

Anxiety disorders

Quality standard

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Contents

Introduction	5
Why this quality standard is needed	5
How this quality standard supports delivery of outcome frameworks	7
Coordinated services.....	12
List of quality statements.....	13
Quality statement 1: Assessment of suspected anxiety disorders	14
Quality statement.....	14
Rationale	14
Quality measures	14
What the quality statement means for service providers, healthcare professionals and commissioners ..	15
What the quality statement means for service users and carers	15
Source guidance.....	15
Definitions of terms used in this quality statement	15
Equality and diversity considerations.....	17
Quality statement 2: Psychological interventions.....	19
Quality statement.....	19
Rationale	19
Quality measures	19
What the quality statement means for service providers, healthcare professionals and commissioners ..	20
What the quality statement means for service users and carers	20
Source guidance.....	20
Definitions of terms used in this quality statement	20
Equality and diversity considerations.....	21
Quality statement 3: Pharmacological treatment	22
Quality statement.....	22
Rationale	22
Quality measures	22

What the quality statement means for service providers, healthcare professionals and commissioners ..	23
What the quality statement means for service users and carers	23
Source guidance.....	24
Definitions of terms used in this quality statement	24
Quality statement 4: Monitoring treatment response	25
Quality statement.....	25
Rationale	25
Quality measures	25
What the quality statement means for service providers, healthcare professionals and commissioners ..	26
What the quality statement means for service users and carers	26
Source guidance.....	26
Definitions.....	26
Equality and diversity considerations.....	27
Using the quality standard.....	28
Quality measures	28
Levels of achievement	28
Using other national guidance and policy documents.....	28
Information for commissioners	28
Information for the public	29
Diversity, equality and language	30
Development sources.....	31
Evidence sources.....	31
Policy context	31
Definitions and data sources for the quality measures	31
Related NICE quality standards	33
Published.....	33
Future quality standards.....	33
Quality Standards Advisory Committee and NICE project team	34

Quality Standards Advisory Committee.....	34
NICE project team	36
About this quality standard.....	38

This standard is based on CG31, CG113, CG123, CG159 and CG26.

This standard should be read in conjunction with QS48, QS50, QS8, QS14, QS15, QS71, QS73, QS88, QS108, QS102, QS99, QS95, QS80, QS9, QS115 and QS175.

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 [topic 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, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive–compulsive disorder and body dysmorphic disorder.

This quality standard does not explicitly address the management of generalised anxiety disorder and panic disorder in children (younger than 16 years) because these were not covered in the source guideline (NICE clinical guideline 113).

Why this quality standard is needed

Many anxiety disorders go unrecognised or 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.

There is considerable variation in the severity of anxiety disorders, but they have been associated with significant long-term disability. They can be distressing for the person affected, their families, friends and carers, and can have an impact on their local communities. Anxiety disorders can have a lifelong course of relapse and remission. They commonly occur together, or with other problems such as depression or substance misuse.

The 1-week prevalence rates for adults (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.

Generalised anxiety disorder is characterised by 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 a job or failing an exam.

Social anxiety disorder (previously known as 'social phobia'), is persistent fear of or anxiety about 1 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.

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 2014–15](#)
- 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
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<p>1 Enhancing quality of life for people with care and support needs</p>	<p>Overarching measure</p> <p>1A Social care-related quality of life*</p> <p>Outcome measures</p> <p>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.</p> <p>1F. Proportion of adults in contact with secondary mental health services in paid employment***</p> <p>1H. Proportion of adults in contact with secondary mental health services living independently, with or without support**</p>
<p>3 Ensuring that people have a positive experience of care and support</p>	<p>Overarching measure</p> <p>People who use social care and their carers are satisfied with their experience of care and support services.</p> <p>3E. Improving people's experience of integrated care (placeholder)**</p>
<p>Aligning across the health and care system</p> <p>* Indicator complementary</p> <p>** Indicator shared</p> <p>*** Indicator complementary with the Public Health Outcomes Framework and the NHS Outcomes Framework</p>	

Table 2 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
<p>1 Preventing people from dying prematurely</p>	<p>Overarching indicators</p> <p>1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p> <p>1b Life expectancy at 75 i males ii females</p> <p>Improvement areas</p> <p>Reducing premature death in people with serious mental illness</p> <p>1.5 Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9*)</p>

<p>2 Enhancing quality of life for people with long-term conditions</p>	<p>Overarching indicator</p> <p>2 Health related quality of life for people with long-term conditions* (ASCOF 1A)</p> <p>Improvement areas</p> <p>Ensuring people feel supported to manage their condition</p> <p>2.1 Proportion of people feeling supported to manage their condition</p> <p>Improving functional ability in people with long-term conditions</p> <p>2.2 Employment of people with long-term conditions (ASCOF 1E**, PHOF 1.6*)</p> <p>Enhancing quality of life for people with mental illness</p> <p>2.5 Employment of people with mental illness (ASCOF 1E**, PHOF 1.8**)</p>
<p>3 Helping people to recover from ill-health or following injury</p>	<p>Improvement areas</p> <p>Improving outcomes from planned treatments</p> <p>3.1 Total health gain as assessed by patients for elective procedures</p> <p>v Psychological therapies</p>

<p>4 Ensuring people have a positive experience of care</p>	<p>Overarching indicators</p> <p>4a Patient experience of primary care i GP services ii GP out-of-hours services</p> <p>4b Patient experience of hospital care</p> <p>4c Friends and Family Test</p> <p>Improvement areas</p> <p>Improving people's experience of outpatient care</p> <p>4.1 Patient experience of outpatient services</p> <p>Improving hospitals' responsiveness to personal needs</p> <p>4.2 Responsiveness to in-patients' personal needs</p> <p>Improving people's experience of accident and emergency services</p> <p>4.3 Patient experience of accident and emergency services</p> <p>Improving experience of healthcare for people with mental illness</p> <p>4.7 Patient experience of community mental health services</p> <p>Improving children and young people's experience of healthcare</p> <p>4.8 <i>Children and young people's experience of outpatient services</i></p> <p>Improving people's experience of integrated care</p> <p>4.9 <i>People's experience of integrated care (ASCOF 3E^{**})</i></p>
<p>Alignment across the health and social care system</p> <p>* Indicator is shared</p> <p>** Indicator is complementary</p> <p><i>Indicators in italics are placeholders, pending development or identification</i></p>	

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

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

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, public health and social care professionals 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.

Role of families and carers

Quality standards recognise the important role families and carers have in supporting people with anxiety disorders. If appropriate, health, public health and social care professionals should ensure that family members and carers are involved in the decision-making process about assessment, treatment and care.

List of quality statements

Statement 1. People with a suspected anxiety disorder receive an assessment that identifies whether they have a specific anxiety disorder, the severity of symptoms and associated functional impairment.

Statement 2. People with an anxiety disorder are offered evidence-based psychological interventions.

Statement 3. People with an anxiety disorder are not prescribed benzodiazepines or antipsychotics unless specifically indicated.

Statement 4. People receiving treatment for an anxiety disorder have their response to treatment recorded at each treatment session.

Quality statement 1: Assessment of suspected anxiety disorders

Quality statement

People with a suspected anxiety disorder receive an assessment that identifies whether they have a specific anxiety disorder, the severity of symptoms and associated functional impairment.

Rationale

Accurate diagnosis of a person's specific anxiety disorder can help them understand their condition and ensure that they are offered the most appropriate treatment at the earliest opportunity.

Quality measures

Structure

a) Evidence of local arrangements for people with a suspected anxiety disorder to receive an assessment that identifies whether they have a specific anxiety disorder, the severity of symptoms and associated functional impairment.

Data source: Local data collection.

b) Evidence of local arrangements to ensure that healthcare professionals receive training to perform assessments of anxiety disorders.

Data source: Local data collection.

Process

Proportion of people with a suspected anxiety disorder who receive an assessment that identifies whether they have a specific anxiety disorder, the severity of symptoms and associated functional impairment.

Numerator – the number of people in the denominator who receive an assessment that identifies whether they have a specific anxiety disorder, the severity of symptoms and associated functional impairment.

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

Data source: Local data collection.

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

Service providers ensure they provide services for people who have a suspected anxiety disorder to diagnose specific anxiety disorders, and that the assessment services are delivered by fully trained healthcare professionals.

Healthcare professionals carry out an assessment for people who have a suspected anxiety disorder to diagnose specific anxiety disorders, or refer to a practitioner who is trained to carry out such an assessment.

Commissioners ensure that 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 may have an anxiety disorder are offered an assessment to find out whether they do have an anxiety disorder, what type of disorder it is and the effect it may have on their everyday life.

Source guidance

- Common mental health disorders (NICE clinical guideline 123), recommendations [1.3.2.4](#) and [1.3.2.6](#).
- Social anxiety disorder (NICE clinical guideline 159), recommendations [1.2.5](#) to [1.2.9](#) and [1.4.5](#) to [1.4.8](#).

Definitions of terms used in this quality statement

Anxiety disorder

Anxiety disorders are generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder and body dysmorphic disorder.

Assessment of anxiety disorders

Assessment of anxiety disorders includes the nature, duration and severity of the presenting disorder and associated functional impairment. It also includes consideration of the ways in which the following factors may have affected the development, course and severity of the disorder:

- 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.

[[NICE clinical guideline 123](#), recommendations 1.3.2.4 and 1.3.2.6]

A diagnostic or problem identification tool or algorithm may be used to inform the assessment.

[[NICE clinical guideline 123](#), recommendation 1.3.2.3, [NICE clinical guideline 159](#), recommendations 1.2.7 and 1.4.9 to 1.4.12]

Assessment of social anxiety disorder

The assessment of social anxiety disorder is slightly different from assessment of other anxiety disorders. It includes consideration of fear, avoidance, distress and functional impairment. It takes into account comorbid disorders, including avoidant personality disorder, alcohol and substance misuse, mood disorders, other anxiety disorders, psychosis and autism. A detailed description of the person's current social anxiety and associated problems and circumstances is obtained, including:

- feared and avoided social situations
- what they are afraid might happen in social situations (for example, looking anxious, blushing, sweating, trembling or appearing boring)

- anxiety symptoms
- view of self
- content of self-image
- safety-seeking behaviours
- focus of attention in social situations
- anticipatory and post-event processing
- occupational, educational, financial and social circumstances
- family circumstances and support (for children and young people)
- friendships and peer groups (for children and young people)
- medication, alcohol and recreational drug use.

[[NICE clinical guideline 159](#), recommendations 1.2.5 to 1.2.9 and 1.4.5 to 1.4.8]

Suspected anxiety disorder

An anxiety disorder may be suspected in people with a past history of an anxiety disorder, possible somatic symptoms of an anxiety disorder or recent experience of a traumatic event, and in people who avoid social situations. It may be suspected because of the person's responses to initial questions about their symptoms. The 2-item Generalized Anxiety Disorder scale may be used to ask the person about their feelings of anxiety and their ability to stop or control worry. [[NICE clinical guideline 123](#), recommendation 1.3.1]

Equality and diversity considerations

Consideration should be given to modifying the method and mode of delivery of assessment according to the 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 healthcare service. 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.

For people with sensory impairment or a learning disability, use of the distress thermometer and asking a family member or carer about the person's symptoms should be considered.

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 a relevant specialist.

Assessments should be culturally sensitive, using suitable explanatory models of common mental health disorders and addressing any cultural and ethnic needs. Relevant information, including cultural or other individual characteristics that may be important in subsequent care, should be identified during assessment. For example, if the boundary between religious or cultural practice and obsessive–compulsive symptoms is unclear, healthcare professionals should, with the service user's consent, consider seeking the advice and support of an appropriate religious or community leader to support the therapeutic process.

Quality statement 2: Psychological interventions

Quality statement

People with an anxiety disorder are offered evidence-based psychological interventions.

Rationale

Evidence-based psychological interventions can be effective treatments for anxiety disorders. They are recommended first-line treatments in preference to pharmacological treatment. Healthcare professionals should usually offer or refer for the least intrusive, most effective intervention first, in line with the stepped-care approach set out in the NICE guidance.

Quality measures

Structure

Evidence of local arrangements to ensure that people with an anxiety disorder are offered evidence-based psychological interventions.

Data source: Local data collection.

Process

Proportion of people with an anxiety disorder 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 an anxiety disorder.

Data source: Local data collection. National data are collected in the [Improving access to psychological therapies data set](#) and [National audit of psychological therapies for anxiety and depression \(standard 1b\)](#).

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

Service providers ensure that they are able to provide evidence-based psychological interventions to people who are referred to them with anxiety disorders.

Healthcare professionals ensure that they offer evidence-based psychological interventions to people with anxiety disorders.

Commissioners ensure that they commission services from providers who are able to deliver evidence-based psychological interventions to meet the needs of people with anxiety disorders.

What the quality statement means for service users and carers

People with an anxiety disorder are offered psychological treatments (sometimes called 'talking treatments') that have been shown by evidence to be helpful for their disorder.

Source guidance

- Common mental health disorders (NICE clinical guideline 123), recommendation [1.4.1.4](#).
- 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](#) and [1.9.5.2](#) (key priorities 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

Anxiety disorders

Anxiety disorders are generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder and body dysmorphic disorder.

Evidence-based psychological interventions

Evidence-based psychological interventions include both low-intensity interventions incorporating self-help approaches and high-intensity psychological therapies.

For adults with generalised anxiety disorder, panic disorder, post-traumatic stress disorder, obsessive-compulsive disorder or body dysmorphic disorder psychological interventions are offered based on the stepped-care approach. [[NICE clinical guideline 123](#), recommendation 1.4.1.4]

Cognitive behavioural therapy has been specifically developed to treat social anxiety disorder in adults, children and young people. [[NICE clinical guideline 159](#), recommendations 1.3.2 and 1.5.3]

Psychological therapies have been specifically developed to treat obsessive-compulsive disorder, body dysmorphic disorder and post-traumatic stress disorder in children and young people. [[NICE clinical guideline 31](#), recommendations 1.5.1.9 and 1.5.1.10; [NICE clinical guideline 26](#), recommendation 1.9.5]

Equality and diversity considerations

For people with generalised anxiety disorder who have a learning disability or cognitive impairment, methods of delivering treatment and treatment duration should be adjusted if necessary to take account of the disability or impairment, with consideration given to consulting a relevant specialist.

It is important that healthcare professionals familiarise themselves with the cultural background of the person with an anxiety disorder. They 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.

Quality statement 3: Pharmacological treatment

Quality statement

People with an anxiety disorder are not prescribed benzodiazepines or antipsychotics unless specifically indicated.

Rationale

NICE guidance provides recommendations on pharmacological therapies for anxiety disorders. Benzodiazepines are associated with tolerance and dependence, and antipsychotics are associated with a number of adverse effects. Therefore they should not be used routinely to treat anxiety disorders.

Healthcare professionals should be aware of circumstances in which benzodiazepines and antipsychotics may be appropriate, such as short-term care and anxiety disorder crises.

Quality measures

Structure

Evidence of local monitoring arrangements to ensure that people with an anxiety disorder are not prescribed a benzodiazepine or an antipsychotic to treat their disorder unless specifically indicated.

Data source: Local data collection.

Process

a) Proportion of people who have an anxiety disorder and are prescribed a benzodiazepine that is not specifically indicated.

Numerator – the number of people in the denominator for whom a benzodiazepine is not specifically indicated.

Denominator – the number of people with an anxiety disorder who are prescribed a benzodiazepine.

b) Proportion of people who have an anxiety disorder and are prescribed an antipsychotic that is not specifically indicated.

Numerator – the number of people in the denominator for whom an antipsychotic is not specifically indicated.

Denominator – the number of people with an anxiety disorder who are prescribed an antipsychotic.

Data source: Local data collection.

Outcome

a) Rates of prescribing benzodiazepines.

b) Rates of prescribing antipsychotics.

Data source: Local data collection.

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

Service providers ensure that there are procedures and protocols in place to monitor the prescribing of pharmacological treatment for people with anxiety disorders to ensure that benzodiazepines and antipsychotics are not offered to treat that disorder unless specifically indicated.

Healthcare professionals ensure that people with anxiety disorders are not offered benzodiazepines or antipsychotics to treat that disorder unless specifically indicated.

Commissioners ensure that they monitor rates of prescribing of benzodiazepines and antipsychotics to treat anxiety disorders and only commission services from providers who can demonstrate that they have procedures and protocols in place to monitor this prescribing.

What the quality statement means for service users and carers

People with an anxiety disorder are not offered benzodiazepines (medication used to help people sleep or act as a sedative) or antipsychotics (medication used mainly to treat psychotic conditions

such as schizophrenia) for that disorder unless there are specific clinical reasons why these treatments may be of short-term benefit.

Source guidance

- Obsessive-compulsive disorder and body dysmorphic disorder (NICE clinical guideline 31), recommendations [1.5.3.21](#), [1.5.3.22](#), and [1.5.6.21](#).
- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults (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), recommendation [1.6.2](#).

Definitions of terms used in this quality statement

Anxiety disorders

Anxiety disorders are generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive–compulsive disorder and body dysmorphic disorder.

Quality statement 4: Monitoring treatment response

Quality statement

People receiving treatment for an anxiety disorder have their response to treatment recorded at each treatment session.

Rationale

Regular monitoring of psychological and pharmacological treatment response ensures that the effectiveness of treatment can be assessed and treatment adjusted if needed. It also provides an opportunity for healthcare professionals to monitor other outcomes such as effects on any long-term conditions and the person's ability to continue or return to employment.

Quality measures

Structure

Evidence of local arrangements to monitor response to treatment for people being treated for an anxiety disorder at each treatment session 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 response to treatment recorded at initial contact and each subsequent treatment session.

Numerator – the number of people in the denominator whose response to treatment is recorded at initial contact and each subsequent treatment session.

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

Data source: Local data collection. Routine outcome monitoring is part of the [Improving access to psychological therapies data set](#), [The Children and Young People's IAPT Project](#) and the [National audit of psychological therapies for anxiety and depression \(standard 9\)](#).

Outcome

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

Data source: Local data collection.

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

Service providers ensure that systems are in place to record response to treatment at each treatment session for people receiving treatment for anxiety disorders.

Healthcare professionals ensure that they record response to treatment at each treatment session for people receiving treatment for anxiety disorders and adjust treatment if needed.

Commissioners ensure that they commission services that record response to treatment at each treatment session 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 a check at each treatment session to find out how well their treatment is working and 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

Anxiety disorders

Anxiety disorders are generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive–compulsive disorder and body dysmorphic disorder.

Monitoring

This includes individual routine outcome measurement, which can be made available for routine reporting and aggregation of outcome measures, as well as audit and review of effectiveness. Specific monitoring tools and routine outcome measures are used. [Adapted from NICE [clinical guideline 123](#) and [NICE clinical guideline 159](#)]

Treatment for an anxiety disorder

Treatments for which responses are monitored include psychological interventions and pharmacological treatment.

Equality and diversity considerations

The method of collecting self-reported treatment responses 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.

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 professionals, service users and carers alongside the documents listed in [Development sources](#).

Information for commissioners

NICE has produced [support for commissioning](#) that considers the commissioning implications and potential resource impact of this quality standard. This is available on the NICE website.

Information for the public

NICE has produced [information for the public](#) about this quality standard. Service users and carers can use it to find out about the quality of care they should expect to receive; as a basis for asking questions about their care, and to help make choices between providers of social care services.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and [equality assessments](#) are available.

Good communication between health and social care professionals 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).
- [Generalised anxiety disorder and panic disorder \(with or without agoraphobia\) in adults](#). 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:

- [National audit of psychological therapies for anxiety and depression](#). Healthcare Quality Improvement Partnership (2013).
- [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 data set](#). Health and Social Care Information Centre.

- Reference guide to consent for examination or treatment (second edition). (2009) Department of Health.
- Adult psychiatric morbidity survey. (2007) Health and Social Care Information Centre.

Related NICE quality standards

Published

- [Mental wellbeing of older people in care homes](#). NICE quality standard 50 (2013).
- [Depression in children and young people](#). NICE quality standard 48 (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).

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.

Membership of this committee is as follows:

Dr Bee Wee (Chair)

Consultant in Palliative Medicine, Oxford University Hospitals NHS Trust; Senior Lecturer in Palliative Medicine, Oxford University

Dr Jim Stephenson (Acting chair at post-consultation meeting)

Consultant Medical Microbiologist, Epsom and St Helier NHS Trust

Mr Lee Beresford

Head of Strategy and System Restore, NHS Wakefield Clinical Commissioning Group

Dr Gita Bhutani

Professional Lead – Psychological Services, Lancashire Care NHS Foundation Trust

Mrs Jennifer Bostock

Lay Member

Dr Helen Bromley

Specialty Registrar Public Health, University of Liverpool and Liverpool School of Tropical Medicine

Dr Hasan Chowhan

GP, NHS North Essex CCG

Mr Philip Dick

Psychiatric Liaison Team Manager, East London NHS Foundation Trust

Ms Phyllis Dunn

Clinical Lead Nurse, University Hospital of North Staffordshire

Dr Ian Manifold

Clinical Lead for National Cancer Peer Review and Consultant Oncologist, National Cancer Action Team

Dr Colette Marshall

Consultant Vascular Surgeon, University Hospitals Coventry and Warwickshire NHS Trust

Mr Gavin Maxwell

Lay Member

Ms Robyn Noonan

Service Manager, Joint Commissioning, Oxfordshire County Council

Ms Joanne Panitzke

Quality Assurance and Improvement Lead, South Devon & Torbay Clinical Commissioning Group

Ms Karen Whitehead

Strategic Lead Health/Families/Partnerships Children's Service, Bury Council

Ms Alyson Whitmarsh

Clinical Audit Programme Manager, The Health and Social Care Information Centre

Ms Jane Worsley

Operations Director/Deputy CEO, Community Integrated Care

Dr Arnold Zermansky

GP, Leeds

The following specialist members joined the committee to develop this quality standard:

Professor John Cape

Head of Psychological Therapies, Camden and Islington NHS Foundation Trust

Dr Cathy Creswell

Honorary Consultant Clinical Psychologist (children and young people), University of Reading

Professor Carolyn Chew-Graham

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

Dr Melanie Dix

Consultant Child and Adolescent Psychiatrist, Cumbria Partnership Foundation Trust

Ms Judy Leibowitz

Consultant Clinical Psychologist, Camden Psychological Therapies Service

Mrs Catherine O'Neill

Lay member

Dr Gianetta Rands

Consultant Psychiatrist and Honorary Senior Lecturer , Camden and Islington NHS Foundation Trust, UCL Medical School and Royal College of Psychiatrists (Old Age Faculty)

NICE project team

Dr Dylan Jones

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Lead Technical Analysts

Ms Esther Clifford

Project Manager

Mr Lee Berry
Coordinator

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](#).

This quality standard has been incorporated into the NICE pathways for [common mental health disorders in primary care](#), [generalised anxiety disorder](#), [obsessive-compulsive disorder](#) and [body dysmorphic disorder](#), [panic disorder](#), [post-traumatic stress disorder](#) and [social anxiety disorder](#).

Changes after publication

April 2015: minor maintenance

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have

agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Anxiety UK](#)
- [College of Mental Health Pharmacy](#)
- [Royal College of General Practitioners](#)