NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Anxiety (update) GDG - Meeting 1
Tuesday 16th June, 11.00-16.30
4th Floor Standon House, 21 Mansell Street, London E1 8AA

Present:

GDG:
John Cape (JC)
Marta Buszewicz (MB)
Carolyn Chew- Graham (CCG)
Jill Keegan (JK)
Judy Leibowitz (JL)
Karina Lovell (KL)
Catherine O'Neill (CO)
Jan Scott (JS)
Phillip Cowen (PC)

NCCMH:
Tim Kendall (TK)
Nick Meader (NM)
Ifigeneia Mavranezouli (IM)
Esther Flanagan (EF)
Sarah Stockton (SS)

NICE:
Claire Turner (CT)
Victoria Thomas (VT)

Agenda item	Discussions and conclusions	Actions	Who
Introductions and apologies	The chair (JC) welcomed the group to its first GDG and everyone introduced themselves. Apologies were received from Paul Salkovskis and Joanna Hackman		
Declaration of interests (DOI)	TK explained what types of interests should be declared. GDG members declared the original interests they submitted when applying for GDG membership. New interests were also declared. MB, CCG, KL, CO, JS, PC, TK, NM, IM, EF, SS, CT, & VT all declared that they knew of no new personal pecuniary, personal family, non-personal pecuniary or personal non-pecuniary interest in the development of this guideline other than those already reported in the conflict of interest forms already submitted. JC declared a personal non-pecuniary interest: IAPT clinical lead for Islington and member of British Association of Behavioural and Cognitive Therapy.		

	CO declared a non-personal pecuniary interest: Anxiety UK received £5000 from Pfizer for a GAD booklet and £2000 for patients carrying out a GAD survey. JL declared a personal non-pecuniary interest: IAPT clinical lead for Camden. JK declared a personal non-pecuniary interest: member of British Association of Counselling and Psychotherapy.		
Timescale	JC noted the additional GDG meeting dates at the end of development due to the 4 month extension.		
NCCMH introduction	TK presented on the NCCMH and the current scope. Issues that emerged included: • Mixed anxiety and depression. Important as often co-morbid, however the other guideline on ID and referral should cover this. We should think about how to integrate these different pieces of guidance. • JS noted that the original guideline looked at over 18s even though the original scope states over 16s. We will consider 18+ for consistency. • Patient choice is an important part of the care pathway, and from the service user and carer experience chapter, good practice points can be developed based on emerging themes. • We are not looking at the evidence behind diagnosis; however we will clearly spell out the current diagnostic criteria, prevalence, co-morbidity etc in the introduction.	Find out the reason for the population changing. Amend scope	CT EF
Methods overview and outcomes example	TK presented on a brief overview to systematic reviewing, and used and example of duloxetine in the PICO format. Issues that emerged included: • The type of research we use is typically secondary only - RCTs. To look at lower level data would be unfair if we did it only for a certain intervention, and to do it for all interventions would be extremely time-consuming. However in the past we have looked at patient level data- e.g. perspectives of children on Ritalin.		
Clinical Questions	The GDG went through the clinical questions and made comments and changes. <u>CCBT</u>: • A sub-question was added to consider the impact on training and support, and also issues of equality, e.g. those with physical/learning difficulties or those with English as their second language. <u>Pharmacology</u>: • Discussed whether to include unlicensed drugs, such as mirtazapine and buproprion- Should be included as they are used in practice and if there is enough evidence for their efficacy we can push for a TA. • Overlap between antidepressants in depression guideline- should refer to it and make sure	Send out equalities form to group.	EF

	we are consistent. • Dose response and discontinuation was added to this question. <u>Psychosocial</u>: • More interventions were added, such as mindfulness, DBT, group therapies & email therapy. • A separate question on collaborative care or other service level interventions was added. • JL raised the issue of signposting- even though it's referral it is an intervention in itself. • Should look at support vs non-support? <u>Relapse prevention</u>: • Different treatments will have different impacts on duration of relapse prevention, even though previous standards are approx. 6 months. <u>Diagnosis</u>: • Self-help may be difficult to review in terms of GAD, as likely to be no diagnosis. But if we are only looking at a working diagnosis of GAD for other interventions can we make exceptions here? TK suggested looking for GAD only at first, then if the evidence is really thin we may have to look at lower levels of evidence or broader anxiety problems. <u>Outcomes</u>: • Outcomes added include GAD7 and Work and Social Adjustment Scale.		
Presentation on searching	SS presented on the role of the information scientist and search strategies. • GDG should look at search terms and see whether anything is missing or need to be changed. Important psychological synonyms should also be identified.	Any marker papers identified should be sent to SS/NM. Look at search terms	GDG
Presentation on service users/carers	VT presented on service user and carer issues in guideline development.		
Presentation on HE	TK did a brief introduction to meta-analysis and forest plots, followed by a Health Economic presentation by IM.	Send out HE workshop dates to group	EF