These can range from transient mild symptoms to established anxiety disorders [5]. Anxiety disorders can exist in isolation but more commonly occur with other anxiety and depressive disorders and often exist alongside mental health problems such as substance-use disorder. More than half of people aged 16 to 64 years who meet the diagnostic criteria for at least one common mental health disorder experience comorbid anxiety and depressive disorders[6].Recent estimates suggest that the costs of mental health problems as a whole in England could be close to £105 billion. Costs include lost productivity and the wider impact on wellbeing[7].

1.4 Management

The vast majority of depression and anxiety disorders that are diagnosed are treated in primary care (up to 90%). Recognition of anxiety disorders is particularly poor in primary care and only a small minority of people experiencing anxiety disorders ever receive treatment.

People with mental health disorders and their families may face stigma and discrimination, which contributes to the low proportion of people presenting to services for assessment and treatment (around 30% of all people with common mental health disorders). For those who do access services, treatment is often limited to the prescription of medication or referral on to specialist/secondary mental health services. This may be partly because evidence-based psychological services are not universally available.

Although under-recognition is generally more common in mild rather than severe cases, mild disorders are still a source of concern, as without treatment, people may develop more severe conditions or have adverse effects later on.

The Improving Access to Psychological Therapies (IAPT) programme, which was set up to help services implement NICE guidelines for people with depression and

[4] McManus S, Meltzer H, Brugha T, et al (2007) Adult psychiatric morbidity in England, 2007: results of a household survey.
[5] Beesdo K, Knappe S, Pine DS. Anxiety and anxiety disorders in children and adolescents: developmental issues and implications for DSM-V. The Psychiatric clinics of North America. 2009;32:483-524.
[6] American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders (fourth edition, text revision). Washington DC: American Psychiatric Association.
[7] HM Government (2011) No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.

anxiety disorders, provides guidance and support for implementing a stepped-care model. However, the extent to which the IAPT programme is being implemented varies in practice[8].

Current practice information highlights that access to services is uneven and not all groups have benefited equally, or at all, from improvements, for example black and minority ethnic communities.

See appendices 1-7 for selected patient pathway, algorithms and key priority for implementation (KPI) recommendations from the NICE clinical guidelines listed as potential development sources for this quality standard.

[8] HM Government (2011) No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages

1.5 National Outcome Frameworks

The table below shows the indicators from the NHS Outcomes Framework that the quality standard could contribute to:

NHS Outcomes Framework 2013/14	
Preventing people from dying prematurely	Improvement area: Reducing premature death in people with serious mental illness 1.5 Excess under 75 mortality rate in adults with serious mental illness
Enhancing quality of life for people with long-term conditions	Overarching Indicator 2 Health related quality of life for people with long-term conditions Improvement area: Ensuring people feel supported to manage their condition 2.1 Proportion of people feeling supported to manage their condition Improving functional ability in people with long-term conditions 2.2 Employment of people with long-term conditions Improvement area: Enhancing quality of life for people with mental illness 2.5 Employment of people with mental illness
Helping people to recover from ill-health or following injury	Improvement area: Improving outcomes from planned treatments 3.1 Total health gain as assessed by patients for elective procedures v Psychological therapies
Ensuring people have a positive experience of care	Overarching indicator: 4a Patient experience of primary care i GP services ii GP out-of-hours services Overarching indicator: 4b Patient experience of hospital care Overarching indicator: 4.c Friends and Family Test Improvement area: Improving hospitals' responsiveness to personal needs 4.2 Responsiveness to in-patients' personal needs Improvement area: Improving people's experience of accident and emergency services 4.3 Patient experience of accident and emergency services Improvement area: Improving experience of healthcare for people with mental illness

	4.7 Patient experience of community mental health services

2 Summary of suggestions

2.1 Responses

In total 6 stakeholders responded to the 2-week engagement exercise 02/05/13 – 17/05/13.

Stakeholders were asked to suggest up to 5 areas for quality improvement. These have been summarised in table 1 for further consideration by the Committee. The full detail of the suggestions is provided in appendix 6 for information.

Additional comments relating to issues other than the improvement areas are included in the full table of suggestions set out in appendix 6. These will be considered by the QSAC during development of the quality standard.

Table 1 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholder
Identification and assessment • Identification • Assessment	AUK PLTD RD&SHFT SWYPFT NHSE
Initiating the correct treatment	AUK RD&SHFT NHSE
Review and follow-up • Review of treatment • Follow-up	PLTD
Pharmacological treatment for people with refractory anxiety disorders	PLTD
Reduction in use of non-NICE recommended pharmacological therapies	PLTD
Treatment for children and adolescents	AFREBT
Access to, and promotion of, exercise	AUK
Peer support schemes • Referral to peer support schemes including self-help • Out of hours peer-led crisis support	AUK

The details of stakeholder organisations who submitted suggestions are provided in the table 2.

Table 2 Stakeholder details (abbreviations)

Abbreviation	Full name
AFREBT	Association for Rational Emotive Behaviour Therapy
AUK	Anxiety UK
NHSE	NHS England
PLTD	Pfizer Ltd
RD&SHFT	Rotherham Doncaster and South Humber NHS Foundation Trust
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust

3 Suggested improvement area: identification and assessment

3.1 Summary of suggestions

Identification

Stakeholders highlighted the importance of identification and diagnosis of the correct and full range of anxiety disorder(s). This is seen as key to ensuring the patient accesses treatment at an early stage and is signposted to the appropriate treatment pathway for their specific anxiety condition and primary presenting disorder, reducing mild to moderate anxiety disorders becoming more complex as a result of incorrect initial diagnosis .

One stakeholder (Anxiety UK) drew attention to current practice where people are often incorrectly diagnosed with depression as the main condition when depression is secondary to an anxiety disorder presentation.

Assessment

Stakeholders) reported that people who might have anxiety should receive an assessment to identify the specific anxiety disorder, the severity of symptoms, the degree of associated functional impairment and the duration of the episode.

The range of anxiety disorders was noted, highlighting the need for GPs and other relevant healthcare professionals to diagnose accurately to ensure correct treatment intervention.

Note There is a published NICE quality standard for depression in adults (QS08) which includes a quality statement for assessment:

- Quality statement 1: People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode.

The table below presents recommendations that have been provisionally selected from the development sources and which might support potential statement development.

Suggested quality improvement area	**NICE guidance**
Identification and assessment of anxiety disorders	**Identification** • **Common mental health disorders. NICE CG123.** Recs 1.3.1.2 (KPI) and 1.3.1.3. *** These recommendations are presented in full below.* The following recommendations relating to identification of specific anxiety disorders are provisionally highlighted below. • **Social Anxiety Disorder. NICE CG159** Recs 1.2.1, 1.4.1. • **GAD. NICE CG113** Recs (GAD: 1.2.2 (KPI), 1.2.3 (KPI), 1.2.4) (Panic disorder: 1.4.2, 1.4.3, 1.4.6). • **OCD/BDD. NICE CG31** Recs 1.4.1.1 and 1.4.2.1, 1.4.2.2, 1.4.2.6. • **PTSD. NICE CG26** Recs 1.3.1.1, 1.3.1.2, 1.3.1.4, 1.3.2.1, 1.3.3.1 (KPI), 1.3.3.2, 1.3.4.1, 1.3.4.2. **Assessment** • **Common mental health disorders. NICE CG123**. Recs 1.3.2.1, 1.3.2.2, 1.3.2.3, 1.3.2.4, 1.3.2.5, 1.3.2.6, 1.3.2.7, 1.3.2.9. *** These recommendations are presented in full below.* The following recommendations relating to assessment of specific anxiety disorders are provisionally highlighted below. • **Social Anxiety Disorder. NICE CG159** Recs 1.2.2, 1.2.3, 1.2.5, 1.2.6, 1.2.7, 1.2.8, 1.4.5, 1.4.6, 1.4.7, 1.4.8, 1.4.9, 1.4.10, 1.4.11, 1.4.12

	• **GAD. NICE CG113** Recs (GAD: 1.2.5, 1.2.6, 1.2.8, 1.2.37) and (Panic disorder: 1.4.4, 1.4.5). • **OCD/BDD. NICE CG31** Recs 1.4.1.2, 1.4.1.3 and 1.4.2.3, 1.4.2.4, 1.4.2.5. • **PTSD. NICE CG26** Recs 1.4.1, 1.4.2.

3.2 Selected recommendations from development sources

Common mental health disorders. NICE clinical guideline 123 (2011)

The following recommendations relating to the identification of common mental health disorders have been provisionally selected.

Step 1: Identification and assessment

Identification

NICE CG123 Recommendation 1.3.1.2 (KPI)

Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or in those who have experienced a recent traumatic event). Consider asking the person about their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2; see appendix D).

- If the person scores three or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment (see section 1.3.2).
- If the person scores less than three on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following: 'Do you find yourself avoiding places or activities and does this cause you problems?'. If the person answers 'yes' to this question consider an anxiety disorder and follow the recommendations for assessment (see section 1.3.2).

NICE CG123 Recommendation 1.3.1.3

For people with significant language or communication difficulties, for example people with sensory impairments or a learning disability, consider using the Distress Thermometer and/or asking a family member or carer about the person's symptoms to identify a possible common mental health disorder. If a significant level of distress is identified, offer further assessment or seek the advice of a specialist.

Assessment

The following recommendations have been provisionally selected that relate to the assessment of common mental health disorders.

NICE CG123 Recommendation 1.3.2.1

If the identification questions (see section 1.3.1) indicate a possible common mental health disorder, but the practitioner is not competent to perform a mental health assessment, refer the person to an appropriate healthcare professional. If this professional is not the person's GP, inform the GP of the referral.

NICE CG123 Recommendation 1.3.2.2

If the identification questions (see section 1.3.1) indicate a possible common mental health disorder, a practitioner who is competent to perform a mental health assessment should review the person's mental state and associated functional, interpersonal and social difficulties.

NICE CG123 Recommendation 1.3.2.3

When assessing a person with a suspected common mental health disorder, consider using:

- a diagnostic or problem identification tool or algorithm, for example, the Improving Access to Psychological Therapies (IAPT) screening prompts tool
- a validated measure relevant to the disorder or problem being assessed, for example, the 9-item Patient Health Questionnaire (PHQ-9), the Hospital Anxiety and Depression Scale (HADS) or the 7-item Generalized Anxiety Disorder scale (GAD-7) to inform the assessment and support the evaluation of any intervention.

NICE CG123 Recommendation 1.3.2.4

All staff carrying out the assessment of suspected common mental health disorders should be competent to perform an assessment of the presenting problem in line with the service setting in which they work, and be able to:

- determine the nature, duration and severity of the presenting disorder
- take into account not only symptom severity but also the associated functional impairment
- identify appropriate treatment and referral options in line with relevant NICE guidance.

NICE CG123 Recommendation 1.3.2.5

All staff carrying out the assessment of common mental health disorders should be competent in:

- relevant verbal and non-verbal communication skills, including the ability to elicit problems, the perception of the problem(s) and their impact, tailoring information, supporting participation in decision-making and discussing treatment options
- the use of formal assessment measures and routine outcome measures in a variety of settings and environments.

NICE CG123 Recommendation 1.3.2.6

In addition to assessing symptoms and associated functional impairment, consider how the following factors may have affected the development, course and severity of a person's presenting problem:

- a history of any mental health disorder
- a history of a chronic physical health problem
- any past experience of, and response to, treatments
- the quality of interpersonal relationships
- living conditions and social isolation
- a family history of mental illness
- a history of domestic violence or sexual abuse
- employment and immigration status.

If appropriate, the impact of the presenting problem on the care of children and young people should also be assessed, and if necessary local safeguarding procedures followed.

NICE CG123 Recommendation 1.3.2.7

When assessing a person with a suspected common mental health disorder, be aware of any learning disabilities or acquired cognitive impairments, and if necessary consider consulting with a relevant specialist when developing treatment plans and strategies.

NICE CG123 Recommendation 1.3.2.9

Always ask people with a common mental health disorder directly about suicidal ideation and intent. If there is a risk of self-harm or suicide:

- assess whether the person has adequate social support and is aware of sources of help
- arrange help appropriate to the level of risk (see section 1.3.3)
- advise the person to seek further help if the situation deteriorates

3.3 Current UK practice

One of the three workstreams in the Quality, Innovation, Productivity and Prevention (QIPP) programme is improved identification and treatment of anxiety or depression for those with medically unexplained symptoms. It includes better diagnosis and treatment of mental health problems for those with long-term physical conditions[9].

Stakeholders highlighted variation in diagnoses of the different types of anxiety disorders. Attention was also drawn to the fact that people are often incorrectly diagnosed with depression as the main condition when depression is secondary to an anxiety disorder presentation. As anxiety is often comorbid with depression, accurate diagnosis can be problematic.

A peer review into the quality of community children and adult mental health services (CAMHS) highlighted variations in the content of assessments. Only 37% of case notes across the network showed that assessments evidence whether there are concerns about alcohol or drug usage, however 92% of services ensure that assessments include consideration of the young person's family and community needs and context[10].

[9] HM Government (2011) No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages.
[10] Royal College of Psychiatry (2011) Quality Network for Community CAMHS, cycle 6.

4 Suggested improvement area: initiating the correct treatment

4.1 Summary of suggestions

Stakeholders commented that correct identification and adequate assessment (as covered in previous suggested improvement area) should enable people to receive the appropriate treatment.

The table below presents recommendations that have been provisionally selected from the development sources and which might support potential statement development.

Suggested quality improvement area	**NICE guidance**
Initiating the correct treatment	**Common mental health disorders. NICE CG123.** Recs 1.4.1.1, 1.4.1.2 and 1.4.1.4** ** *These recommendations are presented in full below.* Additional overarching considerations are covered in **NICE CG123** recommendations 1.4.1.4 – 1.4.1.10 The following recommendations relating to initiation of correct treatment for specific anxiety disorders are provisionally highlighted below. **GAD. NICE CG113.** Recs 1.2.1, 1.2.7, 1.2.8. **Panic Disorder. NICE CG113**. Rec 1.4.9. **OCD/BDD. NICE CG31** Recs 1.5.1.1(KPI), 1.5.1.2 (KPI), 1.5.1.3 (KPI), 1.5.1.4, 1.5.1.5, 1.5.1.6 (KPI), 1.5.1.7, 1.5.1.8, 1.5.1.9 (KPI), 1.5.1.10 (KPI), 1.5.1.11, 1.5.1.12. **PTSD. NICE CG26.** Recs 1.9.1.1 (KPI), 1.9.1.4 (KPI), 1.9.1.5, 1.9.1.7, 1.9.2.1 (KPI), 1.9.2.2, 1.9.5.1 (KPI), 1.9.5.2 (KPI). **Social Anxiety Disorder. NICE CG159.** 1.2.10 – 1.2.12, 1.3.2, 1.3.4 – 1.3.7, 1.5.3 –

	1.5.6.

4.2 Selected recommendations from development sources

Common mental health disorders. NICE clinical guideline 123 (2011)

Identifying the correct treatment options

NICE CG123 Recommendation 1.4.1.1

When discussing treatment options with a person with a common mental health disorder, consider:

- their past experience of the disorder
- their experience of, and response to, previous treatment
- the trajectory of symptoms
- the diagnosis or problem specification, severity and duration of the problem
- the extent of any associated functional impairment arising from the disorder itself or any chronic physical health problem
- the presence of any social or personal factors that may have a role in the development or maintenance of the disorder
- the presence of any comorbid disorders.

NICE CG123 Recommendation 1.4.1.2

When discussing treatment options with a person with a common mental health disorder, provide information about:

- the nature, content and duration of any proposed intervention
- the acceptability and tolerability of any proposed intervention
- possible interactions with any current interventions
- the implications for the continuing provision of any current interventions.

NICE CG123 Recommendation 1.4.1.3

When making a referral for the treatment of a common mental health disorder, take account of patient preference when choosing from a range of evidence-based treatments.

NICE CG123 Recommendation 1.4.1.4

When offering treatment for a common mental health disorder or making a referral, follow the stepped-care approach, usually offering or referring for the least intrusive, most effective intervention first.

****See appendix 1 for stepped-care model relating to above recommendation.**

NICE CG123 Recommendation 1.4.1.5

When a person presents with symptoms of anxiety and depression, assess the nature and extent of the symptoms, and if the person has:

- depression that is accompanied by symptoms of anxiety, the first priority should usually be to treat the depressive disorder, in line with the NICE guideline on depression
- an anxiety disorder and comorbid depression or depressive symptoms, consult the NICE guidelines for the relevant anxiety disorder and consider treating the anxiety disorder first
- both anxiety and depressive symptoms, with no formal diagnosis, that are associated with functional impairment, discuss with the person the symptoms to treat first and the choice of intervention
- development or maintenance of the disorder
- the presence of any comorbid disorders.

4.3 Current UK practice

Results of an adult psychiatry morbidity survey conducted in England in 2007 show that that almost 66% of people with GAD and 69% of people with OCD reported receiving no treatment, compared with over 7% of people with panic disorder. Just over half of people with two or more common mental health disorders were not receiving any treatment for a mental or emotional problem. For those who were receiving treatment, medication was more commonly accessed than counselling or therapy[11]. Older participants were less likely than younger adults to receive talking therapy, although various limitations were identified in interpreting the data[12].

[11] McManus S, Meltzer H, Brugha T, et al (2007) Adult psychiatric morbidity in England, 2007: results of a household survey.
[12] Cooper C, Bebbington P, McManus S et al (2010) The treatment of Common Mental Disorders across age groups: results from the 2007 Adult Psychiatric Morbidity Survey, Journal of affective disorders, Dec;127(1-3):96-101.

The expectation is that by the end of 2014/15 a minimum of 15% per annum of those in need will be able to access psychological therapy services[13]. Data from the Improving Access to Psychological Therapies (IAPT) key performance indicators for quarter 3 of 2012 shows an increase in the number of people entering psychological therapy to 2.36% (compared to the agreed trajectory published in the NHS Operating Framework, which set out an anticipated prevalence rate of 2.82%). Regional variation in access, data quality and completeness has been reported through the programme[14].

[13] Department of Health (2011) Talking Therapies: A four-year plan of action.
[14] IAPT Programme IAPT Q3 key performance indicator (KPI) headlines (2013).

5 Suggested improvement area: review and follow-up (including quality of life)

5.1 Summary of suggestions

One stakeholder (Pfizer Ltd) reported that an emphasis exclusively on diagnosis might not necessarily improve the ultimate outcomes of patients who require continued review and follow up to improve quality of life. Regular review of anxiety symptoms following all types of intervention at all stages of the pathway is important.

It was reported that there are a high proportion of patients not completing their course and achieving recovery with considerable variability in local protocols and provisions. It was suggested that clarifying requirements for GPs and other healthcare professionals to take ownership of patients who fail or drop out of IAPT services could ensure that patients continue on the NICE recommended pathway of care, reducing variability and improving outcomes for patients with anxiety.

The table below presents recommendations that have been provisionally selected from the development sources and which might support potential statement development.

Suggested quality improvement area	**NICE guidance**
Review and follow-up (including quality of life).	**Identifying the correct treatment options (Stepped care models)** **Common mental health disorders. NICE CG123** Rec 1.4.1.4 ** *This recommendation is presented in full below.* There are also condition-specific recommendations including stepped care models: **GAD. NICE CG113** Rec 1.2.1 **Panic Disorder. NICE CG113** Rec 1.4 **OCD/BDD. NICE CG31** Rec 1.2

Additional areas related to review and follow-up (including quality of life)

In addition to recommendations referencing stepped care models, which should support people to progress to the relevant level of treatment, a number of additional recommendations have been identified relating to the following areas:

- Poor response to treatment (GAD, OCD and BDD, PTSD and Social Anxiety Disorder).
- Monitoring efficacy and risks (GAD, OCD and BDD, PTSD and Social Anxiety Disorder).
- Support at discharge stage (OCD and BDD).
- Follow-up of missed appointments (PTSD).
- Removing obstacles to attendance (Social Anxiety Disorder).

5.2 Selected recommendations from development sources

Common mental health disorders. NICE clinical guideline 123 (2011)

Identifying the correct treatment options

NICE CG123 Recommendation 1.4.1.4

When offering treatment for a common mental health disorder or making a referral, follow the stepped-care approach, usually offering or referring for the least intrusive, most effective intervention first.

****See appendix 1 for stepped-care model relating to above recommendation.**

5.3 Current UK practice

'Talking Therapies: A four-year plan of action'[15] sets out the expectation that by the end of 2014/15, at least 50% of those completing treatment will recover (i.e. move from caseness to non-caseness). Data collected for quarter 3 of 2012 against the IAPT key performance indicators[16] shows a rate of recovery of 44.4% for those completing treatment. However, although number of people completing courses of treatment has increased as service provision has grown, the latest national review of the IAPT programme shows that the proportion of people completing a course of treatment has decreased[17].

'Talking Therapies: A four-year plan of action'[15] also highlighted the government's intention to broaden the benefits to people with long-term physical or mental health conditions. The policy identified that people with long-term physical health conditions

[15] Department of Health (2011) Talking Therapies: A four-year plan of action
[16] IAPT Programme IAPT Q3 key performance indicator (KPI) headlines (2013)
[17] Department of health (2012) IAPT three-year report – the first million patients

were rarely referred for psychological interventions, despite the fact that these people are between three and four times more likely to experience depression and anxiety disorders than the rest of the population. Roll-out of a pathfinder project among 15 therapy teams commenced on 1st April 2012, with the overall aim of improving access to psychological therapies for people with long term conditions and medically unexplained symptoms[18].

A study of the impact of implementing stepped care for people with depression and anxiety[19] found that only half of people referred for stepped care went on to receive treatment. Of 7859 consecutive patients followed over 24 months, 54.7% of those treated for anxiety met reliable improvement or reliable and clinically significant change criteria. Recovery rates of 40 – 46% were identified for people receiving stepped care-empirically supported treatments for anxiety and depression in routine practice.

A peer review into the quality of community CAMHS' highlighted that over 88% of services measure progress towards the goals of the young person and their parents/carers and that these are agreed in the care plan and monitored at regular intervals[20].

[18] University of Surrey (2013) IAPT LTC/MUS Pathfinder Evaluation Project Interim report
[19] Richards, DA and Borglin, G Implementation of psychological therapies for anxiety and depression in routine practice: two year prospective cohort study, Journal of Affective Disorders 133 (2011) 51–60
[20] Royal College of Psychiatry (2011) Quality Network for Community CAMHS, cycle 6.

6 Suggested improvement area: pharmacological treatment for refractory anxiety disorders

6.1 Summary of suggestions

Stakeholder(s) report that the current focus on talking therapies could mean pharmacological treatments are overlooked. In addition, stakeholder (s) reported inappropriately high use of atypical antipsychotics and benzodiazepines in primary care, including unlicensed drugs.

The table below presents recommendations that have been provisionally selected from the development sources and which might support potential statement development.

Suggested quality improvement area	**NICE guidance**
Pharmacological treatment for refractory anxiety disorders	**Common mental health disorders. NICE CG123** Rec 1.4.3.5. **GAD. NICE CG113** Recs 1.2.16 (KPI), 1.2.33, 1.4.9 **OCD/BDD. NICE CG31** Recs 1.5.1.2 (KPI), 1.5.1.9 (KPI), 1.5.4.2, 1.5.5.2 (KPI), 1.5.5.3 (KPI) **PTSD. NICE CG26**. Rec 1.9.3.4 **Social anxiety disorder. NICE CG159** Rec 1.3.8 *** These recommendations are presented in full below.*

6.2 Selected recommendations from development sources

Common mental health disorders. NICE clinical guideline 123 (2011)

Step 3: Treatment and referral advice for persistent subthreshold depressive symptoms or mild to moderate common mental health disorders with inadequate response to initial interventions, or moderate to severe common mental health disorders

NICE clinical guideline 123 states that if there has been an inadequate response following the delivery of a first-line treatment for persistent subthreshold depressive symptoms or mild to moderate common mental health disorders, a range of psychological, pharmacological or combined interventions may be considered.

NICE CG123 Recommendation 1.4.3.5

For people with generalised anxiety disorder who have marked functional impairment or have not responded to a low-intensity intervention, offer or refer for one of the following:

- CBT **or**
- applied relaxation **or**
- if the person prefers, drug treatment

Generalised anxiety disorder. NICE clinical guideline 113 (2011)

Step 3: GAD with marked functional impairment or that has not improved after step 2 interventions

Treatment options

NICE CG113 Recommendation 1.2.16 (KPI)

For people with GAD and marked functional impairment, or those whose symptoms have not responded adequately to step 2 interventions:

- Offer either
    - an individual high-intensity psychological intervention (see 1.2.17–1.2.21) **or**
    - drug treatment (see 1.2.22–1.2.32).

- Provide verbal and written information on the likely benefits and disadvantages of each mode of treatment, including the tendency of drug treatments to be associated with side effects and withdrawal syndromes.

- Base the choice of treatment on the person's preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug treatment) is better.

Inadequate response to step 3 interventions

NICE CG113 Recommendation 1.2.33

If a person's GAD has not responded to a full course of a high-intensity psychological intervention, offer a drug treatment

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

NICE CG113 Recommendation 1.4.9

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:

- psychological therapy (see 1.4.12–1.4.18)
- pharmacological therapy (antidepressant medication) (see 1.4.19–1.4.31)
- self-help (see 1.4.32–1.4.34).

Obsessive compulsive disorder (OCD) and body dysmorphic disorder. NICE clinical guideline 31 (2005)

Steps 3–5: treatment options for people with OCD or BDD

Initial treatment options: adults

NICE CG31 Recommendation 1.5.1.2 (KPI)

Adults with OCD with mild functional impairment who are unable to engage in low intensity CBT (including ERP), or for whom low intensity treatment has proved to be inadequate, should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.

Initial treatment options: Children and young people

NICE CG31 Recommendation 1.5.1.9 (KPI)

Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self-help has been ineffective or refused, should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers.

Poor response to initial treatment in adults

NICE CG31 Recommendation 1.5.4.2

Following multidisciplinary review, for adults with OCD or BDD, if there has not been an adequate response to treatment with an SSRI alone (within 12 weeks) or CBT (including ERP) alone (more than 10 therapist hours per patient), combined treatment with CBT (including ERP) and an SSRI should be offered

Poor response to initial treatment in children and young people

NICE CG31 Recommendation 1.5.5.2 (KPI)

Following multidisciplinary review, for a ***child*** (aged 8–11 years) with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment may be considered. Careful monitoring should be undertaken, particularly at the beginning of treatment.

NICE CG31 Recommendation 1.5.5.3 (KPI)

Following multidisciplinary review, for a ***young person*** (aged 12–18 years) with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment should be offered. Careful monitoring should be undertaken, particularly at the beginning of treatment.

Post traumatic stress disorder. NICE CG26 (2005)

Drug treatmentNICE CG26 Recommendation 1.9.3.4

Drug treatments (paroxetine or mirtazapine for general use and amitriptyline or phenelzine for initiation only by mental health specialists) should be considered for adult PTSD sufferers who have gained little or no benefit from a course of trauma-focused psychological treatment.

Social anxiety disorder. NICE CG159 (2013)

Options for adults with no or a partial response to initial treatment

NICE CG159 Recommendation 1.3.8

For adults whose symptoms of social anxiety disorder have only partially responded to individual CBT after an adequate course of treatment, consider a pharmacological intervention (see recommendation 1.3.6) in combination with individual CBT.

6.3 Current UK practice

Results of the adult psychiatry morbidity survey conducted in England in 2007[21] show that that medication was more commonly accessed than counselling or therapy for those receiving treatment.

[21] McManus S, Meltzer H, Brugha T, et al (2007) Adult psychiatric morbidity in England, 2007: results of a household survey

7 Suggested improvement area: reduction in use of non-NICE recommended pharmacological therapies

7.1 Summary of suggestions

Stakeholder(s) commented that despite being unlicensed and not recommended by NICE for routine use in primary care, there appears to be considerable use of some drugs. These include benzodiazepines and atypical antipsychotics, such as quetiapine, in primary care.

The table below presents recommendations that have been provisionally selected from the development sources and which might support potential statement development.

Suggested quality improvement area	**NICE guidance**
Reduction in use of non-NICE recommended pharmacological therapies	**GAD. NICE CG113** Recs 1.2.25 (KPI), 1.4.7, 1.4.8 **OCD/BDD. NICE CG31** Recs 1.5.3.20, 1.5.3.21, 1.5.3.22, 1.5.6.19, 1.5.6.20, 1.5.6.21 **Social anxiety disorder. NICE CG159**. Recs 1.6.2, 1.6.4, 1.6.5, 1.6.6 ** *These recommendations are presented in full below.*

7.2 Selected recommendations from development sources

Generalised anxiety disorder. NICE clinical guideline 113 (2011)

Step 3: GAD with marked functional impairment or that has not improved after step 2 interventions

Drug treatment

NICE CG113 Recommendation 1.2.25 (KPI)

Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises. Follow the advice in the 'British national formulary' on the use of a benzodiazepine in this context.

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

NICE CG113 Recommendation 1.4.7

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.

NICE CG113 Recommendation 1.4.8

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

Obsessive compulsive disorder (OCD) and body dysmorphic disorder. NICE clinical guideline 31 (2005)

How to use pharmacological interventions in adults

Choice of drug treatment: Other drugs

NICE CG31 Recommendation 1.5.3.20

The following drugs should not normally be used to treat OCD or BDD without comorbidity:

- tricyclic antidepressants other than clomipramine
- tricyclic-related antidepressants
- serotonin and noradrenaline re-uptake inhibitors (SNRIs), including venlafaxine
- monoamine oxidase inhibitors (MAOIs)
- anxiolytics (except cautiously for short periods to counter the early activation of SSRIs).

NICE CG31 Recommendation 1.5.3.21

Antipsychotics as a monotherapy should not normally be used for treating OCD.

NICE CG31 Recommendation 1.5.3.22

Antipsychotics as a monotherapy should not normally be used for treating BDD (including beliefs of delusional intensity).

How to use pharmacological treatments in children and young people

Other drugs

NICE CG31 Recommendation 1.5.6.19

Tricyclic antidepressants other than clomipramine should not be used to treat OCD or BDD in children and young people.

NICE CG31 Recommendation 1.5.6.20

Other antidepressants (MAOIs, SNRIs) should not be used to treat OCD or BDD in children and young people.

NICE CG31 Recommendation 1.5.6.21

Antipsychotics should not be used alone in the routine treatment of OCD or BDD in children or young people, but may be considered as an augmentation strategy.

Social anxiety disorder. NICE CG159 (2013)

Interventions that are not recommended to treat social anxiety disorder

NICE CG159 Recommendation 1.6.2

Do not routinely offer anticonvulsants, tricyclic antidepressants, benzodiazepines or antipsychotic medication to treat social anxiety disorder in adults.

NICE CG159 Recommendation 1.6.4

Do not offer St John's wort or other over-the-counter medications and preparations for anxiety to treat social anxiety disorder. Explain the potential interactions with other prescribed and over-the-counter medications and the lack of evidence to support their safe use.

NICE CG159 Recommendation 1.6.5

Do not offer botulinum toxin to treat hyperhidrosis (excessive sweating) in people with social anxiety disorder. This is because there is no good-quality evidence showing benefit from botulinum toxin in the treatment of social anxiety disorder and it may be harmful.

NICE CG159 Recommendation 1.6.6

Do not offer endoscopic thoracic sympathectomy to treat hyperhidrosis or facial blushing in people with social anxiety disorder. This is because there is no good-

quality evidence showing benefit from endoscopic thoracic sympathectomy in the treatment of social anxiety disorder and it may be harmful.

7.3 Current UK practice

Results from the adult psychiatry morbidity survey conducted in England in 2007[22] show that 13% of people with one comorbidity, and 32% of people with two comorbidities were taking antidepressants. In comparison, 2% of people with one comorbidity and 11% of people with two comorbidities were taking Anxiolytics.

[22] McManus S, Meltzer H, Brugha T, et al (2007) Adult psychiatric morbidity in England, 2007: results of a household survey

8 Suggested improvement area: treatment for children and adolescents

8.1 Summary of suggestions

One stakeholder specifically highlighted treatment for children and young people as requiring focus for improvement. It was noted that anxiety affects more children and adolescents than any other psychiatric illness.

The table below presents recommendations that have been provisionally selected from the development sources which cover children and young people and which might support potential statement development.

Suggested quality improvement area	**NICE guidance**
Treatment of children and adolescents.	**OCD/BDD. NICE CG31** Recs 1.3.1.1 (KPI), 1.5.1.8, 1.5.1.9 (KPI), 1.5.1.10 (KPI), 1.5.1.11, 1.5.1.12, 1.5.2.12, 1.5.2.13, 1.5.5.1, 1.5.5.2 (KPI), 1.5.5.3 (KPI), 1.5.5.4, 1.5.6.1 – 1.5.6.21 **PTSD. NICE CG26** Recs 1.9.5.1 (KPI), 1.9.5.2 (KPI), 1.9.5.3 – 1.9.5.6 **Social anxiety disorder. NICE CG159** Recs 1.5.1 – 1.5.6, 1.6.1.

8.2 Current UK practice

A review of national CAMHS progress[23] reported that despite some decreases in waiting times between 2005 and 2007, children and young people are still waiting too long to access services. A report by the Mental Health Policy Group of the London School of Economics[24] reported through an ad hoc survey of GPs that in 2010, 78% were rarely able to access specialist psychological therapy within two months.

The government pledged to extend the IAPT programme to children and young people in 'Talking therapies: A four-year plan of action'[25], which commenced roll-out in 2011, and saw further funding for child mental health services, including the CYP IAPT project, of up to £22 million in total for 2012–15[26]. It suggests that many children and young people are currently unable to access treatments. It also

[23] Department of Health (2006) Children and young people in mind: the final report of the National CAMHS Review
[24] London School of Economics (2012) How mental illness loses out in the NHS.
[25] Department of Health (2011) Talking Therapies: A four-year plan of action
[26] Department of Health (2012) IAPT three-year report: The first million patients

identifies that treatments currently provided for children and young people are not always firmly based on NICE and best practice guidelines. ‘Talking Therapies: A four year plan of action’ identified that similar psychological interventions to those offered by the IAPT programme for adults would be effective in meeting the needs of children and young people with anxiety. However, it acknowledges that expertise and experience in engaging and working with young people and their families through to adolescence and young adulthood is required, as well as skills to deliver evidence-based therapies[6]. The children and young people IAPT programme will work with existing CAMHS services to focus on extending training and embedding evidence based practice. By the end of 2013, services covering 34% of the population aged 0–19 years will have been through the CYP IAPT service transformation process[27].

[27] Department of Health (2012) IAPT three-year report: The first million patients

9 Suggested improvement area: access to, and promotion of, exercise

9.1 Summary of suggestions

Stakeholder(s) report that the promotion of physical exercise schemes available on prescription with equitable access can help play a significant role in the prevention and recovery of anxiety and other associated mental health disorders.

9.2 Selected recommendations from development sources

No recommendations were identified that related to specific exercise programmes; however one recommendation was identified from relating to general benefits of exercise for people with Panic Disorder.

Generalised anxiety disorder. NICE clinical guideline 113 (2011)

Step 2 for people with panic disorder: offer treatment in primary care: Self-help

NICE CG113 Recommendation 1.4.34

The benefits of exercise as part of good general health should be discussed with all people with panic disorder as appropriate.

9.3 Current UK practice

No current practice information was identified.

10 Suggested improvement area: peer support schemes

10.1 Summary of suggestions

Stakeholder(s) report that peer support schemes and self-help groups provide cost effective method of complementing clinical services.

Stakeholder(s) report that provision of out of hours, peer-led crisis support for mild to moderate anxiety via a non-bedded facility will allow access for support when other services are not available and prevent those with anxiety disorders presenting to statutory crisis/NHS services inappropriately.

The table below presents recommendations that have been provisionally selected from the development sources and which might support potential statement development.

Suggested quality improvement area	**NICE guidance**
Peer support schemes.	**Common mental health disorders. NICE CG123.** Recs 1.4.1.10, 1.4.2.1, 1.4.2.2 *** These recommendations are presented in full below.* Condition-specific recommendations have also been identified which include: **GAD. NICE CG123** Rec 1.4.2.4; **NICE CG113** Recs 1.1.4, 1.2.11 (KPI), 1.2.14 **Panic Disorder. NICE CG113** Recs 1.3.7, 1.4.33. **OCD. NICE CG123** Rec 1.4.2.6, **NICE CG31** Recs 1.1.3.3, 1.5.1.1 (KPI), 1.5.1.9 (KPI). **BDD. NICE CG31** Recs 1.1.3.3 1.5.1.5. **Social Anxiety Disorder. NICE CG159** Rec 1.5.3 (children only).

10.2 Selected recommendations from development sources

Common mental health disorders. NICE CG 123 (2011)

Identifying the correct treatment options

NICE CG123 NICE Recommendation 1.4.1.10

If a person with a common mental health disorder needs social, educational or vocational support, consider:

- informing them about self-help groups (but not for people with PTSD), support groups and other local and national resources
- befriending or a rehabilitation programme for people with long-standing moderate or severe disorders
- educational and employment support services.

Step 2: Treatment and referral advice for subthreshold symptoms and mild to moderate common mental health disorders

NICE CG123 Recommendation 1.4.2.1

For people with persistent subthreshold depressive symptoms or mild to moderate depression, offer or refer for one or more of the following low-intensity interventions:

- individual facilitated self-help based on the principles of cognitive behavioural therapy (CBT)
- computerised CBT
- a structured group physical activity programme
- a group-based peer support (self-help) programme (for those who also have a chronic physical health problem)
- non-directive counselling delivered at home (listening visits) (for women during pregnancy or the postnatal period)

NICE CG123 Recommendation 1.4.2.2

For pregnant women who have subthreshold symptoms of depression and/or anxiety that significantly interfere with personal and social functioning, consider providing or referring for:

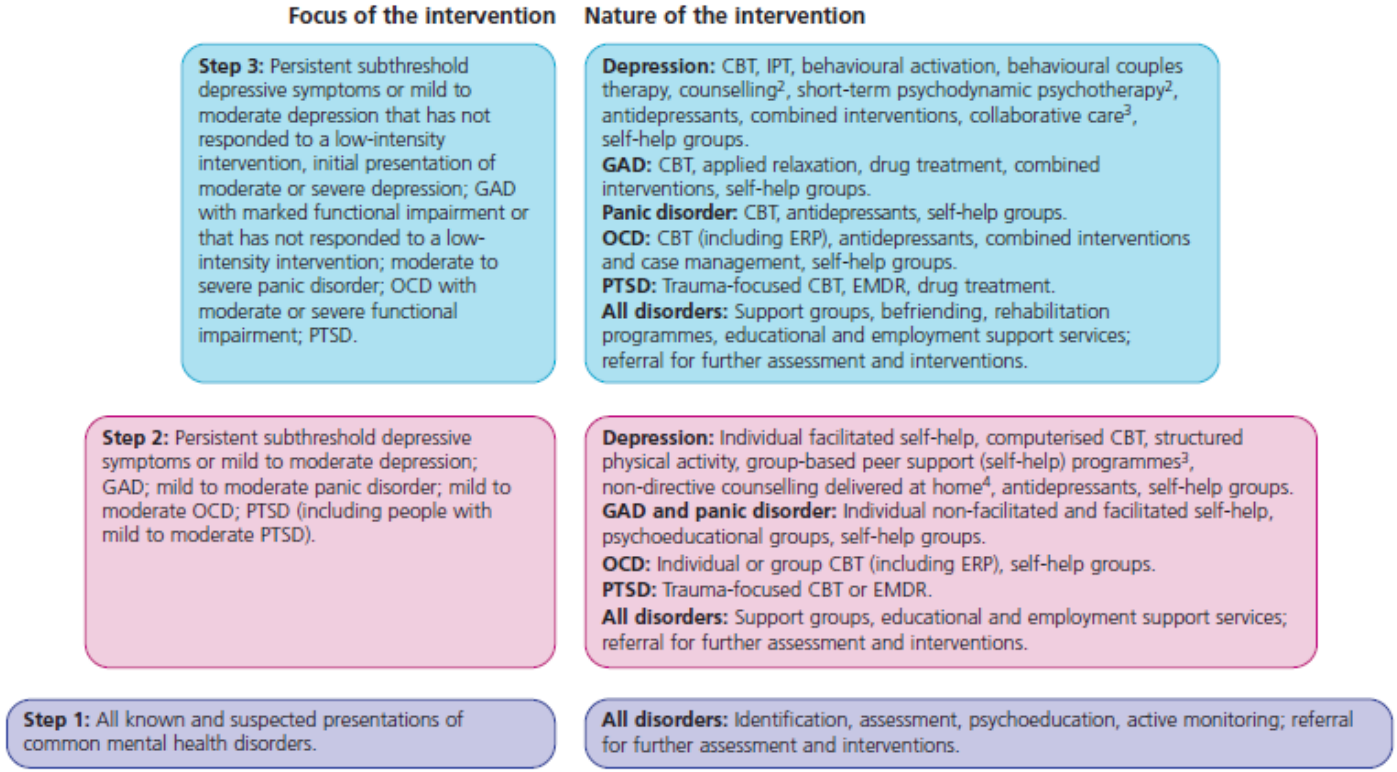
- individual brief psychological treatment (four to six sessions), such as interpersonal therapy (IPT) or CBT for women who have had a previous episode of depression or anxiety
- social support during pregnancy and the postnatal period for women who have not had a previous episode of depression or anxiety; such support may consist of regular informal individual or group-based support

10.3 Current UK practice

No current practice information was identified.

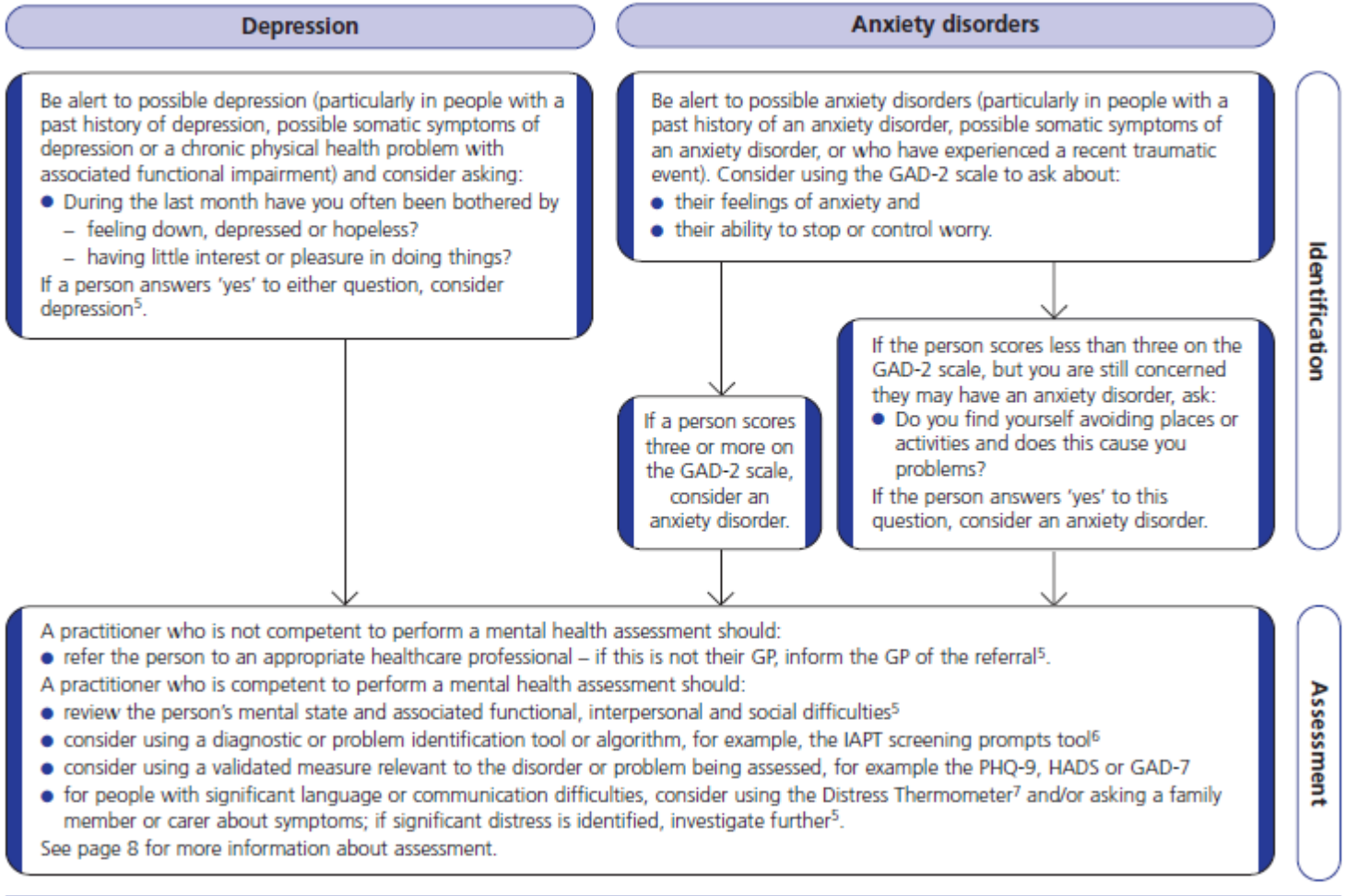
Appendix 1 The stepped care model for common mental health disorders (taken from NICE CG 123 quick reference guide)

A stepped-care model is used to organise the provision of services and to help people with common mental health disorders, their families, carers and healthcare professionals to choose the most effective interventions. The model presents the key interventions from this guideline. For recommendations focused solely on specialist mental health services see related NICE guidance (page 22).



[2] Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.
[3] For people with depression and a chronic physical health problem.
[4] For women during pregnancy or the postnatal period.

Step 1 Identification and assessment



Step 2 Treatment and referral advice for subthreshold symptoms and mild to moderate disorders

Step 2 Treatment and referral advice

Disorder	Psychological interventions	Pharmacological interventions	Psychosocial interventions
Depression – persistent subthreshold symptoms, or mild to moderate depression	Offer or refer for one or more of the following low-intensity interventions: • individual facilitated self-help based on the principles of CBT • computerised CBT • a structured group physical activity programme • a group-based peer support (self-help) programme (for those who also have a chronic physical health problem) • non-directive counselling delivered at home (listening visits) (for women during pregnancy or the postnatal period)[a,b,c].	Do not offer antidepressants routinely but consider them, or refer for an assessment, for: • initial presentation of subthreshold depressive symptoms that have been present for a long period (typically at least 2 years) **or** • subthreshold depressive symptoms or mild depression that persist(s) after other interventions **or** • a past history of moderate or severe depression **or** • mild depression that complicates the care of a physical health problem[a,b].	Consider: • informing people about self-help groups, support groups and other local and national resources • educational and employment support services[a].
GAD – that has not improved after psychoeducation and active monitoring in step 1	Offer or refer for one of the following low-intensity interventions: • individual non-facilitated self-help • individual facilitated self-help • psychoeducational groups[d].	N/A	
Panic disorder – mild to moderate	Offer or refer for one of the following low-intensity interventions: • individual non-facilitated self-help • individual facilitated self-help.	N/A	

Continued

Step 3 Treatment and referral advice for persistent subthreshold symptoms, mild to moderate disorders with inadequate response to initial interventions, or moderate to severe disorders

Step 3 Treatment and referral advice

Disorder	Psychological or pharmacological interventions	Combined and complex interventions	Psychosocial interventions
Depression – persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention	Offer or refer for: • antidepressant medication **or** • a psychological intervention (CBT, IPT, behavioural activation or behavioural couples therapy)[a]. For people who decline the interventions above consider providing or referring for: • counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression • short-term psychodynamic psychotherapy for people with mild to moderate depression[a]. Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression[a].	N/A	Consider: • informing people about self-help groups, support groups and other local and national resources • befriending or a rehabilitation programme for people with long-standing moderate or severe disorders • educational and employment support services[a].
Depression – moderate or severe (first presentation)	See combined and complex interventions column.	Offer or refer for a psychological intervention (CBT or IPT) in combination with an antidepressant[a].	
Depression – moderate to severe depression and a chronic physical health problem	See combined and complex interventions column.	For people with no, or only a limited, response to psychological or drug treatment alone or combined in the current or in a past episode, consider referral to collaborative care[b].	
			Continued

Step 3 Treatment and referral advice *(continued)*

Disorder	Psychological or pharmacological interventions	Combined and complex interventions	Psychosocial interventions
GAD – with marked functional impairment or non-response to a low-intensity intervention	Offer or refer for one of the following: • CBT **or** • applied relaxation **or** • if the person prefers, drug treatment[c].	N/A	Consider: • informing people about self-help groups, support groups and other local and national resources • befriending or a rehabilitation programme for people with long-standing moderate or severe disorders • educational and employment support services[a].
Panic disorder – moderate to severe (with or without agoraphobia)	Consider referral for: • CBT **or** • an antidepressant if the disorder is long-standing or the person has not benefitted from or has declined psychological interventions[c].	N/A	
OCD – moderate or severe functional impairment, and in particular where there is significant comorbidity with other common mental health disorders[d]	For moderate impairment, offer or refer for CBT (including ERP) or antidepressant medication[e]. Offer home-based treatment where the person is unable or reluctant to attend a clinic or has specific problems (for example, hoarding)[e].	For severe impairment offer or refer for CBT (including ERP) combined with antidepressant medication and case management[e,f]. Offer home-based treatment where the person is unable or reluctant to attend a clinic or has specific problems (for example, hoarding)[e].	
PTSD	Offer or refer for a psychological intervention (trauma-focused CBT or EMDR). Do not delay the intervention or referral, particularly for people with severe and escalating symptoms in the first month after the traumatic event[g]. Offer or refer for drug treatment only if a person declines an offer of a psychological intervention or expresses a preference for drug treatment[g].	N/A	Consider: • informing people about support groups and other local and national resources • befriending or a rehabilitation programme for people with long-standing moderate or severe disorders • educational and employment support services[a].

[a] Adapted from 'Depression' (NICE clinical guideline 90).
[b] Adapted from 'Depression in adults with a chronic physical health problem.' (NICE clinical guideline 91).
[c] Adapted from 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults' (NICE clinical guideline 113).
[d] For people with long-standing OCD or with symptoms that are severely disabling and restrict their life, consider referral to a specialist mental health service.
[e] Adapted from 'Obsessive-compulsive disorder' (NICE clinical guideline 31).
[f] For people with OCD who have not benefitted from two courses of CBT (including ERP) combined with antidepressant medication, refer to a service with specialist expertise in OCD.
[g] Adapted from 'Post-traumatic stress disorder' (NICE clinical guideline 26).

Appendix 2 Key priorities for implementation recommendations (CG123 – Common mental health disorders)

Improving access to services

- [CG123 Recommendation 1.1.1.1] Primary and secondary care clinicians, managers and commissioners should collaborate to develop local care pathways (see also section 1.5) that promote access to services for people with common mental health disorders by:
    - supporting the integrated delivery of services across primary and secondary care
    - having clear and explicit criteria for entry to the service
    - focusing on entry and not exclusion criteria
    - having multiple means (including self-referral) to access the service
    - providing multiple points of access that facilitate links with the wider healthcare system and community in which the service is located.

Identification

- [CG123 Recommendation 1.3.1.1] Be alert to possible depression (particularly in people with a past history of depression, possible somatic symptoms of depression or a chronic physical health problem with associated functional impairment) and consider asking people who may have depression two questions, specifically:
    - During the last month, have you often been bothered by feeling down, depressed or hopeless?
    - During the last month, have you often been bothered by having little interest or pleasure in doing things?

If a person answers 'yes' to either of the above questions consider depression and follow the recommendations for assessment (see section 1.3.2)[3]

- [CG123 Recommendation 1.3.1.2] Be alert to possible anxiety disorders (particularly in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or in those who have experienced a recent traumatic event). Consider asking the person about their feelings of anxiety and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2; see appendix D).
    - If the person scores three or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment (see section 1.3.2).
    - If the person scores less than three on the GAD-2 scale, but you are still concerned they may have an anxiety disorder, ask the following: 'Do you find yourself avoiding places or activities and does this cause you problems?'. If the person answers 'yes' to this question consider an anxiety disorder and follow the recommendations for assessment (see section 1.3.2).

Developing local care pathways

- [CG123 Recommendation 1.5.1.3] Primary and secondary care clinicians, managers and commissioners should work together to design local care pathways that promote a stepped-care model of service delivery that:
    - provides the least intrusive, most effective intervention first
    - has clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
    - does not use single criteria such as symptom severity to determine movement between steps
    - monitors progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed.
- [CG123 Recommendation 1.5.1.8] Primary and secondary care clinicians, managers and commissioners should work together to design local care pathways that provide an integrated programme of care across both primary and secondary care services. Pathways should:
    - minimise the need for transition between different services or providers

    - allow services to be built around the pathway and not the pathway around the services
    - establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
    - have designated staff who are responsible for the coordination of people's engagement with the pathway.
- [CG123 Recommendation 1.5.1.9] Primary and secondary care clinicians, managers and commissioners should work together to ensure effective communication about the functioning of the local care pathway. There should be protocols for:
    - sharing and communicating information with people with common mental health disorders, and where appropriate families and carers, about their care
    - sharing and communicating information about the care of service users with other professionals (including GPs)
    - communicating information between the services provided within the pathway
    - communicating information to services outside the pathway.

[3]Adapted from 'Depression' (NICE clinical guideline 90).

Appendix 3 Key priorities for implementation recommendations (CG113 – Generalised anxiety disorder and panic disorder in adults)

Step 1: All known and suspected presentations of GAD

Identification

- [CG113 Recommendation 1.2.2] Identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly.
- [CG113 Recommendation 1.2.3] Consider the diagnosis of GAD in people presenting with anxiety or significant worry, and in people who attend primary care frequently who:
    - have a chronic physical health problem **or**
    - do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups) **or**
    - are repeatedly worrying about a wide range of different issues.

Step 2: Diagnosed GAD that has not improved after step 1 interventions

Low-intensity psychological interventions for GAD

- [CG113 Recommendation 1.2.11] For people with GAD whose symptoms have not improved after education and active monitoring in step 1, offer one or more of the following as a first-line intervention, guided by the person's preference:
    - individual non-facilitated self-help
    - individual guided self-help
    - psychoeducational groups.

Step 3: GAD with marked functional impairment or that has not improved after step 2 interventions

Treatment options

- [CG113 Recommendation 1.2.16] For people with GAD and marked functional impairment, or those whose symptoms have not responded adequately to step 2 interventions:
    - Offer either:
        - an individual high-intensity psychological intervention (see 1.2.17–1.2.21) **or**
        - drug treatment (see 1.2.22–1.2.32).
    - Provide verbal and written information on the likely benefits and disadvantages of each mode of treatment, including the tendency of drug treatments to be associated with side effects and withdrawal syndromes.
    - Base the choice of treatment on the person's preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug treatment) is better.

High-intensity psychological interventions

- [CG113 Recommendation 1.2.17] If a person with GAD chooses a high-intensity psychological intervention, offer either cognitive behavioural therapy (CBT) or applied relaxation.

Drug treatment

- [CG113 Recommendation 1.2.22] If a person with GAD chooses drug treatment, offer a selective serotonin reuptake inhibitor (SSRI). Consider offering sertraline first because it is the most cost-effective drug, but note that at the time of publication (January 2011) sertraline did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented. Monitor the person carefully for adverse reactions.
- [CG113 Recommendation 1.2.25] Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises. Follow the advice in the 'British national formulary' on the use of a benzodiazepine in this context.
- [CG113 Recommendation 1.2.26] Do not offer an antipsychotic for the treatment of GAD in primary care.

Inadequate response to step 3 interventions

- [CG113 Recommendation 1.2.36] Consider referral to step 4 if the person with GAD has severe anxiety with marked functional impairment in conjunction with:
    - a risk of self-harm or suicide **or**
    - significant comorbidity, such as substance misuse, personality disorder or complex physical health problems **or**
    - self-neglect **or**
    - an inadequate response to step 3 interventions.

Appendix 4 Key priorities for implementation recommendations (CG26 – Post-traumatic stress disorder)

Initial response to trauma

- [CG26 Recommendation 1.9.1.3] For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident, should **not** be routine practice when delivering services.
- [CG26 Recommendation 1.9.1.1] Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by people with post-traumatic stress disorder (PTSD), should be considered. A follow-up contact should be arranged within 1 month.

Trauma-focused psychological treatment

- [CG26 Recommendation 1.9.1.4] Trauma-focused cognitive behavioural therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis.
- [CG26 Recommendation 1.9.2.1] All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]). These treatments should normally be provided on an individual outpatient basis.

Children and young people

- [CG26 Recommendation 1.9.5.1] Trauma-focused CBT should be offered to older children with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.
- [CG26 Recommendation 1.9.5.2] Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused CBT adapted appropriately to suit their age, circumstances and level of development.

Drug treatments for adults

- [CG26 Recommendation 1.9.3.1] Drug treatments for PTSD should not be used as a routine first-line treatment for adults (in general use or by specialist mental health professionals) in preference to a trauma-focused psychological therapy.
- [CG26 Recommendation 1.9.3.2] Drug treatments (paroxetine or mirtazapine for general use, and amitriptyline or phenelzine for initiation only by mental health specialists) should be considered for the treatment of PTSD in adults who express a preference not to engage in trauma-focused psychological treatment[1].

Screening for PTSD

- [CG26 Recommendation 1.3.3.1] For individuals at high risk of developing PTSD following a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at 1 month after the disaster.

[1] Paroxetine is the only drug listed with a current UK product license for PTSD at the date of publication (March 2005).

Appendix 5 Key priorities for implementation recommendations (CG31 – Obsessive-compulsive disorder)

All people with OCD or BDD

- [CG31 Recommendation 1.3.1.1] Each PCT, mental healthcare trust and children's trust that provides mental health services should have access to a specialist obsessive-compulsive disorder (OCD)/body dysmorphic disorder (BDD) multidisciplinary team offering age-appropriate care. This team would perform the following functions: increase the skills of mental health professionals in the assessment and evidence-based treatment of people with OCD or BDD, provide high-quality advice, understand family and developmental needs, and, when appropriate, conduct expert assessment and specialist cognitive-behavioural and pharmacological treatment.
- [CG31 Recommendation 1.7.1.2] OCD and BDD can have a fluctuating or episodic course, or relapse may occur after successful treatment. Therefore, people who have been successfully treated and discharged should be seen as soon as possible if re-referred with further occurrences of OCD or BDD, rather than placed on a routine waiting list. For those in whom there has been no response to treatment, care coordination (or other suitable processes) should be used at the end of any specific treatment programme to identify any need for continuing support and appropriate services to address it.

Adults with OCD or BDD

- [CG31 Recommendation 1.5.1.1] In the initial treatment of adults with OCD, low intensity psychological treatments (including exposure and response prevention [ERP]) (up to 10 therapist hours per patient) should be offered if the patient's degree of functional impairment is mild and/or the patient expresses a preference for a low intensity approach. Low intensity treatments include:
    - brief individual cognitive behavioural therapy (CBT) (including ERP) using structured self-help materials
    - brief individual CBT (including ERP) by telephone

    - group CBT (including ERP) (note, the patient may be receiving more than 10 hours of therapy in this format).
- [CG31 Recommendation 1.5.1.2] Adults with OCD with mild functional impairment who are unable to engage in low intensity CBT (including ERP), or for whom low intensity treatment has proved to be inadequate, should be offered the choice of either a course of a selective serotonin re-uptake inhibitor (SSRI) or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.
- [CG31 Recommendation 1.5.1.3] Adults with OCD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive CBT (including ERP) (more than 10 therapist hours per patient), because these treatments appear to be comparably efficacious.
- [CG31 Recommendation 1.5.1.6] Adults with BDD with moderate functional impairment should be offered the choice of either a course of an SSRI or more intensive individual CBT (including ERP) that addresses key features of BDD.

Children and young people with OCD or BDD

- [CG31 Recommendation 1.5.1.9] Children and young people with OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self-help has been ineffective or refused, should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers.
- [CG31 Recommendation 1.5.5.2] Following multidisciplinary review, for a child (aged 8–11 years) with OCD or BDD with moderate to severe functional impairment, if there has not been an adequate response to CBT (including ERP) involving the family or carers, the addition of an SSRI to ongoing psychological treatment may be considered. Careful monitoring should be undertaken, particularly at the beginning of treatment.
- [CG31 Recommendation 1.5.5.3] Following multidisciplinary review, for a young person (aged 12–18 years) with OCD or BDD with moderate to severe functional impairment if there has not been an adequate response to CBT (including ERP)

involving the family or carers, the addition of an SSRI to ongoing psychological treatment should be offered. Careful monitoring should be undertaken, particularly at the beginning of treatment.

- [CG31 Recommendation 1.5.1.10] All children and young people with BDD should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child or young person as first-line treatment.

Appendix 6 Key priorities for implementation recommendations (CG159 – Social anxiety disorder)

General principles of care in mental health and general medical settings

Improving access to services

- [CG159 Recommendation 1.1.3] When a person with social anxiety disorder is first offered an appointment, in particular in specialist services, provide clear information in a letter about:
    - where to go on arrival and where they can wait (offer the use of a private waiting area or the option to wait elsewhere, for example outside the service's premises)
    - location of facilities available at the service (for example, the car park and toilets)
    - what will happen and what will not happen during assessment and treatment.

      When the person arrives for the appointment, offer to meet or alert them (for example, by text message) when their appointment is about to begin.

Identification and assessment of adults

Identification of adults with possible social anxiety disorder

- [CG159 Recommendation 1.2.1] Ask the identification questions for anxiety disorders in line with recommendation 1.3.1.2 in Common mental health disorders (NICE clinical guideline 123), and if social anxiety disorder is suspected:
    - use the 3-item Mini-Social Phobia Inventory (Mini-SPIN) **or**
    - consider asking the following 2 questions:
        - Do you find yourself avoiding social situations or activities?
        - Are you fearful or embarrassed in social situations?

If the person scores 6 or more on the Mini-SPIN, or answers yes to either of the 2 questions above, refer for or conduct a comprehensive assessment for social anxiety disorder (see recommendations 1.2.5–1.2.9).

Interventions for adults with social anxiety disorder

Treatment principles

- [CG159 Recommendation 1.3.1] All interventions for adults with social anxiety disorder should be delivered by competent practitioners. Psychological interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should:
    - receive regular, high-quality outcome-informed supervision
    - use routine sessional outcome measures (for example, the Social Phobia Inventory or the Liebowitz Social Anxiety Scale) and ensure that the person with social anxiety is involved in reviewing the efficacy of the treatment
    - engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny if appropriate.

Initial treatment options for adults with social anxiety disorder

- [CG159 Recommendation 1.3.2] Offer adults with social anxiety disorder individual cognitive behavioural therapy (CBT) that has been specifically developed to treat social anxiety disorder (based on the Clark and Wells model or the Heimberg model; see recommendations 1.3.13 and 1.3.14).
- [CG159 Recommendation 1.3.4] For adults who decline CBT and wish to consider another psychological intervention, offer CBT-based supported self-help (see recommendation 1.3.15).
- [CG159 Recommendation 1.3.5] For adults who decline cognitive behavioural interventions and express a preference for a pharmacological intervention, discuss their reasons for declining cognitive behavioural interventions and address any concerns.

- [CG159 Recommendation 1.3.6] If the person wishes to proceed with a pharmacological intervention, offer a selective serotonin reuptake inhibitor (SSRI) (escitalopram or sertraline). Monitor the person carefully for adverse reactions (see recommendations 1.3.17–1.3.23).

Interventions for children and young people with social anxiety disorder

Treatment for children and young people with social anxiety disorder

- [CG159 Recommendation 1.5.3] Offer individual or group CBT focused on social anxiety (see recommendations 1.5.4 and 1.5.5) to children and young people with social anxiety disorder. Consider involving parents or carers to ensure the effective delivery of the intervention, particularly in young children.

Appendix 7 Suggestions from stakeholder engagement exercise

Organisation name	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Association for Rational Emotive Behaviour Therapy	**Anxiety treatment for children and adolescents.**	There is a large body of evidence that indicates that anxiety affects more children and adolescents than any other psychiatric illness.	The National Institute of Mental Health in the United States has compiled a large body of research on anxiety assessment and treatment of children and adolescents and has made recommendations that may be of aid to NICE in their effort to target this specific population for treatment.	http://www.nimh.nih.gov/health/publicatio ns/anxiety-disorders-in-children-andadolescents/anxiety_dis_children_adolescents_508_ln.pdf Brewin, C. R. (1996). Theoretical foundations of cognitive-behavioral therapy for anxiety and depression.Annual Review of Psychology, 47, 33-57.Creswell, C., & Cartwright-Hatton, S.(2007). Family treatment of childanxiety: Outcomes, limitations, and future directions. Clinical Child andFamily Psychology, 10, 232-252. ilverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., Amaya-Jackson, L. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. Journal of Clinical Child and Adolescent Psychology,37, 156-183.Silverman, W. K., Pina, A. A., &Viswesvaran, C. (2008). Evidence-basedpsychosocial treatments for phobic andanxiety disorders in children andadolescents. Journal of Clinical Child andAdolescent Psychology, 37, 105-130.Walkup, J. T., Albano, A. M., Piacentini,J., Birmaher, B., Compton, S. N., Sherrill,J. T., et al. (2008). Cognitive behavioural therapy,

				sertraline, or a combination in childhood anxiety. New England Journalof Medicine, 359, 2753-2766.Weissman, A. S., Antinoro, D., & Chu, B. C. (2008). Cognitive-behavioral therapy for anxiety in school settings: Advances and challenges. In M. Mayer, R. Van Acker, J. E. Lochman, & F. M. Gresham (Eds.), Cognitive-behavioral interventions for students with emotional/behavioural disorders (pp. 173-203). New York: Guilford Press.
Anxiety UK	Detection & diagnosis of the correct anxiety disorder/s and better training to improve recognition of joint physical & mental health conditions amongst GPs/other healthcare professionals	Detection & diagnosis of the correct anxiety disorder/s is key to ensuring the client is signposted to the right treatment pathway for their specific anxiety condition and primary presenting disorder.	This will help to improve and eliminate diagnostic overshadowing (seen often in primary care where physicians frequently diagnose depression as the main condition when in fact it is secondary to an anxiety disorder presentation). This would ensure the client receives the appropriate treatment for the primary presenting disorder which will in itself minimise and reduce the likelihood the onset/impact of secondary conditions whereby mild to moderate anxiety disorders become more complex as a result of incorrect initial diagnosis. Given the range of anxiety disorders, it is imperative that GPs and other relevant healthcare professionals diagnose accurately so as to ensure that the correct treatment intervention is deployed.	http://www.rightdiagnosis.com/artic/anxiety_disorders_nimh.htm

Anxiety UK	Provision of out of hours, peer-led crisis support for mild to moderate anxiety via a non-bedded facility	It will allow access for support when other services are not available and prevent those with anxiety disorders presenting to statutory crisis/NHS services inappropriately	Because the threshold for current services is too high and presenting to A&E for mild to moderate anxiety – which is the only option currently – is not suitable for these types of conditions. A & E environment can often exacerbate anxiety disorders.	
Anxiety UK	Audit of adherence to the NICE guidelines on anxiety/anxiety disorders by GPs	This will enable and ensure that the guidelines that have been developed are used and followed to delivery consistent outcomes of service delivery and those with anxiety receiving the appropriate evidence based intervention. It is vital that they are audited to ensure quality standards are being maintained.	It is key to the delivery of consistent treatment and will help eliminate "postcode lottery", whereby the standard of service deliveries varies from one area to another. While we support the principal of localism and devolved commissioning, quality standards and the adherence to NICE guidelines is core to the provision of successful outcomes. This can also be linked to QOF payments as an incentive to CCGs and GPs to adhere to and comply with guidelines. At present there is too much variance and subjectivity at play when it comes to the treatment of anxiety disorders in primary care.	
Anxiety UK	A quality standard for anxiety disorder specific peer support schemes	Peer support schemes and self help groups are a proven, cost effective method of complementing clinical services	Peer mentoring, peer support and user led self-help groups have proven to be an effective and valuable method of users helping one another manage and cope with their anxiety. The provision of quality standards and clear guidelines will help to ensure these support schemes are delivering to a more consistent level while also being seen by CCGs and GPs as a valuable asset and addition to enhance current services such as IAPT provision etc.	Anxiety UK's community forum site has proven to be extremely valuable channel for those with an anxiety disorder to support one another and share experiences which has often led to other users feeling less anxious and reassured they are not alone or their symptoms are not uncommon thereby helping to relieve their levels of anxiety. Additionally Anxiety UK's Manchester focussed peer mentoring scheme has proven a valuable addition to local NHS

				primary care mental health services with mentors working with clinicians in a collaborative manner to support clients with anxiety.
Anxiety UK	Greater promotion, access to & use of physical exercise in the treatment of anxiety	The promotion of physical exercise schemes available on prescription with equitable access can help play a significant role in the prevention and recovery of anxiety and other associated mental health disorders. The role of physical exercise in the management of anxiety disorders is well documented however it remains less of a priority in terms of treatment approaches.	This would lead to more consistent and improved outcomes in the treatment for all anxiety related disorders. Currently the coverage across the country for such schemes is patchy at best with varying degrees of criteria to allow access. This would help standardise the provision and help to eliminate the current disparity. It would also position physical exercise alongside other evidence based interventions currently recommended in the treatment of anxiety.	The theme for this year's Mental Health Awareness Week (13-19 May) is physical activity and exercise, highlighting the impact they have on mental health and wellbeing. In the campaign's own words "Physical activity is often described as something we 'ought to do' to avoid developing health problems such as diabetes and heart disease. What's less often explained is the huge potential it has to enhance our happiness and quality of life and reduce mental illness." http://www.mentalhealth.org.uk/our-work/mentalhealthawarenessweek/get-involved/
Pfizer Ltd	Key area for quality improvement 1 **Management of patients post-referral to Improving Access to Psychological Therapy (IAPT) service**	The IAPT 3-year report, recovery rates have improved from 17% to 45% over the first three years of the programme. Similarly, the programme is achieving around 60% completion rate. However, this means that around 40% of patients do not complete their course, and around 55% of patients do not achieve a 'recovery' from the course. There does not appear to be any requirement to follow-up these	The NHS outcomes framework for 2013/2014 emphasises the importance of mental health, with new indicators to measure the response to depression and anxiety disorders, through the delivery of IAPT services. A requirement for GPs or other healthcare professionals to take ownership of patients who fail or drop out of IAPT services and ensure that patients continue on the NICE recommended pathway of care would reduce variability and improve outcomes	NHS outcomes framework for 2013/2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127106/121109-NHS-Outcomes-Framework-2013-14.pdf.pdf IAPT 3-year Report: Available at http://www.iapt.nhs.uk/silo/files/iapt-3-year-report.pdf CG113: Available at www.nice.org.uk/nicemedia/live/13314/5

		patients in the key performance indicators associated with IAPT and it is not clear whose responsibility this is. It is expected that there is considerable variability in local protocols and provisions for these patients and hence in quality.	for patients with anxiety.	2667/52667.pdf
Pfizer Ltd	Key area for quality improvement 2 **Access to pharmacological therapies for refractory anxiety patients**	In addition to the failure rates associated with IAPT noted above, there are also considerable capacity constraints. This creates inequity in access to psychological therapies. According to CG113, pharmacological treatment should be considered after low intensity psychological interventions either as an alternative to or in combination with high intensity interventions and before high-cost specialist care. However, the current focus on talking therapies (e.g. via incentivised performance metrics) means that equally effective alternatives, such as pharmacological interventions, which are not generally limited by capacity constraints, are often over-looked.	The recent evidence update for CG113 reports on a study by Goncalves et al. (2012), stating that: *"The results of this study suggest that both drug treatment and psychotherapy are effective for treating GAD in older people, so management strategies do not seem to need to differ between age groups."* Improving access to the full range of anxiety interventions, including pharmacological therapies, in primary care, prior to high-cost specialist interventions, is likely to be both an efficient use of NHS resources and to improve patient outcomes and the quality of anxiety management. Specifically, there should be equal focus in terms of incentives and investment into the full range of therapies rather than the apparent focus exclusively on non-pharmacological approaches.	CG113: Available at www.nice.org.uk/nicemedia/live/13314/52667/52667.pdf NHS Evidence. 2012. Generalised anxiety disorder in adults: Evidence Update September 2012 Gonçalves DC, Byrne GJ (2012) Interventions for generalized anxiety disorder in older adults: Systematic review and meta-analysis. Journal of Anxiety Disorders 26: 1–11
Pfizer Ltd	Key area for quality improvement 3	The awareness of GAD remains poor. In the latest adult psychiatric household survey, the estimated	Since 2006 in England, the quality and outcomes framework (QOF) of the general medical services contract has	Goodwin R, Gorman JM. Am J Psychiatry 2002;159:1935–7

	Diagnosis and awareness of generalised anxiety disorders	proportion of adults with GAD was 4.4% (McManus 2007). In a recent analysis of primary care prescribing from 2011, the prevalence of patients with a recorded diagnosis of GAD within a 1 year period was only 0.21% (THIN 2011, data on file).	incentivised GPs to screen for depression in diabetes and coronary heart disease (CHD). This has led to an increase in the diagnosis and awareness of depression. The importance of screening for mental health disorders, including anxiety, in long-term conditions (LTCs) is now well recognised. A target to improve the routine diagnosis of anxiety in patients with LTCs in primary care is likely to greatly improve the wider treatment outcomes for these patients. For example, one study has found that the treatment of GAD was associated with almost halving the risk of subsequently developing depression (Goodwin 2002).	McManus 2007. Adult psychiatric morbidity in England, 2007. Results of a household survey. Available from: https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf THIN Analysis. 2011. Pfizer Data on File (can be provided on request)
Pfizer Ltd	Key area for quality improvement 4 **Regular review of anxiety patients and a focus on patient quality of life**	As noted above, GPs have been incentivised to screen for depression. Whilst it is acknowledged that this has generally improved the diagnosis of depression, a recent survey of GPs found that this has in some cases led to a lower quality of consultation in the context of LTCs, due to the focus on screening questionnaires (Coventry 2011). An emphasis exclusively on diagnosis may not necessarily	The NICE guidelines recommend, for example, that for pharmacological interventions, the effectiveness and side effects of the drug should be assessed every 2–4 weeks during the first 3 months of treatment and every 3 months thereafter. Similar recommendations for follow-up after psychological interventions are not included. It is important to incentivise the regular review of anxiety symptoms following all types of intervention at all stages of the	CG113: Available at www.nice.org.uk/nicemedia/live/13314/52667/52667.pdf Coventry et al. 2011. Talking about depression: a qualitative study of barriers to managing depression in people with long term conditions in primary care. BMC Family Practice 2011, 12:10. http://www.biomedcentral.com/1471-2296/12/10

		improve the ultimate outcomes of patients.	pathway. Pfizer Ltd	
Pfizer Ltd	Key area for quality improvement 5 **High use of unlicensed and non-NICE recommended pharmacological therapies in primary care**	Despite being unlicensed and not recommended by NICE for routine use in primary care, there appears to be considerable use of benzodiazepines and atypical antipsychotics, such as quetiapine, in primary care. In a recent analysis of primary care prescribing from 2011, it was observed that 43% of patients with a GAD diagnosis were receiving an 'anxiety-related' medication. Of these patients, 31% received a benzodiazepine and 5% received quetiapine compared to licensed and recommended alternatives such as pregabalin, used in only 3% of GAD patients.	In CG113, it is stated that benzodiazepines and atypical antipsychotics should not be offered routinely in primary care. Specifically, the GDG noted that with limited evidence of efficacy, but seemingly high discontinuation rates due to AEs for the antipsychotics and associated dependence for the benzodiazepines, the benefits did not appear to justify the risks for these drugs. As such, the high use of atypical antipsychotics and benzodiazepines in primary care may represent an ineffective use of NHS resources, but more importantly could pose a safety and quality of life risk for patients.	CG113: Available at www.nice.org.uk/nicemedia/live/13314/52667/52667.pdf THIN Analysis. 2011. Pfizer Data on File (can be provided on request)
Rotherham Doncaster and South Humber NHS Foundation Trust	Key area for quality improvement 1 The recognition of anxiety disorders in Primary Care	The recognition of anxiety disorders in primary care are underdeveloped in comparison with the recognition of depression	Improved recognition of anxiety disorders would enable more people to access treatment at an earlier stage	

Rotherham Doncaster and South Humber NHS Foundation Trust	Key area for quality improvement 2 People who may have anxiety receive an assessment to identify the specific anxiety disorder, the severity of symptoms, the degree of associated functional impairment and the duration of the episode.	Assessment is key to clarifying the specific anxiety disorder in order to commence the most appropriate treatment intervention to improve symptoms and functional impairment	To ensure people receive the most appropriate intervention to meet their needs at the most appropriate time.	
South West Yorkshire Partnership NHS Foundation Trust	Key area for quality improvement 1 – Correctly identifying generalised anxiety disorder.	A number of patients have reached services who were diagnosed with depression by GPs and have had recurrent mental health problems, sometimes coming into contact with CMHTs and other services. By focusing on the issue of worry, GAD has been identified in some cases and they have usually recovered well when their difficulties have been identified and treated appropriately. Also, some staff within the IAPT service have difficulty correctly identifying GAD. Also, there is also a growing body of evidence about the links between dementia and late onset GAD which merits further investigation.		They are identified and treated appropriately using the evidence based model of Dugas and Robicheaud (2007).

NHS England	Identification of Anxiety Disorders	We suggest that one of the quality standards should relate to identification of the full range of anxiety disorders. There is good evidence that anxiety disorders predominantly characterised by worry (e.g. GAD) are reasonably well recognised in primary care but that anxiety disorders predominantly characterised by avoidance or intrusions (such as social anxiety disorder , posttraumatic stress disorder and obsessive-compulsive disorder) are seriously under recognised. Many workers in primary care also have considerable difficulty in distinguishing between the different types of anxiety disorder. This is a serious problem as the evidence-based psychological treatments that are appropriate for different anxiety disorders vary considerably depending on the particular disorder	Better recognition of individual anxiety disorders will increase the chance that the patient gets the relevant NICE approved treatment for the specific anxiety disorder. This will improve efficiency by reducing the chance of the use of inappropriate treatments. This will be better for patients as they will receive an appropriate treatment giving them the best chance of improvement and recovery from the anxiety disorder. Inequalities in health care provision will be reduced	NICE Clinical Guidelines for social anxiety disorders to be published 22/05/13 NICE Clinical Guidance CG31 - Obsessive Compulsive Disorder (OCD) & Body Dysmorphic Disorder (BDD) NICE Clinical Guidance CG26 – Post Traumatic Stress Disorder (PTSD) Ehlers et al (2009). Low recognition of posttraumatic stress disorder in primary care. London Journal of Primary Care., 2, 36-42.
NHS England	Key Development Sources (NICE)	The Topic Overview lists the NICE common mental health disorders and the NICE GAD and panic disorder guidelines as primary sources. However it places the NICE social anxiety disorder, posttraumatic stress disorder, and obsessive-compulsive disorder	If this is not done, the quality standard overview will perpetuate our existing problem in which primary care services are ill informed about most of the anxiety disorders other than GAD. Better information on all anxiety disorders to improve patient care	New NICE Clinical Guidelines for Social Anxiety Disorder to be published 22/05/13 NICE Clinical Guidance CG31 - Obsessive Compulsive Disorder (OCD) & Body Dysmorphic Disorder (BDD)

		guidelines in a lower status category ("other sources that may be used"). This is inappropriate. All of the guidelines that NICE has issued for the various different anxiety disorders need to be considered at an equivalent level.		NICE Clinical Guidance CG26 – Post Traumatic Stress Disorder (PTSD)
NHS England	Key policy documents, reports and national audits	The IAPT Quality Standards document could usefully be included among the documents considered in this section. It lays out minimum quality standards for delivering NICE recommended psychological treatments for different anxiety disorders within IAPT services.	Clear minimum quality standards are effective in driving up and maintaining the quality of psychological interventions for anxiety disorders	http://www.iapt.nhs.uk/silo/files/iapt-for-adults-minimum-quality-standards.pdf
NHS England	Existing Indicators	It is good to see that the IAPT Key Performance Indicators (KPIs) will be considered. IAPT is in the process of moving from a simplistic small set of KPIs (mainly related to access and recovery) to a more nuanced set of KPIs, which cover amount of improvement as well as recovery with measures that index each of the different anxiety disorders.	It will be important to take into account the new, more nuanced system, as this is more likely to drive quality improvements. More granular data capture allows for improved supervision of therapists and provides service managers with quality outcome data to support the improved management of psychological therapy services	http://www.iapt.nhs.uk/data/measuring-outcomes/