Anxiety disorders

NICE quality standard

Draft for consultation

September 2013

Introduction

This quality standard covers the identification and management of anxiety disorders in primary, secondary and community care for children, young people and adults. For more information see the anxiety disorders overview.

Anxiety disorders are types of common mental health disorders (depression is another type of common mental health disorder).This quality standard covers a range of anxiety disorders, including generalised anxiety disorder (GAD), social anxiety disorder, post-traumatic stress disorder (PTSD), panic disorder, obsessive–compulsive disorder (OCD) and body dysmorphic disorder (BDD).

Why this quality standard is needed

Many people do not seek treatment for common mental health disorders, which often go unrecognised. Although under-recognition is generally more common in mild than severe cases, mild disorders are still a source of concern, because without treatment people may develop more severe conditions or have adverse effects later on.

There is considerable variation in the severity of common mental health disorders, but they have been associated with significant long-term disability. They can be distressing to individuals, their families, friends and carers, and can affect their local communities. They are also associated with lower socioeconomic status. Anxiety disorders can have a lifelong course of relapse and remission. Anxiety disorders commonly occur together, or with other problems, such as depression or with substance misuse. More than half of people aged 16 to 64 years who meet the diagnostic criteria for at least 1 common mental health disorder experience comorbid anxiety and depressive disorders.

The 1-week prevalence rates (a snapshot of anxiety disorders over a 1-week period) from the Office of National Statistics 2007 national survey in England were 4.4% for generalised anxiety disorder, 3.0% for post-traumatic stress disorder, 1.1% for panic disorder and 1.1% for obsessive–compulsive disorder. In the US, the lifetime prevalence of social anxiety disorder is 12%.

Generalised anxiety disorder is a common disorder; its 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. For the disorder to be diagnosed, 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 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. At least 2 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 is characterised by the presence of obsessions or compulsions, or commonly both. 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. The symptoms can cause significant functional impairment and distress.

Post-traumatic stress disorder can develop after a stressful event or situation of an exceptionally threatening or catastrophic nature that is likely to cause pervasive distress in almost anyone. People might develop the disorder in response to 1 or more traumatic events such as deliberate acts of interpersonal violence, severe accidents, disasters or military action. Post-traumatic stress disorder does not develop after 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'), 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.

Most anxiety disorders have a relatively early age of onset, with symptoms and syndromes likely to have started in childhood or adolescence. Anxiety disorders in children and young people commonly run a chronic course and are associated with increased risk of other serious mental health problems, including depression and substance misuse. Thus early identification and treatment of anxiety disorders in children and young people is important. Poor recognition, inadequate assessment and limited awareness or availability of treatments may limit access to effective interventions.

Many anxiety disorders remain undiagnosed. Most of those that are diagnosed are treated in primary care. However, recognition of anxiety disorders in primary care is poor and only a small minority of people experiencing anxiety disorders ever receive treatment. When anxiety disorders coexist with depression, the depressive episode may be recognised without detecting the underlying and more persistent anxiety disorder. For people who use services for anxiety disorders, treatment is often limited to the prescription of drugs. This may be partly because evidence-based psychological services are not universally available.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measureable quality improvements within a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- The Adult Social Care Outcomes Framework 2013–14 (Department of Health, November 2012)
- NHS Outcomes Framework 2013/14

- Improving outcomes and supporting transparency: a public health outcomes framework for England 2013–2016, Part 1 and Part 1A.

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 The Adult Social Care Outcomes Framework 2013–14

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life* ***Outcome measures*** **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.** 1F. Proportion of adults in contact with secondary mental health services in paid employment*** 1H. Proportion of adults in contact with secondary mental health services living independently, with or without support**
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with their experience of care and support services.** 3E. Improving people's experience of integrated care (placeholder)**
Aligning across the health and care system * Indicator complementary ** Indicator shared *** Indicator complementary with the Public Health Outcomes Framework and the NHS Outcomes Framework	

Table 2 NHS Outcomes Framework 2013/14

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicators*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare 1b Life expectancy at 75 i males ii females ***Improvement areas*** **Reducing premature death in people with serious mental illness** 1.5 Excess under 75 mortality rate in adults with serious mental illness*

2 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 areas*** **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** * **Enhancing quality of life for people with mental illness** 2.5 Employment of people with mental illness****
3 Helping people to recover from ill-health or following injury	***Improvement areas*** **Improving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures v Psychological therapies
4 Ensuring people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services ii GP out-of-hours services 4b Patient experience of hospital care 4.c Friends and Family Test ***Improvement areas*** **Improving people's experience of outpatient care** 4.1 Patient experience of outpatient services **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to in-patients' personal needs **Improving people's experience of accident and emergency services** 4.3 Patient experience of accident and emergency services **Improving experience of healthcare for people with mental illness** 4.7 Patient experience of community mental health services **Improving children and young people's experience of healthcare** 4.8 An indicator is under development **Improving people's experience of integrated care** 4.9 An indicator is under development***
Alignment across the health and social care system * Indicator shared with Public Health Outcomes Framework (PHOF) ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF) *** Indicator shared with Adult Social Care Outcomes Framework **** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework	

Table 3 Public health outcomes framework for England, 2013-2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.6 Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation † *1.7 People in prison who have a mental illness or a significant mental illness (Placeholder)* Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services * †† ** 1.9 Sickness absence rate
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.8 Emotional well-being of looked after children *2.10 Self-harm (Placeholder)* 2.23 Self-reported well-being
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities. ***Indicators*** 4.9 Excess under 75 mortality rate in adults with serious mental illness* 4.10 Suicide rate *4.13 Health-related quality of life for older people (Placeholder)*
alignment across the Health and Care System * Indicator shared with the NHS Outcomes Framework. ** Complementary to indicators in the NHS Outcomes Framework † Indicator shared with the Adult Social Care Outcomes Framework †† Complementary to indicators in the Adult Social Care Outcomes Framework *Indicators in italics are placeholders, pending development or identification*	

Coordinated services

The quality standard for anxiety disorders specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the

whole anxiety disorders care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people with anxiety disorders in primary and secondary care.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality anxiety disorders service are listed in Related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health and social care practitioners involved in assessing, caring for and treating people with anxiety disorders should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard.

List of quality statements

Statement 1. People who have symptoms of anxiety are asked questions to determine the need for an assessment to diagnose anxiety disorders.

Statement 2. People with a suspected anxiety disorder receive an assessment to diagnose specific anxiety disorders and the impact of the disorders.

Statement 3. People with a diagnosed anxiety disorder who meet criteria for psychological interventions are offered evidence-based psychological interventions.

Statement 4. People with an anxiety disorder who are prescribed pharmacological treatment receive this in accordance with NICE guidance.

Statement 5. People receiving treatment for an anxiety disorder have their treatment-related outcomes recorded at each appointment.

Questions for consultation

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

Quality statement 1: Identification of suspected anxiety disorders

Quality statement

People who have symptoms of anxiety are asked questions to determine the need for an assessment to diagnose anxiety disorders.

Rationale

Anxiety disorders often go unrecognised or undiagnosed. There is a lack of awareness of the different ways anxiety disorders may present, and people may not always realise that their symptoms are may be caused by an anxiety disorder. Under-recognition is more likely if the anxiety disorder is mild or moderate or coexists with other mental health problems that are the primary focus of treatment. Practitioners should be alert to symptoms of anxiety that could indicate anxiety disorders and ask people about these, so that an assessment can be provided as needed (this may involve referral), to diagnose specific anxiety disorders and ensure appropriate treatment follows.

Quality measures

Structure

Evidence of local arrangements for practitioners to ask people who have symptoms of anxiety questions to determine whether they need an assessment.

Data source: Local data collection.

Process

Proportion of people who have symptoms of anxiety who are asked questions to determine whether they need an assessment.

Numerator – the number of people in the denominator who are asked questions to determine whether they need an assessment.

Denominator – the number of people who have symptoms of anxiety.

Data source: Local data collection.

What the quality statement means for service providers, health and social care practitioners and commissioners

Service providers ensure that systems are in place to ask people with symptoms of anxiety questions to determine whether they need an assessment.

Health and social care practitioners ask people with symptoms of anxiety questions to determine whether they need an assessment.

Commissioners ensure that they commission services that ask people with symptoms of anxiety questions to determine whether they need an assessment.

What the quality statement means for service users and carers

People who have symptoms of anxiety are asked questions to see whether they need an assessment to find out if they have anxiety disorders.

Source guidance

- Common mental health disorders (NICE clinical guideline 123), recommendations 1.3.1.2 (key priority for implementation) and 1.3.1.3.
- Obsessive-compulsive disorder and body dysmorphic disorder (NICE clinical guideline 31), recommendations 1.4.1.1 and 1.4.2.1.
- Anxiety (NICE clinical guideline 113), recommendation 1.2.3 (key priority for implementation).
- Post-traumatic stress disorder (NICE clinical guideline 26), recommendation 1.3.1.3.
- Social anxiety disorder (NICE clinical guideline 159), recommendation 1.2.1 (key priority for implementation) and 1.4.1.

Definitions of terms used in this quality statement

Questions to determine need for assessment

NICE clinical guideline 123 recommendation 1.3.1.2 states that practitioners consider asking adults about their feelings of anxiety, and their ability to stop or control worry, using the 2-item Generalized Anxiety Disorder scale (GAD-2):

- If the person scores 3 or more on the GAD-2 scale, consider an anxiety disorder and follow the recommendations for assessment.
- If the person scores less than 3 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.

Anxiety disorders may present differently in children and young people. NICE clinical guideline 159 recommendation 1.4.1 states that health and social care professionals in primary care and education and community settings should be alert to possible anxiety disorders in children and young people, particularly those who avoid school, social or group activities or talking in social situations, or are irritable, excessively shy or overly reliant on parents or carers. It sets out questions that practitioners should consider asking the child or young person. This includes asking the child or young person (or a parent or carer) about their feelings of anxiety, fear, avoidance, distress and associated behaviours to help establish whether social anxiety disorder is present.

Equality and diversity considerations

For adults with significant language or communication difficulties, for example people with sensory impairments or a learning disability, NICE clinical guideline 123 recommendation 1.3.1.3 states that consideration should be given to using the Distress Thermometer tool 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, further assessment should be offered or the advice of a specialist sought.

NICE clinical guideline 159 recommendation 1.1.10 states that when communicating with children and young people and their parents or carers the child or young person's developmental level, emotional maturity and cognitive capacity should be taken into account, including any learning disabilities, sight or hearing problems and delays in language development.

Quality statement 2: Assessment and diagnosis

Quality statement

People with a suspected anxiety disorder receive an assessment to diagnose specific anxiety disorders and the impact of the disorders.

Rationale

Accurate diagnosis of anxiety disorders is important to ensure that people can understand their condition and can be offered the most appropriate treatment at the earliest opportunity, including self-help interventions if suitable. Assessments should identify any comorbidities, such as depression or substance misuse, so that the appropriate disorder can be treated first. They should also consider wider issues, such as social circumstances that might affect the person's condition.

Quality measures

Structure

Evidence of local arrangements for people with a suspected anxiety disorder to receive an assessment to diagnose specific anxiety disorders.

Data source: Local data collection.

Process

Proportion of people with a suspected anxiety disorder who receive an assessment to diagnose specific anxiety disorders.

Numerator – the number of people in the denominator who receive an assessment.

Denominator – the number of people with a suspected anxiety disorder.

Outcome

a) Reported prevalence of specific anxiety disorders compared with the expected prevalence.

b) Severity of symptoms and degree of functional impairment at diagnosis.

Data source:

a) Local data collection. Data is collected against the Improving Access to Psychological Therapies, Key Performance Indicators (IAPT KPIs).

b) Local data collection.

What the quality statement means for service providers, healthcare practitioners and commissioners

Service providers ensure that people who have a suspected anxiety disorder receive an assessment to diagnose specific anxiety disorders.

Healthcare practitioners carry out an assessment for people who have a suspected anxiety disorder to diagnose specific anxiety disorders, or refer to a practitioner who has the competence to carry out such an assessment.

Commissioners ensure they commission services that carry out assessments for people with a suspected anxiety disorder to diagnose specific anxiety disorders.

What the quality statement means for service users and carers

People who might have an anxiety disorder are offered an assessment to find out whether they have an anxiety disorder, what type of disorder it is and whether they have more than one.

Source guidance

- Common mental health disorders (NICE clinical guideline 123), recommendations 1.3.2.1 and 1.3.2.2.
- Anxiety (NICE clinical guideline 113), recommendation 1.2.2 (key priority for implementation).
- Social anxiety disorder (NICE clinical guideline 159), recommendations 1.2.2 and 1.2.3, and 1.4.2, 1.4.3 and 1.4.4.

Definitions of terms used in this quality statement

Assessment

Assessments for people with suspected anxiety disorders should be carried out by practitioners who are trained and competent in performing them to ensure accurate

diagnosis of specific anxiety disorders. This could mean that assessments are carried out in primary care, or via referral to a specialist. Further detail about competency can be found in NICE clinical guideline 123 recommendations 1.3.2.4 and 1.3.2.5; NICE clinical guideline 113 recommendation 1.4.1; NICE clinical guideline 31 recommendations 1.4.1.3, 1.4.2.3 and 1.4.2.6 and NICE clinical guideline 26 recommendations 1.4.1 and 1.4.2.

NICE clinical guideline123 recommendation 1.3.2.3 suggests that practitioners consider using a diagnostic or problem identification tool or algorithm to inform the assessment and support the evaluation of any intervention for adults.

NICE clinical guideline 123 recommendation 1.3.2.6 states that as well as assessing symptoms and associated functional impairment, practitioners consider how the following factors may have affected the development, course and severity of a an adult'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 that the adult has responsibility for should also be assessed, and if necessary local safeguarding procedures followed.

NICE clinical guideline 113 recommendation 1.4.3 states that there is insufficient evidence on which to recommend a well-validated, self-reporting screening instrument to use in the diagnostic process for generalised anxiety disorder in adults, and so consultation skills should be relied upon to elicit all necessary information. Recommendations 1.2.5, 1.4.2 and 1.4.4 provide more detail about the content of assessments.

NICE clinical guideline 31 recommendations 1.4.1.1 and 1.4.2.2 provides questions healthcare professionals should routinely consider and explore the possibility of comorbid obsessive–compulsive, or body dysmorphic disorder for people known to be at higher risk of these. NICE clinical guideline 31 recommendation 1.1.5.3 provides further detail about the content of assessments.

NICE clinical guideline 159 recommendations 1.2.1 and 1.2.5 to 1.2.9 provide information about the content of assessments for social anxiety disorder, including diagnostic tools that could be used.

NICE clinical guideline 159 recommendation 1.4.1 provides questions practitioners should consider asking a child or young person about their feelings of anxiety, fear, avoidance, distress and associated behaviours (or a parent or carer) to help establish if social anxiety disorder is present. Recommendation 1.4.2 states that if a need is indicated, practitioners should consider a comprehensive assessment for social anxiety disorder. The detail of the comprehensive assessment is set out in recommendations 1.4.5 to 1.4.12. Recommendation 1.4.5 states that a comprehensive assessment of a child or young person with possible social anxiety disorder should:

- provide an opportunity for the child or young person to be interviewed alone at some point during the assessment
- if possible involve a parent, carer or other adult known to the child or young person who can provide information about current and past behaviour
- if necessary involve more than one professional to ensure a comprehensive assessment can be undertaken.

NICE clinical guideline 159 recommendation 1.1.10 includes strategies for communicating with children and young people and their parents or carers, taking into account emotional maturity and cognitive capacity and being aware of issues relating to social anxiety. It recommends tailoring communication methods and using communication aids if needed. Recommendations 1.1.12 and 1.1.13 set out confidentiality and consent issues to consider when working with children.

NICE clinical guideline 26 recommendations 1.3.1.1, 1.3.1.4 and 1.3.2.1 provide detail about questions that practitioners should ask when seeking to identify post-

traumatic stress disorder. Recommendation 1.3.4.1 states that when assessing a child or young person for post-traumatic stress disorder, healthcare professionals should ensure that they separately and directly question the child or young person about post-traumatic stress disorder symptoms. They should not rely solely on information from the parent or guardian in any assessment.

Specific anxiety disorder

Specific anxiety disorders covered by this quality standard include generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive–compulsive disorder and body dysmorphic disorder.

Suspected anxiety disorder

A practitioner might identify a person who is displaying symptoms of anxiety as having a suspected anxiety disorder based on their responses to initial questioning about their symptoms.

Equality and diversity considerations

Consideration should be given to modifying the method and mode of delivery of assessment according to individual needs of the person with a suspected anxiety disorder. Technology should be considered for people who may find it difficult to, or choose not to, attend a specific service, for example people with social anxiety who are anxious about attending a health setting. Communication needs should be considered for people who do not have English as their first language, for example by providing bilingual therapists or independent translators.

When assessing people with a suspected anxiety disorder and a moderate to severe learning disability or moderate to severe acquired cognitive impairment, consideration should be given to consulting with a relevant specialist.

Assessment should be culturally sensitive, using suitable explanatory models of common mental health disorders and addressing any cultural and ethnic needs when developing and implementing treatment plans. Relevant information, including cultural or other individual characteristics that may be important in subsequent care, should be identified during assessment. NICE clinical guideline 31 recommendation 1.1.4.1 states that when the boundary between religious or cultural practice and

obsessive-compulsive symptoms is unclear, healthcare professionals should, with the patient's consent, consider seeking the advice and support of an appropriate religious or community leader to support the therapeutic process.

For people with obsessive–compulsive disorder or body dysmorphic disorder, NICE clinical guideline 31 recommendation 1.1.2.1 suggests ensuring continuity of care and minimising the need for multiple assessments by different healthcare professionals, these conditions are frequently recurring or chronic conditions that often affect some of the most intimate aspects of a person's life.

Quality statement 3: Psychological interventions

Quality statement

People with a diagnosed anxiety disorder who meet criteria for psychological interventions are offered evidence-based psychological interventions.

Rationale

The Improving Access to Psychological Therapies Programme (IAPT) includes a range of evidence-based psychological interventions that are effective in treating anxiety disorders in adults, children and young people. In accordance with NICE guidance, healthcare professionals should discuss the potential benefits of psychological interventions with people with an anxiety disorder if assessment indicates that they might benefit, and offer or refer them for appropriate interventions. This should take account of the person's preferences. Practitioners should usually offer or refer for the least intrusive, most effective intervention first.

Quality measures

Structure

Evidence of local arrangements to ensure that people with a diagnosed anxiety disorder who meet criteria for psychological interventions are offered evidence-based psychological interventions.

Data source: Local data collection.

Process

Proportion of people who have a diagnosed anxiety disorder and who meet criteria for psychological interventions who receive evidence-based psychological interventions.

Numerator – the number of people in the denominator who receive evidence-based psychological interventions.

Denominator – the number of people with a diagnosed anxiety disorder who meet criteria for psychological interventions.

Data source: Local data collection. Data is collected against the IAPT key performance indicators (KPIs), including KPI 3a: The number of people who have been referred for psychological therapies during the reporting period 1 and KPI 4: The number of people who have entered (that is, received) psychological therapies during the reporting period.

What the quality statement means for service providers, healthcare practitioners and commissioners

Service providers ensure that systems are in place to offer evidence-based psychological interventions to people with anxiety disorders who meet the criteria for psychological interventions.

Healthcare practitioners ensure that they discuss the benefits of psychological therapy with people who have a diagnosed anxiety disorder who meet the criteria for psychological interventions and offer evidence-based psychological interventions.

Commissioners ensure that they commission services that offer people with anxiety disorders who meet the criteria for psychological interventions evidence-based psychological interventions.

What the quality statement means for service users and carers

People with an anxiety disorder are offered psychological treatments if they and their healthcare professional think it might help them.

Source guidance

- Common mental health disorders (NICE clinical guideline 123), recommendations 1.2, 1.4.1.4 and 1.4.2.2.
- Obsessive-compulsive disorder and body dysmorphic disorder (NICE clinical guideline 31), recommendations 1.5.1.8, 1.5.1.9 (key priority for implementation) and 1.5.1.10 (key priority for implementation).
- Post-traumatic stress disorder: (NICE clinical guideline 26), recommendations 1.9.5.1 (key priority for implementation) and 1.9.5.2 key priority for implementation).

- Social anxiety disorder (NICE clinical guideline 159), recommendations 1.3.2 (key priority for implementation), 1.3.4 (key priority for implementation), 1.3.7, 1.3.12, 1.5.3 (key priority for implementation) and 1.5.6.

Definitions of terms used in this quality statement

Criteria for psychological interventions

Referrals for psychological interventions for adults with generalised anxiety disorder, panic disorder, post-traumatic stress disorder, obsessive–compulsive disorder or body dysmorphic disorder should be made following the stepped-care approach set out in NICE clinical guideline 123 recommendation 1.2.

Practitioners should discuss treatment options with adults who have anxiety disorders (and their families if appropriate and possible) so that they are informed, and treatment and care can take into account their individual needs and preferences. NICE clinical guideline 123 recommendations 1.4.1.1 to 1.4.1.3 lists what the content of discussions should consider.

NICE clinical guideline 159 recommendation 1.3.2 states that adults with social anxiety disorder should be offered individual cognitive behavioural therapy (CBT) that has been specifically developed to treat social anxiety disorder. Recommendation 1.3.4 states that CBT-based supported self-help should be offered to adults who decline CBT and wish to consider another psychological intervention. Recommendation 1.3.12 suggests discussing the option of individual CBT with adults whose symptoms have not responded to pharmacological interventions.

NICE clinical guideline 159 recommendation 1.5.3 states that children and young people with social anxiety disorder should be offered individual or group CBT focused on social anxiety. Consideration should be given to involving parents or carers to ensure the effective delivery of the intervention, particularly in young children.

NICE clinical guideline 159 recommendation 1.1.16 states that if parents or carers are involved in the assessment or treatment of a young person with social anxiety disorder, the practitioner should discuss with the young person (taking into account their developmental level, emotional maturity and cognitive capacity) what form they

would like this involvement to take. Such discussions should take place at intervals to take account of any changes in circumstances, including developmental level, and should not happen only once.

NICE clinical guideline 26 recommendation 1.9.5.2 states that children and young people with post-traumatic stress disorder, including those who have been sexually abused, should be offered a course of trauma-focused cognitive behavioural therapy adapted appropriately to suit their age, circumstances and level of development.

NICE clinical guideline 31 recommendation 1.5.1.9 states that children and young people with obsessive–compulsive disorder with moderate to severe functional impairment, and those with obsessive–compulsive disorder with mild functional impairment for whom guided self-help has been ineffective or refused, should be offered CBT (including exposure and response prevention [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. Recommendation 1.5.1.10 states that all children and young people with body dysmorphic disorder 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.

Evidence-based psychological interventions

The IAPT programme includes psychological interventions that are based on NICE recommendations. The recommendations are based on the best available evidence.

Equality and diversity considerations

NICE clinical guideline 123 suggests providing services for adults with anxiety disorders in a variety of settings to support access for all groups. Examples are included in recommendation 1.1.1.7. Recommendation 1.1.1.8 lists a range of support services that primary and secondary care clinicians, managers and commissioners should consider to facilitate access and uptake of services.

NICE clinical guideline 159 states that changing of healthcare professionals or services should be minimised for people with social anxiety disorder, because they

may find these particularly stressful. Concerns should be discussed beforehand and detailed information provided about any changes, especially those that were not requested by the service user.

NICE clinical guideline 159 also states that practitioners should offer to provide treatment in settings where children and young people with social anxiety disorder and their parents or carers feel most comfortable (for example, at home or in schools or community centres) with appointments set in a way that does not interfere with school or other peer and social activities. Practitioners should consider providing childcare (for example, for siblings) to support parent and carer involvement.

NICE clinical guideline 113 recommendation 1.1.5 states that interventions provided for adults with generalised anxiety disorder should be offered to people with generalised anxiety disorder who have a mild learning disability or mild acquired cognitive impairment with the methods of delivery or duration adjusted if necessary to take account of the disability or impairment. Recommendation 1.1.6 states that when offering an intervention to adults with generalised anxiety disorder and a moderate to severe learning disability or moderate to severe acquired cognitive impairment, practitioners should consider consulting a relevant specialist.

Healthcare professionals should familiarise themselves with the cultural background of the person with an anxiety disorder. NICE clinical guideline 26 states that healthcare professionals should pay particular attention to identifying people with post-traumatic stress disorder whose work or home culture is resistant to recognising the psychological consequences of trauma.

If a person with an anxiety disorder does not have the capacity to make decisions, or a child or young person is not old enough to do so, healthcare professionals should follow the Department of Health guidelines Reference guide to consent for examination or treatment (second edition).

Quality statement 4: Pharmacological treatment

Quality statement

People with an anxiety disorder who are prescribed pharmacological treatment receive this in accordance with NICE guidance.

Rationale

Pharmacological treatment might be offered to people with an anxiety disorder who have not benefited from low- or high-intensity psychological interventions (although pharmacological treatment is not recommended as routine treatment for a number of anxiety disorders in adults or children). The NICE guidance provides the recommended treatment options and the circumstances in which pharmacological therapy should be prescribed. It includes advice on which therapies are associated with a higher risk of adverse events and those that should not be prescribed for long periods.

Quality measures

Structure

Evidence of local monitoring arrangements to ensure that prescribing of pharmacological treatment for people with anxiety disorders is in accordance with NICE guidance.

Data source: Local data collection.

Outcome

Rates of prescribing of non-NICE recommended drugs for anxiety disorders.

Data source:

Local data collection.

What the quality statement means for service providers, healthcare practitioners and commissioners

Service providers ensure that there are systems in place to monitor the prescribing of pharmacological treatment for people with anxiety disorders to ensure that prescribing is in accordance with NICE guidance.

Healthcare practitioners ensure that people with anxiety disorders who are prescribed pharmacological treatment are prescribed treatment in accordance with NICE guidance.

Commissioners ensure that they commission services that prescribe pharmacological treatment in accordance with NICE guidance for people with anxiety disorders.

What the quality statement means for service users and carers

People with an anxiety disorder who are offered medication are offered the types of medication that are recommended by NICE.

Source guidance

- Obsessive-compulsive disorder and body dysmorphic disorder (NICE clinical guideline 31), recommendations 1.5.3.20, 1.5.3.21, 1.5.3.22, 1.5.6.19, 1.5.6.20 and 1.5.6.21.
- Anxiety (NICE clinical guideline 113), recommendations 1.2.25 (key priority for implementation), 1.4.7 and 1.4.8.
- Social anxiety disorder (NICE clinical guideline 159), recommendations 1.6.2, 1.6.4, 1.6.5 and 1.6.6.

Definitions of terms used in this quality statement

Pharmacological therapy

There are a number of recommendations in NICE guidance for anxiety disorders that relate to the appropriate use of pharmacological treatments. These include recommendations on:

- anticonvulsants

- antipsychotics
- anxiolytics
- benzodiazepine
- botulinum toxin
- monoamine oxidase inhibitors (MAOIs)
- sedating antihistamines
- serotonin and noradrenaline reuptake inhibitors (SNRIs), including venlafaxine
- St John's wort
- tricyclic antidepressants other than clomipramine
- tricyclic-related antidepressants.

Equality and diversity considerations

Clinical judgement should be used when the use of non-NICE recommended drugs is being reviewed, on a case-by-case basis. For example, some older people may have been receiving long-term prescriptions for anxiety that pre-date NICE guidance.

Quality statement 5: Monitoring of outcomes

Quality statement

People receiving treatment for an anxiety disorder have their treatment-related outcomes recorded at each appointment.

Rationale

Regular monitoring of treatment outcomes is important to ensure that the effectiveness of treatment can be assessed and adjusted if needed. It also provides an opportunity for practitioners to monitor other health outcomes, such as effects on any long-term conditions, and wider considerations such as people's ability to continue or return to employment.

Quality measures

Structure

Evidence of local arrangements to monitor health outcomes for people being treated for an anxiety disorder at each appointment and use the findings to adjust delivery of interventions.

Data source: Local data collection.

Process

Proportion of people receiving treatment for an anxiety disorder who have their health outcomes recorded at initial contact and each subsequent appointment.

Numerator – the number of people in the denominator whose treatment related outcomes are recorded at initial contact and each subsequent appointment.

Denominator – the number of people receiving treatment for an anxiety disorder.

Data source: Local data collection.

Outcome

a) IAPT outcome measures submitted at each session.

b) Evidence from feedback that people receiving treatment for an anxiety disorder are aware of their progress.

Data source:

a) Routine outcome monitoring is part of: Key Performance Indicators (IAPT KPIs) returns and will be part of The Children and Young People's IAPT project.

b) Local data collection.

What the quality statement means for service providers, healthcare practitioners and commissioners

Service providers ensure that systems are in place to record treatment-related outcomes at each appointment for people receiving treatment for anxiety disorders.

Healthcare practitioners ensure that they record treatment-related outcomes at each appointment for people receiving treatment for anxiety disorders.

Commissioners ensure that they commission services that record treatment-related outcomes at each appointment for people receiving treatment for anxiety disorders.

What the quality statement means for service users and carers

People who are receiving treatment for an anxiety disorder have their progress checked at each appointment to help decide how best to continue with their treatment.

Source guidance

- Common mental health disorders (NICE clinical guideline 123), recommendations 1.5.1.3 (key priority for implementation) and 1.5.1.10.
- Social anxiety disorder (NICE clinical guideline 159), recommendations 1.3.1 (key priority for implementation) and 1.5.1.

Definitions

Monitoring

NICE clinical guideline 123 states that 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. It should monitor progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed.

NICE clinical guideline 159 states that specific monitoring tools should be used for people with social anxiety disorders. For adults, recommendation 1.3.1 suggests that for all interventions practitioners should:

- use routine sessional outcome measures (for example, the SPIN or LSAS) 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.

For children with a social anxiety disorder, recommendation 1.5.1 suggests that for all interventions practitioners should:

- use routine sessional outcome measures, for example:
  - the LSAS – child version or the SPAI-C, and the SPIN or LSAS for young people
  - the MASC, RCADS, SCAS or SCARED for children
- 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.

Expert consensus is that outcomes should be monitored at each appointment.

Treatment for an anxiety disorder

Treatment for which outcomes should be monitored includes psychological interventions and pharmacological treatment.

Equality and diversity considerations

The method of collecting self-reported outcome measures should be tailored to the person with an anxiety disorder, according to their communication needs and preferences. It should be culturally appropriate, accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with anxiety disorders should have access to an interpreter or advocate if needed.

Status of this quality standard

This is the draft quality standard released for consultation from 27 August to 24 September 2013. It is not NICE's final quality standard on anxiety disorders. The statements and measures presented in this document are provisional and may change after consultation with stakeholders.

Comments on the content of the draft standard must be submitted by 5pm on 24 September 2013. All eligible comments received during consultation will be reviewed by the Quality Standards Advisory Committee and the quality statements and measures will be refined in line with the Quality Standards Advisory Committee's considerations. The final quality standard will be available on the NICE website from March 2014.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. These include indicators developed by the Health and Social Care Information Centre through its Indicators for Quality Improvement Programme. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See NICE's What makes up a NICE quality standard? for further information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of

100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered by commissioners, providers, health and social care practitioners, patients, service users and carers alongside the documents listed in Development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments [add correct link] are available.

Good communication between health and social care practitioners and people with anxiety disorders is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. People with anxiety disorders should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards Process guide on the NICE website.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the Quality Standards Advisory Committee to develop the quality standard statements and measures.

- Social anxiety disorder. NICE clinical guideline 159 (2013).
- Common mental health disorders. NICE clinical guideline 123 (2011).
- Anxiety. NICE clinical guideline 113 (2011).
- Obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005).
- Post-traumatic stress disorder. NICE clinical guideline 26 (2005).

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Anxiety. Map of Medicine (2012).
- National Audit of Psychological Therapies for Anxiety and Depression. Healthcare Quality Improvement Partnership (2011).
- The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders. Department of Health (2007).

Definitions and data sources for the quality measures

- The Children and Young People's IAPT project. Health and Social Care Information Centre.
- Improving Access to Psychological Therapies, Key Performance Indicators (IAPT KPIs). Health and Social Care Information Centre.
- Reference guide to consent for examination or treatment (second edition). Department of Health.

Related NICE quality standards

Published

- Health and wellbeing of looked-after children. NICE quality standard 31 (2013).
- Patient experience in adult NHS services. NICE quality standard 15 (2012).
- Service user experience in adult mental health. NICE quality standard 14 (2011).
- Depression in adults. NICE quality standard 8 (2011).

In development

- Depression in children and young people. NICE quality standard. Publication expected September 2013.
- Mental wellbeing of older people in residential care. NICE quality standard. Publication expected December 2013.

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Antenatal and postnatal mental health.
- Managing the transition from children's to adult services.
- Mental health problems with learning disability.

Quality Standards Advisory Committee and NICE project team

Quality Standards Advisory Committee

This quality standard has been developed by Quality Standards Advisory Committee 1. For further information about the standing members of this committee see the NICE website. The following specialist members joined the committee to develop this quality standard:

Professor John Cape
Head of Psychology, Camden and Islington Primary Care Trust

Cathy Creswell

Honorary Consultant clinical psychologist (children and young people), University of Reading

Dr Carolyn Chew-Graham

General Practitioner; Professor of General Practice Research, NHS Manchester and Keele University, Manchester and Staffordshire

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Child and Adolescent Psychiatrist, Cumbria Partnership Foundation Trust

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About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.