

**Generalised anxiety disorder and panic disorder
(with or without agoraphobia) in adults:
management in primary, secondary and
community care (partial update)**

NICE guideline

Draft for consultation, July 2010

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence for the 2011 recommendations is contained in the full version of the 2011 guideline. Evidence for the 2004 recommendations is in the full version of the 2004 guideline.

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This guidance is a partial update of NICE clinical guideline 22 (published 2004, amended 2007) and will replace it.

The recommendations for the treatment and management of generalised anxiety disorder have been updated.

With the exception of recommendation 1.4.37, the recommendations for the treatment and management of panic disorder (with or without agoraphobia) have not been updated. These recommendations are shaded in grey and end **[2004]**. Yellow shading in these recommendations indicates where wording changes have been made for the purposes of clarification only.

You are invited to comment on the updated recommendations in this guideline only. These are marked as **[new 2011]** if the evidence has been reviewed and the recommendation has been added or updated or **[2011]** if the evidence has been reviewed but no change has been made to the recommendation.

Recommendation 1.4.37 of this guideline updates and incorporates unchanged the recommendation made in 'Computerised cognitive behaviour therapy for depression and anxiety (review)' (NICE technology appraisal guidance 97)¹ for the treatment of panic disorder only.

NICE proposes deleting the 2004 recommendations for generalised anxiety disorder in the 2011 update. This is because the evidence has been reviewed and the recommendation has been updated or because NICE has updated other relevant guidance and has replaced the original recommendations. You are invited to comment on the deleted recommendations as part of the consultation on the 2011 update. These recommendations are in the 2004 NICE guideline, which is available from www.nice.org.uk/CG22

¹Available from www.nice.org.uk/guidance/TA97

Introduction

Generalised anxiety disorder (GAD) is one of a range of anxiety disorders that includes panic disorder (with and without agoraphobia), post-traumatic stress disorder, obsessive–compulsive disorder, social phobia, specific phobias (for example, of spiders) and acute stress disorder. Anxiety disorders can exist in isolation but more commonly occur with other anxiety and depressive disorders. NICE is developing a guideline on case identification and referral for common mental health disorders that will provide further guidance on the identification and treatment of comorbid conditions². GAD is a common disorder of which the central feature is excessive worry about a number of different events associated with heightened tension. A formal diagnosis using the DSM-IV classification system requires two major symptoms (excessive anxiety and worry about a number of events and activities, and difficulty controlling the worry) and three or more additional symptoms out of a list of six³. The ICD-10 diagnostic system requires there to be prominent tension, worry and feelings of apprehension together with four out of a list of 22 symptoms, of which at least one must be from a list of four autonomic symptoms (palpitations, sweating, trembling or dry mouth⁴). In both systems 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. This guideline covers both ‘pure’ GAD, in which no comorbidities are present, and the more typical presentation of GAD comorbid with other anxiety and depressive disorders in which GAD is the primary diagnosis.

According to the DSM-IV-TR⁵, a fundamental characteristic of panic disorder is the presence of recurring, unforeseen panic attacks followed by at least 1 month of persistent worry about having another panic attack and concern

²Common mental health disorders: identification and pathways to care. NICE clinical guideline. Publication expected Summer 2011.

³American Psychiatric Association (1994) Diagnostic and statistical manual of mental disorders (fourth edition). Washington DC: American Psychiatric Association

⁴World Health Organization (2007) International classification of diseases and related health problems (tenth revision). Available from www.who.int

⁵American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders (fourth edition, text revision). Washington DC: American Psychiatric Association

about the consequences of a panic attack, or a significant change in behaviour related to the attacks. At least two unexpected panic attacks are necessary for diagnosis and the attacks should not be accounted for by the use of a substance, a general medical condition or another psychological problem. Panic disorder can be diagnosed with or without agoraphobia.

This guideline uses DSM-IV rather than ICD-10 criteria to define the diagnosis of GAD and panic disorder, because the evidence for treatments is largely based on DSM-IV.

GAD and panic disorder vary in severity and complexity and this has implications for response to treatment. Therefore it is important to consider duration, degree of distress, functional impairment, personal past history and diagnostic comorbidities when undertaking a diagnostic assessment.

GAD and panic disorder can follow both chronic and remitting courses. Where possible, the goal of an intervention should be complete relief of symptoms (remission), which is associated with better functioning and a lower likelihood of relapse.

The guideline assumes that prescribers will use a drug's summary of product characteristics (SPC) and the 'British national formulary' (BNF) to inform their decisions made with individual service users.

Person-centred care

This guideline offers best practice advice on the care of adults with generalised anxiety disorder and panic disorder (with or without agoraphobia).

Treatment and care should take into account people's needs and preferences. People with generalised anxiety disorder or panic disorder (with or without agoraphobia) should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If people do not have the capacity to make decisions, practitioners should follow the Department of Health's advice on consent (available from www.dh.gov.uk/consent) and the code of practice that accompanies the Mental Capacity Act (summary available from www.publicguardian.gov.uk). In Wales, healthcare professionals should follow advice on consent from the Welsh Assembly Government (available from www.wales.nhs.uk/consent).

Good communication between practitioners and people with generalised anxiety disorder or panic disorder is essential. It should be supported by evidence-based written information tailored to the person's needs. Treatment and care, and the information people are 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.

If the person agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Families and carers should also be given the information and support they need.

Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

Stepped care for people with GAD

- Identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly. **[new 2011] [1.2.2]**
- Consider the diagnosis of GAD in people presenting with anxiety or significant worry, and in people who attend primary care frequently who:
 - have a chronic physical health problem, **or**
 - do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups), **or**
 - are repeatedly worrying about a range of different issues. **[new 2011] [1.2.3]**
- For people with GAD whose symptoms have not improved after education and active monitoring in step 1, offer one or more of the following as a first-line intervention, guided by the person's preference:
 - individual pure self-help
 - individual guided self-help
 - psychoeducational groups. **[new 2011] [1.2.11]**
- Offer people with GAD and marked functional impairment, or those whose symptoms have not responded adequately to step 2 interventions, either:
 - an individual high-intensity psychological intervention (see 1.2.17–1.2.21), **or**
 - drug treatment (see 1.2.22–1.2.32).

Provide the person with verbal and written information on the likely benefits and disadvantages of each mode of treatment, including the tendency of drug treatments to be associated with side effects and withdrawal syndromes. Base the decision on patient preference as there is no evidence that either mode of treatment is better. **[new 2011] [1.2.16]**

- If a person with GAD chooses a high-intensity psychological intervention, offer either CBT or applied relaxation. **[new 2011] [1.2.17]**
- If a person with GAD chooses drug treatment, offer a selective serotonin reuptake inhibitor (SSRI). Offer sertraline⁶ first because it is the most cost-effective drug. Monitor the person carefully for adverse reactions. **[1.2.22] [new 2011] [1.2.22]**
- Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises. Follow the advice in the BNF on the use of a benzodiazepine in this context. **[new 2011] [1.2.25]**
- Do not offer an antipsychotic for the treatment of GAD in primary care. **[new 2011] [1.2.26]**
- Consider referral to secondary care (step 4) if the person with GAD has severe anxiety with marked functional impairment in conjunction with:
 - a risk of self-harm or suicide, **or**
 - significant comorbidity, such as drug misuse, personality disorder or complex physical health problems, **or**
 - self-neglect, **or**
 - an inadequate response to step 3 interventions. **[new 2011] [1.2.36]**

⁶At the time of publication ([Month], [year]), sertraline did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

1 Guidance

The following guidance is based on the best available evidence. The full guideline ([\[hyperlink to be added for final publication\]](#)) gives details of the methods and the evidence used to develop the guidance.

1.1 *Principles of care for people with generalised anxiety disorder (GAD)*

Information and support for people with GAD, their families and carers

1.1.1 When working with people with GAD:

- build a relationship and work in an open, engaging and non-judgemental manner
- explore empathically all of the person's worries in order to jointly understand the impact of GAD
- explore treatment options collaboratively with the person, indicating that decision making is a shared process
- ensure that discussion takes place in settings in which confidentiality, privacy, dignity are respected. **[new 2011]**

1.1.2 When working with people with GAD:

- provide information appropriate to the person's level of understanding about the nature of GAD and the range of treatments available
- ensure that comprehensive written information is available in the person's preferred language and in audio format if possible
- offer independent interpreters if needed. **[new 2011]**

1.1.3 When families and carers are involved in supporting a person with GAD, consider:

- offering a carer's assessment of their caring, physical and mental health needs

- providing information, including contact details, about family and carer support groups and voluntary organisations, and helping families or carers to access these
- negotiating between the person with GAD and their family or carers about confidentiality and the sharing of information
- providing written and verbal information on GAD and its management, including how families and carers can support the person
- providing contact numbers and information about what to do and who to contact in a crisis. **[new 2011]**

1.1.4 Inform people with GAD about local and national self-help organisations and support groups, in particular where they can talk to others with similar experiences. **[new 2011]**

1.1.5 For people with GAD who have a mild learning disability or mild acquired cognitive impairment, offer the same interventions as for other people with GAD, adjusting the method of delivery or duration of the intervention if necessary to take account of the disability or impairment. **[new 2011]**

1.1.6 When assessing or offering an intervention to people with GAD and a moderate to severe learning disability or moderate to severe acquired cognitive impairment, consider consulting with a relevant specialist. **[new 2011]**

1.2 *Stepped care for people with GAD*

1.2.1 Follow the [stepped-care model](#) to organise the provision of services and to help people with GAD, their families, carers and practitioners to choose and access the most effective interventions (see figure 1). Offer the least intrusive, most effective intervention first. **[new 2011]**

Figure 1. The stepped-care model

Focus of the intervention	Nature of the intervention
<p>STEP 4: Complex treatment-refractory GAD and very marked functional impairment, such as self-neglect or a high risk of self-harm</p>	<p>Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care</p>
<p>STEP 3: GAD with an inadequate response to step 2 interventions or marked functional impairment</p>	<p>Choice of a high-intensity psychological intervention (cognitive behavioural therapy/applied relaxation) or a drug treatment</p>
<p>STEP 2: Diagnosed GAD that has not improved after education and active monitoring in primary care</p>	<p>Low-intensity psychological interventions: pure self-help*, guided self-help and psychoeducational groups</p>
<p>STEP 1: All known and suspected presentations of GAD</p>	<p>Identification and assessment; education about GAD and treatment options; active monitoring</p>

*Pure self-help is defined as a self-administered intervention intended to treat GAD and involves self-help materials (usually a book or workbook). It is similar to guided self-help but without any contact with a healthcare professional.

Step 1: All known and suspected presentations of GAD

Identification and assessment

- 1.2.2 Identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly. **[new 2011]**
- 1.2.3 Consider the diagnosis of GAD in people presenting with anxiety or significant worry, and in people who attend primary care frequently who:
- have a chronic physical health problem, **or**

- do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups), **or**
- are repeatedly worrying about a range of different issues. **[new 2011]**

1.2.4 When a person with known or suspected GAD attends primary care seeking reassurance about a chronic physical health problem or somatic symptoms and/or repeated worrying, explain in an accepting and non-judgmental way that these may be symptoms of GAD. **[new 2011]**

Assessment and education

1.2.5 For people who may have GAD, conduct a comprehensive assessment that does not rely solely on the number, severity and duration of symptoms, but also considers the degree of distress and functional impairment. **[new 2011]**

1.2.6 As part of the comprehensive assessment, consider how the following factors might have affected the development, course and severity of the person's GAD:

- presence of a comorbid depressive disorder or other anxiety disorder
- presence of comorbid substance misuse
- any comorbid medical condition
- a history of mental health disorders
- past experience of, and response to, treatments. **[new 2011]**

1.2.7 For people with GAD and a comorbid depressive or other anxiety disorder, treat the primary disorder first (that is, the one that is more severe and in which it is more likely that treatment will improve overall functioning). **[new 2011]**

1.2.8 While alcohol problems can be a complication of GAD, non-harmful alcohol misuse should not be a contra-indication to the treatment of

GAD. However, for people with GAD with harmful and dependent alcohol misuse, treat the alcohol misuse first as this alone may lead to significant improvement in the symptoms of GAD^{7, 8}. **[new 2011]**

1.2.9 Following assessment and diagnosis of GAD:

- provide education about the nature of GAD and the options for treatment, including the 'Understanding NICE guidance' booklet
- monitor the person's symptoms and functioning (known as active monitoring).

Education and monitoring may improve less severe presentations and avoid the need for further interventions. **[new 2011]**

1.2.10 Discuss the use of over-the-counter preparations with people with GAD. Explain the potential for interactions with other medications and that there is not enough evidence to support their safe use. **[new 2011]**

Step 2: Diagnosed GAD that has not improved after education and active monitoring in step 1

Low-intensity psychological interventions for GAD

1.2.11 For people with GAD whose symptoms have not improved after education and active monitoring in step 1, offer one or more of the following as a first-line intervention, guided by the person's preference:

- individual pure self-help
- individual guided self-help
- psychoeducational groups. **[new 2011]**

⁷See: 'Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications' (NICE clinical guideline 100), available from www.nice.org.uk/guidance/CG100 and 'Alcohol-use disorders: preventing the development of hazardous and harmful drinking' (NICE public health guidance 24), available from www.nice.org.uk/guidance/PH24

⁸NICE is developing a guideline on the diagnosis and management of alcohol dependence and harmful alcohol use in young people and adults. Publication expected January 2011.

- 1.2.12 Individual pure self-help for people with GAD should:
- include written or electronic materials of a suitable reading age (or alternative media)
 - be based on the treatment principles of cognitive behavioural therapy (CBT)
 - include instructions for the person to work systematically through the materials over a period of at least 6 weeks
 - typically involve minimal therapist contact, for example an occasional short telephone call of no more than 5 minutes. **[new 2011]**
- 1.2.13 Individual guided self-help for people with GAD should:
- include written or electronic materials of a suitable reading age (or alternative media)
 - be supported by a trained practitioner, who facilitates the self-help programme and reviews progress and outcome
 - typically consist of five to seven weekly or fortnightly face-to-face or telephone sessions, each lasting 20–30 minutes. **[new 2011]**
- 1.2.14 Psychoeducational groups for people with GAD should:
- be based on CBT principles, have an interactive design and encourage vicarious learning
 - include presentations and self-help manuals
 - be conducted by trained practitioners.
 - have a ratio of one therapist to 12 participants
 - typically consist of six weekly sessions, each lasting 2 hours. **[new 2011]**
- 1.2.15 Practitioners providing guided self-help and/or psychoeducational groups should:
- receive regular high-quality supervision

- use routine outcome measures and ensure that the person with GAD is involved in reviewing the efficacy of the treatment. **[new 2011]**

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

Treatment options

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

- an individual high-intensity psychological intervention (see [1.2.17–1.2.21](#)), **or**
- drug treatment (see [1.2.22–1.2.32](#))

Provide the person with verbal and written information on the likely benefits and disadvantages of each mode of treatment, including the tendency of drug treatments to be associated with side effects and withdrawal syndromes. Base the decision on patient preference as there is no evidence that either mode of treatment is better. **[new 2011]**

High-intensity psychological interventions

1.2.17 If a person with GAD chooses a high-intensity psychological intervention, offer either CBT or applied relaxation. **[new 2011]**

1.2.18 CBT for people with GAD should:

- be based on the treatment manuals used in the clinical trials of CBT for GAD
- be delivered by trained and competent practitioners
- typically consist of 12–15 weekly sessions, each lasting 1 hour. **[new 2011]**

- 1.2.19 Applied relaxation for people with GAD should:
- be based on the treatment manuals used in the clinical trials of applied relaxation for GAD
 - be delivered by competent practitioners who have had training in both CBT and applied relaxation
 - typically consist of 12–15 weekly sessions, each lasting 1 hour. **[new 2011]**
- 1.2.20 Practitioners providing high-intensity psychological interventions for GAD should:
- have regular supervision to monitor fidelity to the treatment model, using audio or video recording of treatment sessions where possible
 - use routine outcome measures and ensure that the person with GAD is involved in reviewing the efficacy of the treatment. **[new 2011]**
- 1.2.21 Consider providing all interventions in the preferred language of the person with GAD if possible. **[new 2011]**

Drug treatment

- 1.2.22 If a person with GAD chooses drug treatment, offer a selective serotonin reuptake inhibitor (SSRI). Offer sertraline⁹ first because it is the most cost-effective drug. Monitor the person carefully for adverse reactions. **[new 2011]**
- 1.2.23 If sertraline is ineffective, offer an alternative SSRI or a serotonin noradrenaline reuptake inhibitor (SNRI), taking into account the following factors:
- UK marketing authorisation for use in GAD

⁹At the time of publication ([Month], [year]), sertraline did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

- tendency to produce a withdrawal syndrome (especially with paroxetine)
- the side effect profile
- the risk of suicide and likelihood of toxicity in overdose (especially with venlafaxine)
- the person's prior experience of treatment with individual SSRIs (particularly effectiveness, side effects, experience of withdrawal syndrome and patient preference). **[new 2011]**

1.2.24 If the person cannot tolerate SSRIs offer pregabalin rather than an SNRI.

1.2.25 Do not offer a benzodiazepine for the treatment of GAD in primary or secondary care except as a short-term measure during crises. Follow the advice in the BNF on the use of a benzodiazepine in this context. **[new 2011]**

1.2.26 Do not offer an antipsychotic for the treatment of GAD in primary care. **[new 2011]**

1.2.27 Before prescribing any medication, discuss the treatment options and any concerns the person with GAD has about taking medication. Explain fully the reasons for prescribing and provide written and verbal information on:

- the likely benefits of different treatments
- the different propensities of each drug for side effects, withdrawal syndromes and drug interactions
- the risk of an activation syndrome with SSRIs and SNRIs, including increased anxiety, agitation, diminished appetite and problems sleeping, especially in people aged under 30
- the gradual development, over 1 week or more, of the full anxiolytic effect

- the importance of taking medication as prescribed and the need to continue treatment after remission to avoid relapse. **[new 2011]**

1.2.28 Take into account the increased risk of bleeding associated with SSRIs, particularly for older people or people taking other drugs that can damage the gastrointestinal mucosa or interfere with clotting. Consider prescribing a gastroprotective drug for older people who are taking non-steroidal anti-inflammatory drugs (NSAIDs) or aspirin. **[new 2011]**

1.2.29 For people aged under 30 who are offered an SSRI or SNRI:

- warn them that these drugs are associated with an increased risk of suicidal thinking and self-harm in a minority of people, **and**
- see them within 1 week of first prescribing, **and**
- monitor the risk of suicidal thinking and self-harm weekly for the first month. **[new 2011]**

1.2.30 For people who develop side effects soon after starting drug treatment, provide information and consider one of the following strategies:

- monitoring symptoms closely (if the side effects are mild and acceptable to the person)
- stopping the drug and offering either an alternative drug (see [1.2.23–1.2.24](#)) or a high-intensity psychological intervention (see [1.2.17–1.2.21](#)) according to the person's preference. **[new 2011]**

1.2.31 Review the effectiveness and side effects of the drug every 2–4 weeks during the first 3 months of treatment and every 3 months thereafter. **[new 2011]**

1.2.32 If the drug is effective warn the person not to stop taking it for at least a year as the likelihood of relapse is high. **[new 2011]**

Inadequate response to step 3 interventions

1.2.33 If a person's GAD has not responded to a full course of a high-intensity psychological treatment, offer a drug treatment (see [1.2.22–1.2.32](#)). **[new 2011]**

1.2.34 If a person's GAD has not responded to drug treatment, offer either a high-intensity psychological intervention (see [1.2.17–1.2.21](#)) or an alternative drug treatment (see [1.2.23–1.2.24](#)). **[new 2011]**

1.2.35 If a person's GAD has partially responded to drug treatment, consider offering a psychological intervention in addition to drug treatment. **[new 2011]**

1.2.36 Consider referral to secondary care (step 4) if the person with GAD has severe anxiety with marked functional impairment in conjunction with:

- a risk of self-harm or suicide, **or**
- significant comorbidity, such as drug misuse, personality disorder or complex physical health problems, **or**
- self-neglect, **or**
- an inadequate response to step 3 interventions. **[new 2011]**

Step 4: Complex, treatment-refractory GAD and very marked functional impairment or high risk of self-harm

Assessment

- 1.2.37 Offer the person with GAD a full multidisciplinary assessment of needs and risks, including:
- duration and severity of symptoms, functional impairment, comorbidities, risk to self and self-neglect
 - a formal review of current and past treatments and their impact on symptoms and functional impairment
 - home environment
 - support in the community
 - relationships with and impact on families and carers. **[new 2011]**
- 1.2.38 Review the needs of families and carers and offer an assessment of their caring, physical and mental health needs if one has not been offered previously. **[new 2011]**
- 1.2.39 Develop a comprehensive care plan that addresses needs, risks and functional impairment and has a clear treatment plan. **[new 2011]**

Treatment

- 1.2.40 Inform people with GAD who have not been offered or have refused the interventions in steps 1–3 about the potential benefits of these interventions and offer them any they have not tried. **[new 2011]**
- 1.2.41 Consider offering combinations of psychological and drug treatments, combinations of antidepressants or augmentation of antidepressants with other drugs, but exercise caution and be aware that:
- evidence for the effectiveness of combination treatments is lacking, **and**

- side effects and interactions are more likely when combining and augmenting antidepressants. **[new 2011]**

1.2.42 Combination treatments should be undertaken only by practitioners with expertise in the psychological and drug treatment of complex, treatment-refractory anxiety disorders and after full discussion with the person about the likely advantages and disadvantages of the treatments suggested. **[new 2011]**

1.2.43 When treating people with complex and treatment-refractory GAD, consider encouraging them to participate in clinical research. **[new 2011]**

1.3 Principles of care for people with panic disorder

General management for panic disorder

People who have panic disorder and their families and carers need comprehensive information, presented in clear and understandable language, about the nature of their condition and the treatment options available. Such information is essential for shared decision-making between people with panic disorder and healthcare professionals, particularly when making choices between broadly equivalent treatments. In addition, given the emotional, social and economic costs panic disorder usually entails, people with panic disorder and their families and carers may need help in contacting support and self-help groups. Support groups can also promote understanding and collaboration between people who have panic disorder, their families and carers, and healthcare professionals at all levels of primary and secondary care.

Shared decision-making and information provision

- 1.3.1 Shared decision-making should take place as it improves concordance and clinical outcomes. **[2004]**
- 1.3.2 Shared decision-making between the individual and healthcare professionals should take place during the process of diagnosis and in all phases of care. **[2004]**
- 1.3.3 **People with panic disorder** and, when appropriate, families and carers should be provided with information on the nature, course and treatment of panic disorder, including information on the use and likely side-effect profile of medication. **[2004]**
- 1.3.4 To facilitate shared decision-making, evidence-based information about treatments should be available and discussion of the possible options should take place. **[2004]**

- 1.3.5 **People's** preference and the experience and outcome of previous treatment(s) should be considered in determining the choice of treatment. **[2004]**
- 1.3.6 Common concerns about taking medication, such as fears of addiction, should be addressed. **[2004]**
- 1.3.7 In addition to being provided with high-quality information, **people with panic disorder and their** families and carers should be informed of self-help groups and support groups and be encouraged to participate in such programmes where appropriate. **[2004]**

Language

- 1.3.8 When talking to **people with panic disorder and their families** and carers, healthcare professionals should use everyday, jargon-free language. If technical terms are used they should be explained to the **person**. **[2004]**
- 1.3.9 Where appropriate, all services should provide written material in the language of the **person**, and appropriate interpreters should be sought for people whose preferred language is not English. **[2004]**
- 1.3.10 Where available, consideration should be given to providing psychotherapies in the person's own language if this is not English. **[2004]**

1.4 Stepped care for people with panic disorder

The guideline provides recommendations for care at different stages of the **person's** journey, represented as different steps:

- Step 1 – recognition and diagnosis
- Step 2 – treatment in primary care
- Step 3 – review and consideration of alternative treatments

- Step 4 – review and referral to specialist mental health services
- Step 5 – care in specialist mental health services.

Step 1: Recognition and diagnosis of panic disorder

Consultation skills

1.4.1 All healthcare professionals involved in diagnosis and management should have a demonstrably high standard of consultation skills so that a structured approach can be taken to the diagnosis and subsequent management plan for panic disorder. The standards detailed in the video workbook 'Summative Assessment For General Practice Training: Assessment Of Consulting Skills – the MRCGP/Summative Assessment Single Route' (see www.rcgp.org.uk/exam) and required of the Membership of the Royal College of General Practitioners are a good example of standards for consulting skills. **[2004]**

Diagnosis

The accurate diagnosis of panic disorder is central to the effective management of these conditions. It is acknowledged that frequently there are other conditions present, such as depression, that can make the presentation and diagnosis confusing.

- 1.4.2 The diagnostic process should elicit necessary relevant information such as personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care. **[2004]**
- 1.4.3 There is insufficient evidence on which to recommend a well-validated, self-reporting screening instrument to use in the diagnostic process, and so consultation skills should be relied upon to elicit all necessary information. **[2004]**

Comorbidities

- 1.4.4 The clinician should be alert to the common clinical situation of comorbidity, in particular, **panic disorder** with depression and **panic disorder** with substance **misuse**. [2004]
- 1.4.5 The main problem(s) to be treated should be identified through a process of discussion with the **person**. In determining the priorities of the comorbidities, the sequencing of the problems should be clarified. This can be helped by drawing up a timeline to identify when the various problems developed. By understanding when the symptoms developed, a better understanding of the relative priorities of the comorbidities can be achieved, and there is a better opportunity of developing an effective intervention that fits the needs of the individual. [2004]
- 1.4.6 When the **person** has depression or anxiety with depression, the NICE guideline on management of depression should be followed. [2004]

Presentation in A&E with panic attacks

It is important to remember that a panic attack does not necessarily constitute a panic disorder and appropriate treatment of a panic attack may limit the development of panic disorder. For people who present with chest pain at A&E services, there appears to be a greater likelihood of the cause being panic disorder if coronary artery disease is not present or the **person** is female or relatively young. Two other variables, atypical chest pain and self-reported anxiety, may also be associated with panic disorder presentations, but there is insufficient evidence to establish a relationship.

- 1.4.7 If a person presents in A&E, or other settings, with a panic attack, they should:

- be asked if they are already receiving treatment for panic disorder
- undergo the minimum investigations necessary to exclude acute physical problems

- not usually be admitted to a medical or psychiatric bed
- be referred to primary care for subsequent care, even if assessment has been undertaken in A&E
- be given appropriate written information about panic attacks and why they are being referred to primary care
- be offered appropriate written information about sources of support, including local and national voluntary and self-help groups.

Panic disorder – steps 2–5

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

The recommended treatment options have an evidence base: psychological therapy, medication and self-help have all been shown to be effective. The choice of treatment will be a consequence of the assessment process and shared decision-making.

There may be instances when the most effective intervention is not available (for example, cognitive behavioural therapy [CBT]) or is not the treatment option chosen by the **person**. In these cases, the healthcare professional will need to consider, after discussion with the **person**, whether it is acceptable to offer one of the other recommended treatments. If the preferred treatment option is currently unavailable, the healthcare professional will also have to consider whether it is likely to become available within a useful timeframe.

General

- 1.4.8 Benzodiazepines are associated with a less good outcome in the long term and should not be prescribed for the treatment of individuals with panic disorder. **[2004]**
- 1.4.9 Sedating antihistamines or antipsychotics should not be prescribed for the treatment of panic disorder. **[2004]**
- 1.4.10 In the care of individuals with panic disorder, any of the following types of intervention should be offered and the preference of the person should be taken into account. The interventions that have

evidence for the longest duration of effect, in descending order, are:

- psychological therapy (see 1.4.13–1.4.19)
- pharmacological therapy (antidepressant medication) (see 1.4.20–1.4.32)
- self-help (see 1.4.33–1.4.36) **[2004]**

1.4.11 The treatment option of choice should be available promptly. **[2004]**

1.4.12 There are positive advantages of services based in primary care (for example, lower rates of people who do not attend) and these services are often preferred by people. **[2004]**

Psychological interventions

1.4.13 Cognitive behavioural therapy (CBT) should be used. **[2004]**

1.4.14 CBT should be delivered only by suitably trained and supervised people who can demonstrate that they adhere closely to empirically grounded treatment protocols. **[2004]**

1.4.15 CBT in the optimal range of duration (7–14 hours in total) should be offered. **[2004]**

1.4.16 For most people, CBT should take the form of weekly sessions of 1–2 hours and should be completed within a maximum of 4 months of commencement. **[2004]**

- 1.4.17 Briefer CBT should be supplemented with appropriate focused information and tasks. **[2004]**
- 1.4.18 Where briefer CBT is used, it should be around 7 hours and designed to integrate with structured self-help materials. **[2004]**
- 1.4.19 For a few people, more intensive CBT over a very short period of time might be appropriate. **[2004]**

Pharmacological interventions – antidepressant medication

- 1.4.20 Antidepressants should be the only pharmacological intervention used in the longer term management of panic disorder. The two classes of antidepressants that have an evidence base for effectiveness are the selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants. **[2004]**
- 1.4.21 The following must be taken into account when deciding which medication to offer:

- the age of the **person**
- previous treatment response
- risks
 - the likelihood of accidental overdose by the person being treated and by other family members if appropriate
 - the likelihood of deliberate self-harm, by overdose or otherwise (*the highest risk is with TCAs*)

- tolerability
- *the possibility of interactions with concomitant medication (consult appendix 1 of the 'British National Formulary')*
- the preference of the person being treated
- cost, where equal effectiveness is demonstrated. **[2004, amended 2007]**

- 1.4.22 All **people** who are prescribed antidepressants should be informed, at the time that treatment is initiated, of potential side effects

(including transient increase in anxiety at the start of treatment) and of the risk of discontinuation/withdrawal symptoms if the treatment is stopped abruptly or in some instances if a dose is missed or, occasionally, on reducing the dose of the drug. **[2004]**

1.4.23 **People** started on antidepressants should be informed about the delay in onset of effect, the time course of treatment, the need to take medication as prescribed, and possible discontinuation/withdrawal symptoms. Written information appropriate to the **person's** needs should be made available. **[2004]**

1.4.24 Unless otherwise indicated, an SSRI licensed for panic disorder should be offered. **[2004]**

1.4.25 If an SSRI is not suitable or there is no improvement after a 12-week course and if a further medication is appropriate, imipramine¹⁰ or clomipramine¹¹ may be considered. **[2004]**

1.4.26 When prescribing an antidepressant, the healthcare professional should consider the following.

- Side effects on the initiation of antidepressants may be minimised by starting at a low dose and increasing the dose slowly until a satisfactory therapeutic response is achieved.
- In some instances, doses at the upper end of the indicated dose range may be necessary and should be offered if needed.
- Long-term treatment may be necessary for some people and should be offered if needed.
- If the person is showing improvement on treatment with an antidepressant, the medication should be continued for at least

¹⁰At the time of publication ([Month], [year]), imipramine did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

¹¹At the time of publication ([Month], [year]), clomipramine did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

6 months after the optimal dose is reached, after which the dose can be tapered. **[2004]**

- 1.4.27 If there is no improvement after a 12-week course, an antidepressant from the alternative class (if another medication is appropriate) or another form of therapy (see 1.4.10) should be offered. **[2004]**
- 1.4.28 **People** should be advised to take their medication as prescribed. This may be particularly important with short half-life medication in order to avoid discontinuation/withdrawal symptoms. **[2004]**
- 1.4.29 Stopping antidepressants abruptly can cause discontinuation/withdrawal symptoms. To minimise the risk of discontinuation/withdrawal symptoms when stopping antidepressants, the dose should be reduced gradually over an extended period of time. **[2004]**
- 1.4.30 All **people** prescribed antidepressants should be informed that, although the drugs are not associated with tolerance and craving, discontinuation/withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly. **[2004]**
- 1.4.31 Healthcare professionals should inform **people** that the most commonly experienced discontinuation/withdrawal symptoms are dizziness, numbness and tingling, gastrointestinal disturbances (particularly nausea and vomiting), headache, sweating, anxiety and sleep disturbances. **[2004]**

- 1.4.32 Healthcare professionals should inform **people** that they should seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms. **[2004]**
- 1.4.33 If discontinuation/withdrawal symptoms are mild, the practitioner should reassure the person and monitor symptoms. If severe symptoms are experienced after discontinuing an antidepressant, the practitioner should consider reintroducing it (or prescribing another from the same class that has a longer half-life) and gradually reducing the dose while monitoring symptoms. **[2004]**

Self-help

- 1.4.34 Bibliotherapy based on CBT principles should be offered. **[2004]**
- 1.4.35 Information about support groups, where they are available, should be offered. (Support groups may provide face-to-face meetings, telephone conference support groups [which can be based on CBT principles], or additional information on all aspects of anxiety disorders plus other sources of help.) **[2004]**
- 1.4.36 The benefits of exercise as part of good general health should be discussed with all **people with panic disorder** as appropriate. **[2004]**
- 1.4.37 FearFighter is recommended as an option for delivering CBT in the management of panic. **[2011]**¹²

Step 3 for people with panic disorder: review and offer alternative treatment if appropriate

- 1.4.38 If, after a course of treatment, the clinician and the **person with panic disorder** agree that there has been no improvement with one type of intervention, the **person** should be reassessed and consideration given to trying one of the other types of intervention. **[2004]**

¹² This recommendation for the management of panic is incorporated unchanged from 'Computerised cognitive behaviour therapy for depression and anxiety (review of technology appraisal 51)'. (NICE technology appraisal guidance 97, 2006).

Step 4 for people with panic disorder: review and offer referral from primary care if appropriate

1.4.39 In most instances, if there have been two interventions provided (any combination of psychological intervention, medication, or bibliotherapy) and the person still has significant symptoms, then referral to specialist mental health services should be offered. **[2004]**

Step 5 for people with panic disorder: care in specialist mental health services

1.4.40 Specialist mental health services should conduct a thorough, holistic reassessment of the individual, their environment and social circumstances. This reassessment should include evaluation of:

- previous treatments, including effectiveness and concordance
- any substance use, including nicotine, alcohol, caffeine and recreational drugs
- comorbidities
- day-to-day functioning
- social networks
- continuing chronic stressors
- the role of agoraphobic and other avoidant symptoms.

A comprehensive risk assessment should be undertaken and an appropriate risk management plan developed. **[2004]**

1.4.41 To undertake these evaluations, and to develop and share a full formulation, more than one session may be required and should be available. **[2004]**

1.4.42 Care and management should be based on the individual's circumstances and shared decisions made. Options include:

- treatment of co-morbid conditions
- CBT with an experienced therapist if not offered already, including home-based CBT if attendance at clinic is difficult

- structured problem solving
- full exploration of pharmaco-therapy
- day support to relieve carers and family members
- referral for advice, assessment or management to tertiary centres. **[2004]**

1.4.43 There should be accurate and effective communication between all healthcare professionals involved in the care of any person with panic disorder, and particularly between primary care clinicians (GP and teams) and secondary care clinicians (community mental health teams) if there are existing physical health conditions that also require active management. **[2004]**

Monitoring and follow-up for individuals with panic disorder

Psychological interventions

1.4.44 There should be a process within each practice to assess the progress of a person undergoing CBT. The nature of that process should be determined on a case-by-case basis. **[2004]**

Pharmacological interventions

1.4.45 When a new medication is started, the efficacy and side-effects should be reviewed within 2 weeks of starting treatment and again at 4, 6 and 12 weeks. Follow the Summary of Product Characteristics (SPC) with respect to all other monitoring required. **[2004]**

1.4.46 At the end of 12 weeks, an assessment of the effectiveness of the treatment should be made, and a decision made as to whether to continue or consider an alternative intervention. **[2004]**

1.4.47 If medication is to be continued beyond 12 weeks, the individual should be reviewed at 8- to 12-week intervals, depending on clinical progress and individual circumstances. **[2004]**

Self-help

1.4.48 Individuals receiving self-help interventions should be offered contact with primary healthcare professionals, so that progress can be monitored and alternative interventions considered if appropriate. The frequency of such contact should be determined on a case-by-case basis, but is likely to be between every 4 and 8 weeks. **[2004]**

Outcome measures

1.4.49 Short, self-completed questionnaires (such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder) should be used to monitor outcomes wherever possible. **[2004]**

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guideline is available from www.nice.org.uk [NICE to add details].

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations. An independent Guideline Review Panel oversaw the development of the guideline (see appendix B).

There is more information about how NICE clinical guidelines are developed on the NICE website (www.nice.org.uk/HowWeWork). A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' (fourth edition, published 2009), is available from NICE publications (phone 0845 003 7783 or email publications@nice.org.uk and quote reference N1739).

3 Implementation

NICE has developed tools to help organisations implement this guidance (see [www.nice.org.uk/guidance/CG\[XXI\]](http://www.nice.org.uk/guidance/CG[XXI])).

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline (see section 5).

4.1 *A comparison of the effectiveness of sertraline and CBT in people with GAD that has not responded to guided self-help and psychoeducation*

What is the relative effectiveness of sertraline compared with CBT in people with GAD that has not responded to guided self-help and psychoeducation in a stepped-care model?

This question should be addressed using a randomised controlled design in which people with GAD that has not responded to step 2 interventions are allocated openly to treatment with sertraline, CBT or wait list control for 12–16 weeks. The control group is important to demonstrate that the two active treatments produce effects greater than those of natural remission. The period of wait list control is the standard length of CBT treatment for GAD and is also commonly the length of time that it would take for specialist CBT to become available in routine practice. After 12–16 weeks all participants should receive further treatment chosen in collaboration with their treating clinicians.

The outcome measures chosen at 12–16 weeks should reflect both observer and participant-rated assessments of improvements in symptomatology and quality of life. The trial needs to be large enough to determine the presence or absence of clinically important effects using a non-inferiority design. Mediators and moderators of response should be investigated. Cost–benefit analyses should also be carried out. Follow-up assessments should continue over the next 2 years to ascertain whether short-term benefits are maintained and, in particular, whether CBT produces a better long-term outcome.

Why this is important

Both sertraline and CBT are efficacious in the treatment of GAD but their relative efficacy has not been compared. In a stepped-care model both CBT and sertraline are treatment options if step 2 interventions (guided self-help and/or psychoeducation) have not resulted in a satisfactory clinical response. At present, however, there are no randomised trial data to help prioritise next-step treatments and no information on how individuals with GAD may be

matched to particular therapies. Clarification of the relative short and longer-term benefits of sertraline and CBT would be helpful in guiding treatment. **[new 2011]**

4.2 *The clinical and cost effectiveness of computerised CBT (CCBT) compared with CBT for the treatment of GAD*

In well-defined GAD, what is the clinical and cost effectiveness of CCBT compared with therapist-delivered CBT?

This question should be answered using a randomised controlled design of at least 12 months' duration that reports both short and medium-term outcomes (including cost-effectiveness outcomes). Particular attention should be paid to the reproducibility of the treatment model with regard to content, duration and the training and supervision of those delivering interventions to ensure that the results are both robust and generalisable. The outcomes chosen should include both observer and participant-rated assessments of improvement in symptoms and functioning, and an assessment of the acceptability and accessibility of the treatment options.

Why this is important

Psychological treatments are a recommended therapeutic option for people with GAD. CCBT is a promising intervention but does not have the substantial evidence base of therapist-delivered CBT. It is therefore important to establish whether CCBT is an effective alternative to therapist-delivered CBT and one that should be provided. The results of this trial will have important implications for the provision, accessibility and acceptability of psychological treatment in the NHS. **[new 2011]**

4.3 *Physical activity compared with wait list control for the treatment of GAD*

For people with GAD who are ready to start a low-intensity intervention, what is the clinical effectiveness of physical activity compared with wait list control?

This question should be answered using a randomised controlled design for people with GAD who have been educated about the disorder (as described in step 1) and are stepping up to a low-intensity intervention. The period of wait list control should be 12 weeks. The outcomes chosen should include observer and participant-rated assessments of improvements in symptomatology and functioning. Response to treatment should be measured as at least a 50% reduction in Hamilton Anxiety Scale scores and remission should be measured as a Hamilton Anxiety Scale score of less than 7.

Why this is important

The evidence base for the effectiveness of physical activity in reducing anxiety symptoms is substantially smaller than that for depression. However, where evidence exists there are signs that physical activity could help to reduce anxiety. As GAD is a commonly experienced mental health disorder the results of this study will have important implications in widening the range of treatment options available in the NHS. [new 2011]

4.4 *The effectiveness of chamomile in the treatment of GAD*

Is chamomile more effective than placebo in increasing response and remission rates and decreasing anxiety ratings for people with GAD?

This question should be addressed using a placebo-controlled, double-blind randomised design to compare the effects of a standardised dose (220–1100 mg) of chamomile in a readily available form, for example a capsule, with placebo. This should assess outcomes at the end of the trial and at 12-month post-trial follow-up. The outcomes chosen should reflect both observer and participant-rated assessments of improvement and side effects.

Response to treatment should be measured as at least a 50% reduction in Hamilton Anxiety Scale scores and remission should be measured as a Hamilton Anxiety Scale score of less than 7. There should be a health economic evaluation included and an assessment of quality of life. The trial should be large enough to determine the presence or absence of clinically important effects using a non-inferiority design. Mediators and moderators of response should be investigated.

Why this is important

GAD is a common mental health disorder and the results of this study will be generalisable to a large number of people. There is evidence for the efficacy of chamomile in reducing anxiety in people with GAD but the evidence base is small (one study). However, the scarce literature on the effectiveness of other herbal interventions for treating GAD points to chamomile as one of the most effective, widely available and relatively inexpensive. Furthermore, at present there is no scientific evidence of side effects or drug–herbal interactions in relation to chamomile. As chamomile is readily available and has no known side effects, it could be used at an early stage as a means of preventing progression to drug treatments, which are associated with a number of undesirable side effects and dependency. **[new 2011]**

4.5 *Effectiveness of a primary care-based collaborative care approach to improving the treatment of GAD compared with usual care*

What are the benefits of a primary care-based collaborative care approach to improving the treatment of GAD compared with usual care?

This question should be addressed using a cluster randomised controlled design in which the clusters are GP practices and people with GAD are recruited following screening of consecutive attenders at participating GP practices. GPs in intervention practices should receive training in recognising GAD and providing both drug treatment and GP-delivered low-intensity psychological interventions (psychoeducation and pure self-help).

Psychological wellbeing practitioners¹³ (PWPs) in intervention practices should provide these low-intensity psychological interventions and support GP-prescribed drug treatment by providing information about side effects, monitoring medication use and liaising about any changes to medication. They should also support the referral for CBT of participants whose symptoms have not improved following low-intensity interventions. Structured, practice-based protocols should define care pathways, the interventions to be provided by practitioners at each point in the care pathway and the mechanisms they should use to liaise about individual patients. In control practices, participants should receive care as usual from the GP, including referral for primary and secondary care psychological interventions or mental health services.

Outcomes should be evaluated at 6 months with follow-up assessments continuing for up to 2 years to establish whether short-term benefits are maintained in the longer term. Both observer and participant-rated measures of clinical symptoms and quality of life should be included. Cost-benefit analyses should also be carried out. The trial needs to be large enough to determine the presence or absence of clinically important effects.

Why this is important

Most people with GAD in the UK do not receive evidence-based management and poor recognition of GAD by GPs contributes to a lack of appropriate interventions being offered. There is some evidence that complex interventions involving the training of primary care practitioners, together with a collaborative care approach involving GPs, other primary care practitioners and mental health professionals, can improve the uptake of evidence-based interventions and clinical and functional outcomes for people with GAD. However, these approaches have not been evaluated in primary care in the UK. Given the differences between the organisation of primary care in different countries, such as the US, it is important to demonstrate whether these approaches can also be effective in the UK. **[new 2011]**

¹³Also known as graduate mental health workers.

5 Other versions of this guideline

5.1 *Full guideline*

The full guideline, 'Anxiety: management of generalised anxiety disorder in adults in primary, secondary and community care (update)' contains details of the methods and evidence used to develop the guideline. It is published by the [National Collaborating Centre for Mental Health, and is available from our website ([www.nice.org.uk/guidance/CG\[XX\]/FullGuidance](http://www.nice.org.uk/guidance/CG[XX]/FullGuidance)). **Note: these details will apply to the published full guideline.**

5.2 *Quick reference guide*

A quick reference guide for healthcare professionals is available from [www.nice.org.uk/guidance/CG\[XX\]/QuickRefGuide](http://www.nice.org.uk/guidance/CG[XX]/QuickRefGuide)

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N[XXXX]). **Note: these details will apply when the guideline is published.**

5.3 *'Understanding NICE guidance'*

A summary for patients and carers ('Understanding NICE guidance') is available from [www.nice.org.uk/guidance/CG\[XX\]/PublicInfo](http://www.nice.org.uk/guidance/CG[XX]/PublicInfo)

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N[XXXX]). **Note: these details will apply when the guideline is published.**

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about generalised anxiety disorder and panic disorder (with or without agoraphobia).

6 Related NICE guidance

Published

- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications. NICE clinical guideline 100 (2010). Available from www.nice.org.uk/guidance/CG100

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- Alcohol-use disorders: preventing the development of hazardous and harmful drinking. NICE public health guidance 24 (2010). Available from www.nice.org.uk/guidance/PH24
- Depression: the treatment and management of depression in adults. NICE clinical guideline 90 (2009). Available from www.nice.org.uk/guidance/CG90
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007). Available from www.nice.org.uk/guidance/CG45
- Hypertension: management of hypertension in adults in primary care. NICE clinical guideline 34 (2006). Available from www.nice.org.uk/guidance/CG34
- Computerised cognitive behaviour therapy for depression and anxiety. NICE technology appraisal guidance 97 (2006). Available from www.nice.org.uk/guidance/TA97
- Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. NICE clinical guideline 31 (2005). Available from www.nice.org.uk/guidance/CG31
- Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26 (2005). Available from www.nice.org.uk/guidance/CG26

Under development

NICE is developing the following guidance (details available from www.nice.org.uk):

Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline. Publication expected January 2011.

Common mental health disorders: identification and pathways to care. NICE clinical guideline. Publication expected Summer 2011.

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations. Please see our website for information about updating the guideline.

Appendix A: The Guideline Development Groups and NICE project team

2011 Guideline Development Group

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Anthea Sutton (in attendance)

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Nancy Turnbull (in attendance)

Chief Executive, National Collaborating Centre for Primary Care

Dr Allan Wailoo

Health Economist, Sheffield Health Economics Group, SchARR, University of Sheffield (until January 2004)

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Appendix B: The Guideline Review Panels

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring adherence to NICE guideline development processes. In particular, the panel ensures that stakeholder comments have been adequately considered and responded to. The panel includes members from the following perspectives: primary care, secondary care, lay, public health and industry.

2011 Guideline Review Panel

[NICE to add]

[Name; style = Unnumbered bold heading]

[job title and location; style = NICE normal]

2004 Guideline Review Panel

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Dr Kevork Hopayian

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Mr Barry Stables

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Dr Robert Walker

Clinical Director, West Cumbria Primary Care Trust

Guideline Review Panel, 2007 amendments to the guideline

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Dr Graham Archard

General Practitioner, Dorset

Mr Barry Stables

Lay Representative

Appendix C: Assessing generalised anxiety disorder

As set out in the introduction to this guideline, the assessment of GAD is based on the criteria in DSM –IV. Assessment should include the number and severity of symptoms, duration of the current episode and course of the disorder.

Key symptoms of GAD

The key symptoms of GAD are:

- excessive anxiety and worry about a number of events or activities
- difficulty controlling the worry.

The worry should occur on a majority of days for at least 6 months. The focus of the worry should not be confined to features of another anxiety disorder (for example, not just about having a panic attack, social embarrassment, a traumatic event, being contaminated or having a serious illness).

If the two key symptoms are present, ask about the following associated symptoms:

- restlessness
- being easily fatigued
- difficulty concentrating
- irritability
- muscle tension
- disturbed sleep.

Then ask about duration, distress, impairment of functioning and past history of anxiety and mood disorders.

Factors that favour initial education about GAD and active monitoring only (step 1) are:

- few symptoms of GAD or symptoms that are intermittent or of less than 6 months' duration (hence subclinical)
- only mild distress and no or limited functional impairment
- no comorbid anxiety or mood disorder
- no past history of anxiety or mood disorders
- individual not interested in any active treatment option.

Factors that favour initial active treatment with low-intensity psychological interventions, including GP-prescribed pure self-help book (step 2) are:

- diagnostic criteria for GAD met
- clinically significant distress and/or impairment in social, occupational or other important areas of functioning
- comorbid anxiety or mood disorder
- individual wishes to pursue active treatment for GAD.

Factors that favour treatment with a high-intensity psychological intervention or a pharmacological intervention (step 3) are:

- marked functional impairment
- less marked but clinically significant functional impairment or distress and inadequate response to a step 2 intervention
- past history of anxiety or mood disorders.

Factors that favour referral for specialist multiprofessional mental health treatment (step 4) are:

- GAD that is refractory to both CBT and drug treatment
- very severe functional impairment (such as self neglect)
- persistent suicidal thoughts
- multiple psychiatric comorbidities.