NICE National Institute for Health and Care Excellence

2020 surveillance of generalised anxiety disorder and panic disorder in adults (NICE guideline CG113)

Surveillance report

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Surveillance decision

We will not update the guideline on generalised anxiety disorder and panic disorder in adults.

Reasons for the decision

For further details and a summary of all evidence identified in surveillance, see appendix A.

New evidence was assessed as either consistent with existing recommendations, from small trials or was inconclusive.

Among the new evidence identified some studies suggested that internet- delivered cognitive behavioural therapy (CBT) was effective compared to waiting list controls for generalised anxiety disorder (GAD) and panic disorder. Evidence also suggested that digital therapies incorporating some type of therapist contact may be more effective than those that do not. The guideline recommendations 1.2.11 and 1.4.10 support both unguided and guided approaches to low intensity therapies and overall we did not find enough consistent evidence to recommend one approach over the other.

Topic experts informed us that there was new evidence for the effectiveness of transdiagnostic therapies and we identified evidence that suggested some advantage for transdiagnostic therapy in the short term but that outcomes were the same as those for disorder specific therapies after 6 months. The evidence was judged as insufficient to make specific recommendations for one approach over the other. We also found a small amount of evidence that appeared to suggest that CBT was less effective in older people than people of working age. It is possible that this conclusion was as a result of different CBT techniques being compared and we concluded further research is required before an assessment of impact can be made. During consultation a stakeholder agreed that further research is needed in this area.

A stakeholder commented that they thought recommendation 1.2.16 which advises that there is no evidence for superiority of either pharmacological or psychological therapies was misleading. They highlighted evidence that suggests larger effects sizes for pharmacological therapies compared with psychological therapies. They also highlighted

evidence that suggests comparing the effects of these therapies is difficult because the effects size for each is frequently measured relative to different comparators. Because of the difficulties highlighted, as well as issues of side effects associated with drug therapies, it is difficult to assess head-to-head superiority. Overall the evidence reports effects for both pharmacological and psychological therapies, and concludes treatment choice should consider patient preference. Recommendation 1.2.16 aims to communicate this and is judged to still be valid.

Topic experts highlighted that the cost-effectiveness of sertraline, which is recommended as a first choice SSRI for GAD, may have been impacted by the availability of escitalopram as a generic. A stakeholder disagreed with the decision to not update saying that the original economic study including sertraline and escitalopram was dated and that there are no placebo-controlled trials investigating relapse prevention in sertraline. A large network meta-analysis highlighted by topic experts in addition to other new evidence for pharmacological interventions indicates that escitalopram and other SSRIs and SNRIs are reasonably well-tolerated and effective. Although escitalopram is available as a generic sertraline remains the cheaper drug by unit cost and evidence suggests it is as effective as escitalopram. For these reasons, recommendation 1.2.22 is judged to still be valid.

A stakeholder highlighted that there was new evidence for the effectiveness of benzodiazepines for panic disorder and that recommendation 1.4.21 needed revising. The evidence was seen during surveillance and it was judged to support the recommendation. Whilst it is acknowledged that benzodiazepines can be effective for panic disorder in the short term, the long-term use of these medicines is associated with dependence. The recommendation was assessed as still being valid.

For further details and a summary of all evidence identified in surveillance, see appendix A.

Overview of 2020 surveillance methods

NICE's surveillance team checked whether recommendations in generalised anxiety disorder and panic disorder (NICE guideline CG113) remain up to date.

The surveillance process consisted of:

- Feedback from topic experts via a questionnaire.
- A search for new or updated Cochrane reviews.
- Consideration of evidence from previous surveillance.
- Examining related NICE guidance and quality standards and NIHR signals.
- A search for ongoing research.
- Examining the NICE event tracker for relevant ongoing and published events.
- Literature searches to identify relevant evidence.
- Assessing the new evidence against current recommendations to determine whether or not to update sections of the guideline, or the whole guideline.
- Consulting on the proposal not to update with stakeholders.
- Considering comments received during consultation and making any necessary changes to the proposal.

For further details about the process and the possible update decisions that are available, see ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual.

Evidence considered in surveillance

Search and selection strategy

We searched for new evidence related to the whole guideline.

We found 85 studies in a search for randomised controlled trials and systematic reviews published between 16 January 2015 and 30 September 2019. Topic experts also provided references to studies. All topic expert highlighted studies were identified by the search for randomised controlled trials and systematic reviews.

See appendix A for details of all evidence considered, and references.

Selecting relevant studies

Studies were included if they were interventional and included adults 18 years or older with generalised anxiety disorder (GAD) or panic disorder. Studies that included participants with different disorders (for example, GAD and social anxiety disorder) were included if the study stated the proportion of included participants with GAD or panic disorder in the abstract and there was no other evidence available for the intervention being investigated.

Ongoing research

We checked for relevant ongoing research; of the ongoing studies identified, none were assessed as having the potential to change recommendations.

Intelligence gathered during surveillance

Views of topic experts

We considered the views of topic experts who were recruited to the NICE Centre for Guidelines Expert Advisers Panel to represent their specialty. For this surveillance review, topic experts completed a questionnaire about developments in evidence, policy and services related to the guidelines.

We received responses from 6 topic experts.

The topic experts comprised health and social care practitioners including GPs, a nurse consultant and psychologists with expertise in the following areas: psychological therapies; physical health problems and anxiety; clinical psychology; psychopathology; translational psychology; anxiety disorders; and primary care.

Psychological therapies

Experts commented that there was new evidence for the effects of transdiagnostic approaches to psychological therapies. This evidence is summarised in appendix A and was assessed as being inconclusive.

An expert highlighted the debate around whether low intensity psychological interventions should be facilitated or non-facilitated. Evidence was identified on this topic but was insufficient to recommend one mode of delivery over another.

Pharmacological therapies

Several experts commented that the SSRI escitalopram was now widely available as a cheaper generic and this may impact the original guideline cost-effectiveness assessment of sertraline. New evidence suggests sertraline is as effective as escitalopram and remains cheaper despite escitalopram's price reduction.

Cross-referral to other NICE guidance

An expert suggested that the guideline would benefit from a more visible cross-referral to anxiety identification and assessment recommendations contained in the NICE guideline on common mental health problems (CG123). Editorial amendments will be made to cross refer from the guideline's section on GAD identification to the common mental health problems guideline.

Physical comorbidities

An expert commented that the guideline would benefit from recommendations covering people with GAD and panic disorder arising from chronic obstructive pulmonary disease (COPD). The surveillance concluded that this issue was adequately addressed by existing guidance about COPD from NICE and other organisations. For example, the NICE guideline on chronic obstructive pulmonary disease in over 16s: diagnosis and management (NG115) includes a section about identifying and managing anxiety and depression which cross-refers to CG113.

Implementation of the guideline

One expert commented that there was a relative lack of expertise to train therapists in the

latest psychological interventions. No evidence was identified to support this comment.

Other sources of information

We considered all other correspondence received since the guideline was published. We considered a correspondence with NICE about using genotype testing to identify people who may have an adverse response to psychotropic medications. We concluded that this was an emerging area of practice and further research was required before an impact assessment could be made.

Views of stakeholders

Stakeholders are consulted on all surveillance reviews except if the whole guideline will be updated and replaced. Because this surveillance proposal was to not update the guideline, we consulted with stakeholders. See ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual for more details on our consultation processes.

Overall, 4 stakeholders commented, 2 agreed with the decision to not update and 2 disagreed. We received comments from the British Association of Behavioural and Cognitive Psychotherapies, the British Association of Psychopharmacology, Anxiety UK and a topic expert with expertise in cognitive behavioural therapy (CBT).

These comments are addressed in detail in appendix B. Stakeholders who disagreed with the decision raised the following issues:

Choice of treatment

A stakeholder commented that recommendation 1.2.16 to base treatment choice on the person's preference as there is no evidence that a psychological or drug intervention is better is misleading as it suggests robust evidence from direct comparisons is available. A comment was made that it was unclear if 'informed consent' in recommendation 1.2.22 refers solely to sertraline or all pharmacological treatments. A further comment was made that the wording of recommendation 1.2.41 is insufficiently nuanced as there is evidence for the effectiveness of combination treatments for treating GAD.

Pharmacological interventions

Stakeholders provided references for evidence around the effectiveness of benzodiazepines for treating panic disorder and for increased panic disorder relapse risk associated with pharmacological intervention discontinuation which was identified and considered during surveillance (see appendix A) and was judged to support existing recommendations.

A stakeholder highlighted that a cheaper generic version of the SSRI escitalopram is available and may impact NICE's cost-effectiveness assessment of sertraline. Evidence considered during surveillance indicates sertraline is effective and tolerated and sertraline's unit cost remains lower than escitalopram's despite the latter's price reduction. For these reasons recommendation 1.2.22 was assessed as valid.

The effectiveness of sertraline and its continuing low cost relative to escitalopram were considered during this surveillance (see appendix A) and were judged to support recommendation 1.2.22.

A stakeholder expressed concern that the MHRA drug safety update for pregabalin was not visible enough in the guideline. We plan to make this more visible by incorporating the link into the recommendation.

Psychological interventions

A stakeholder commented that recommendations for psychological treatments did not explicitly mention the potential adverse effects. However, the recommendations already advise a discussion between the patient and treating practitioner of the advantages and disadvantages of all treatments, including potential adverse effects.

Relationships with other guidelines

A stakeholder noted discrepancies between the antidepressant withdrawal and discontinuation recommendations in the guideline and those in depression in adults (CG90). A separate project is currently identifying and updating these discrepancies across all NICE guidelines including CG113.

Diagnostic issues

One stakeholder highlighted updates to the Diagnostic and Statistical Manual of Mental Disorders (DSM) and one that the guideline should emphasise that using DSM for GAD diagnosis is more appropriate than using International Classification of Diseases (ICD). Changes to DSM were assessed as minimal with no impact on recommendations. It is acknowledged that many trials used to develop the guideline use DSM criteria, but the recommendations are assessed as being valid to ICD-diagnosed GAD. These issues are addressed fully in appendix A.

Service issues

One stakeholder observed that people with severe GAD and panic disorder experience disproportionate barriers in care related to the introduction of the Improving Access to Psychological Therapies (IAPT) programme. The stakeholder commented that this results from pharmacotherapy expertise not being embedded in IAPT which leads to people with severe or difficult to treat GAD and panic disorder who would have previously been referred to secondary mental health services, dropping out of treatment. We will pass these comments on to colleagues working for the NHS England IAPT programme.

Equalities

One topic expert commented that older people and people from black and minority ethnic groups found IAPT services unacceptable or difficult to access. A stakeholder commented that current treatment options tend to appeal to certain sections of society more than others and that talking therapy treatments are accessed more by women. Another commented that current treatment options tend to appeal to certain sections of society more than others and that talking therapy treatments are accessed more by women. During surveillance we found a small amount of evidence that CBT produces smaller effects sizes in older people compared with those of working age, but there was uncertainty about whether this could be attributed directly to age differences. A note will be added to CG113's issue log to highlight this as an issue to be aware of at the next surveillance timepoint.

Overall decision

After considering all evidence and other intelligence and the impact on current recommendations, we decided that no update is necessary.

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