# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

# HEALTH AND SOCIAL CARE DIRECTORATE

# QUALITY STANDARD CONSULTATION

# SUMMARY REPORT

## 1 Quality standard title

Anxiety Disorders

Date of Quality Standards Advisory Committee post-consultation meeting:
5 November 2013

## 2 Introduction

The draft quality standard for Anxiety Disorders was made available on the NICE website for a 4-week public consultation period between 27th August and 24th September. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 7 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the

process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include overarching outcomes, thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

# 3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

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

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

# 4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Overall support for the development of the quality standard on anxiety disorders.
- The quality standard in places lacks holistic approach by not mentioning the potential benefits of peer support, self-help books and exercise.
- Suggestion of expansion of definition to include selective mutism.

**Consultation comments on data collection**

- Data collection issues included reliance on General Practitioner systems and how GPs would be incentivised to collect data.

# 5 Summary of consultation feedback by draft statement

## *5.1 Draft statement 1*

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

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 1:

- Significant measurement issues were noted in terms of breadth of population and accurately defining a known denominator.
- The validity of assessment tool GAD2 was questioned, with a recommendation to either amend the tool or use GAD7 as an alternative.
- Equality and diversity issues were mentioned in how health care professionals communicate with patients with social anxiety disorder.

## *5.2 Draft statement 2*

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

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 2:

- The holistic nature of the assessment within this quality statement was supported.
- It was suggested that some people who present with certain physical symptoms may be considered to have a diagnosis of anxiety and as a result require assessment.
- Equality and diversity issues were raised for those with learning difficulties as it may be difficult to diagnose the specific anxiety disorder patients may have, due to communication difficulties associated with learning difficulties.

## *5.3 Draft statement 3*

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

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 3:

- Support was given to the supporting definitions which reinforce need to offer treatments in settings where children and young people with an anxiety disorder feel most comfortable.
- Concern noted that implementation of statement may lead to increased referrals for psychological interventions with consequence of making consultations shorter and at an increased frequency.

## *5.4 Draft statement 4*

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

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 4:

- Reducing routine offer of some pharmacological treatment seen as priority area.
- Role of choice and individualised information highlighted.
- Suggestion to expand measures to include timing of review of drug treatment for generalised anxiety disorder in line with NICE clinical guideline 113 (within 3 months of treatment and then every 3 months thereafter).
- Need to clarify that statement equally applies to all people regardless of disability.
- A clinical assessment to be considered alongside prescription to assess the side effects and response of pharmacological treatment.

### *5.5 Draft statement 5*

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

**Consultation comments**

Stakeholders made the following comments in relation to draft statement 5:

- Support for this statement - noted that people with GAD may not be properly followed-up during their care pathway.
- While this is routinely recorded by IAPT services, it was highlighted that additional steps will need to be taken by other providers to ensure outcome measurement.
- Additional tools suggested (Beck Anxiety Inventory, Clinical Global Impressions and Hospital Anxiety and Depressions Scale (HADS)

## 6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- An additional statement that ensures patient choice is offered in relation to pharmacological treatment to improve adherence and overall outcomes.

- An additional statement to ensure that pharmacological treatments are never to be used as a stand-alone treatment for children and young people with anxiety disorders.

# Appendix 1: Quality standard consultation comments table

| ID | Stakeholder | Statement No | Comments<br>Please insert each new comment in a new row. |
|---|---|---|---|
| 1 | College of Mental Health Pharmacy | General | The Colleges Supports the Standards Document and would wish to become a publication partner to the Standards |
| 2 | Pfizer | General | Pfizer would like to thank NICE for the opportunity to respond to the draft Quality Standard (QS) for Anxiety Disorder (ADs) and we very much support its development. We welcome the focus of the QS on the identification, assessment and management of ADs and believe that the QS presents an important opportunity to improve identification and the appropriate and timely management of patients with these conditions. |
| 3 | Royal College of Paediatrics and Child Health | General | In the opening general discussion on anxiety disorders it should also be mentioned that these are more common amongst those with intellectual disabilities.<br><br>Evidence:<br>J Intellect Disabil Res. 2011 Feb;55(2):172-81. doi: 10.1111/j.1365-2788.2010.01360.x. Epub 2011 Jan 4. Prevalence and associations of anxiety disorders in adults with intellectual disabilities.<br>Reid KA, Smiley E, Cooper SA.<br><br>This is but one of many studies showing an increased prevalence of anxiety disorders amongst those with intellectual disabilities; for example, there are numerous studies and standard textbook accounts of the increased risk of obsessional disorders and anxiety in people with autism. |
| 4 | SMIRA (Selective Mutism Information and Research Association) | General | NICE Clinical Guideline 159 (Social Anxiety Disorder) Section 1.1.10 identifies 'children with a potential diagnosis of Selective Mutism', and Section 1.4.12, about the 'Assessment of Children and Young People with possible Social Anxiety Disorder', includes Selective Mutism as an example of an 'associated difficulty' alongside SAD. However, Selective Mutism is not mentioned at all in the Draft Anxiety Disorders Quality Standard.<br><br>This anomaly ought to be corrected, considering that the American Psychiatric Association re-categorised Selective Mutism as an Anxiety Disorder in DSM-5, published in May 2013, and the World Health Organisation is also proposing to re-classify Selective Mutism under 'Fear and Anxiety Related Disorders' in ICD-11.<br><br>In the absence of a specific NICE Guideline on Selective Mutism, it should be included in the proposed new Anxiety Disorders Quality Standard. |
| 5 | SMIRA (Selective Mutism Information and Research | General | We recommend that selective mutism be added to the list in the second paragraph. |

| ID | Stakeholder | Statement No | Comments<br>Please insert each new comment in a new row. |
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| | Association) | | The prevalence of selective mutism at primary school has been reported as 0.7 – 2% (Bergman et al, 2002; Elizur and Perednik, 2003; Kumpulainen et al, 1998), but many researchers feel this is an under-estimate due to lack of knowledge of the disorder (Cunningham et al, 2006; Schwartz et al., 2006; Sharkey et al, 2007; Lescano, 2008).<br>We believe the definition of social anxiety disorder could be misleading. To avoid confusion with selective mutism, the description of social anxiety disorder should include the core diagnostic criterion set out in DSM 5 (2013), i.e. that the individual fears negative evaluation, rejection, humiliation or embarrassment. We suggest:<br><br>'Social anxiety disorder (previously known as 'social phobia'), is persistent fear of or anxiety about negative evaluation, rejection, humiliation or embarrassment in one or more social situations that involve interaction, observation and performance. The fear or anxiety is out of proportion to the actual threat posed by the social situation.'<br><br>A description of selective mutism could be inserted between paragraph 1 and paragraph 2, e.g.<br><br>'Selective mutism is characterised by a consistent pattern of failure to speak in certain social situations, despite being able to speak freely in other situations (e.g. to family members when no-one else is listening). The failure to speak is often associated with high anxiety, but children may be willing or eager to engage in social encounters when speech is not required (DSM 5, 2013).'<br><br>We agree with paragraph 2. Selective mutism has a particularly early age of onset, typically before 5 years of age (Cline and Baldwin, 2004; McHolm et al, 2005; Bögels et al, 2010). |
| 6 | Anxiety UK | Question 1 | 1.We welcome all statements and feel that these actions when implemented will give potentially rise to an improvement in the detection, diagnosis and subsequent treatment of those affected by anxiety disorders. Clearly training will be critical in ensuring that there is accurate detection and diagnosis at primary care level. We feel it is important that such training incorporates the user experience and to make use of modern technologies such as apps to make the process more user-friendly, quick and accessible.<br><br>2.Whilst we support the above, we are concerned that the standard does not mention the role of peer support, self help (books on prescription which has an evidence base) and exercise – we feel this is a missed opportunity since there is now so much focus on the recovery movement and in general, taking a wider, more holistic approach to the treatment of common mental health difficulties. NHS commissioned providers are now routinely asked to report on 'recovery outcomes' therefore this needs to be weaved into the standard.<br><br>3. There is no mention of the need to regularly review clients in receipt of psychiatric medication for the |

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| | | | treatment of their anxiety condition – we would recommend that this be more clearly stated.<br><br>4. Our overriding feeling is that the Standard is being overly constrained by the existence of current (relevant) NICE guidelines and that as such rather than this being an opportunity to look at the key issues for those with anxiety that need to be addressed e.g. breaking isolation (which can be achieved through accessing peer support initiatives) it is constrained by existing evidence based guidelines which prevents a 'thinking out of the box' approach. In summary, the standard should drive the guidelines not the other way round. |
| 7 | Anxiety UK | Question 2 | 1. We believe that data collection will be problematic since the majority of the work will need to be undertaken by GPs who are already struggling with collecting data. We could only see this system working if there was an incentive scheme inbuilt into the process combined with an accurate way to monitor compliance at GP practice level. Perhaps some of the lessons learnt from the current QOF for depression could be utilised when implementing the Anxiety Quality Standard. Additionally we are not sure as to how compliance with relevant NICE guidelines in general by GPs and other relevant healthcare professionals will be assessed. Indeed it is unclear how the standard will be audited once implemented.<br><br>2. Whilst the GAD7 is a useful and quick clinical outcome measure used in IAPT services, client progress with many of the anxiety disorders requires tracking through the IAPT Anxiety Disorder Specific Measures (ADSMs) which are not always free to access and which can often take longer to administer than the GAD7 . This will need to be taken into consideration. |
| 8 | Pfizer | Statement 1 | QS1 states that "People who have symptoms of anxiety are asked questions to determine the need for an assessment to diagnose anxiety disorders"<br>GAD is frequently co-morbid with other conditions, in particularly depressive disorders (major depression and dysthymia), other anxiety disorders (panic disorder, social phobia and specific phobias) and somatoform disorders. There is also significant co-morbidity with substance misuse especially among men1.<br>GAD also often co-occurs with physical health problems such as arthritis and gastrointestinal and respiratory disorders and may mimic the presentation of some physical conditions (for example, hyperthyroidism)1<br><br>CG1131 therefore recommends consideration of a diagnosis of GAD not only in people presenting with anxiety or significant worry, but also in people who attend primary care frequently who:<br>• have a chronic physical health problem or<br>• do not have a physical health problem but are seeking reassurance about somatic symptoms (particularly older people and people from minority ethnic groups) or<br>• are repeatedly worrying about a wide range of different issues<br><br>Pfizer would recommend that these specific recommendations are captured in the quality measures for QS1 by |

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| | | | including the following measure in addition to those suggested in the draft QS1:<br><br>• Proportion of people who have a chronic physical health problem, such as depressive disorders, arthritis, gastrointestinal and respiratory disorders symptoms, who are asked about whether they experience any of the symptoms of anxiety |
| 9 | Rotherham, Doncaster and South Humber Healthcare Foundation Trust (RDaSH) | Statement 1 | The use of the GAD2 is a helpful tool to identify those people who may be experiencing symptoms of anxiety and may need further assessment to diagnose an anxiety disorder. However positive answers to the 2 questions, does not necessarily mean the person will want to engage in further assessment or psychological therapy, therefore it would be helpful to ask the third question, (as with the PHQ2), "Do you want help with this" prior to proceeding to the next stage.<br>It may also be difficult to collect the data for this proposed quality measure as the answer to these questions will need to be captured in primary care systems. IAPT services would only be able to capture the data for those people who had been referred on for further assessment. The ability to capture this data could provide real evidence to determining the prevalence of anxiety disorders in local communities. |
| 10 | Royal College of Paediatrics and Child Health | Statement 1 | This statement cannot be measured (without the requirement for considerable resources) and so should be dropped. The denominator is unknown unless a comprehensive survey is undertaken of the entire local population (in every local area), to determine the number of people who have symptoms of anxiety. Such a population-wide survey will require considerable resources in every locality in the country, without which this standard cannot be measured. |
| 11 | Royal College of Psychiatrists | Statement 1 | With regard to screening it was suggested that the Generalised Anxiety Disorder (GAD) 7 questionnaire be used instead of GAD2.<br><br>This states that people who have symptoms of anxiety are asked questions to determine the need for an assessment to diagnose anxiety disorders. This may not be practically possible when people with severe to profound degrees of intellectual disability and they may not seek help for their symptoms and may not be able to describe the symptomatology that they experience. A more objective method has to be adopted and informant history will be crucial. In relation to primary care these adaptive questions could be included as part of the annual health checks. Also more specialised screening tools would have to be used in this population. |
| 12 | SMIRA (Selective Mutism Information and Research Association) | Statement 1 | Refers to NICE Clinical Guideline 159 (Social Anxiety Disorder) Section 1.4.1, about the types of questions that ought to be asked to determine the need for an assessment. Most of the detail concerns assessment of social anxiety disorder and it will again be very important to differentiate this from selective mutism. Children with SAD fear social situations, because they are self-conscious about being watched and concerned about the reactions of others, which is rarely the case for young children with SM.<br><br>In practice, young children with SM often demonstrate minimal social anxiety when they are allowed to gesture |

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| | | | or write, rather than speak (Yeganeh et al, 2003; Sharkey and McNicholas, 2006; Omdal and Galloway, 2008), indicating that their anxiety is linked specifically to the act of speaking; rather than the wider social context and the effect they are having on other people.<br><br>We therefore recommend an extra paragraph is inserted before Equality and diversity considerations:<br>'If selective mutism is suspected, a simple line of questioning is recommended to establish that a consistent pattern of non-speaking and avoidance exists, which seems to be related to the expectation to speak, rather than a fear of humiliation or embarrassment. ' |
| 13 | SMIRA (Selective Mutism Information and Research Association) | Statement 1 | Children 'with significant language or communication difficulties', as well as adults, should also be given the opportunity to express themselves by using a 'Distress Thermometer' or similar pictorial 'Anxiety Scale Indicator'. Changing the opening phrase from 'For adults' to 'For adults and children' would alert practitioners to that possibility. |
| 14 | SMIRA (Selective Mutism Information and Research Association) | Statement 1 | Refers to NICE Clinical Guideline 159 (Social Anxiety Disorder) Section 1.1.10 point 1, but does not mention the second point made in that section about communicating with reluctant speakers and allowing them to use writing, drawing or speaking through a parent or carer to express their views. This is particularly relevant with the inclusion of selective mutism and could also be added here.<br><br>We suggest:<br>NICE clinical guideline 159 recommendation 1.1.10 states that when communicating with children and young people and their parents or carers the child or young person's developmental level, emotional maturity and cognitive capacity should be taken into account, including any learning disabilities, sight or hearing problems and delays in language development. Alternative forms of communication should be offered, if preferred or required by the child or young person, such as writing, drawing, speaking through their parent or using visual aids. The child or young person should be given time to make their response. |
| 15 | Rotherham, Doncaster and South Humber Healthcare Foundation Trust (RDaSH) | Statement 2 | This quality statement provides clear guidance for undertaking holistic assessments and accurately reflects the key areas for quality improvement. With the correct systems and structures the data for this quality measure could be collected. |
| 16 | Royal College of Psychiatrists | Statement 2 | This states that people with a suspected anxiety disorder receive an assessment to diagnose specific anxiety disorders and the impact of these disorders. DSM and ICD assessment criteria's could be used to diagnose anxiety disorders in people with mild to moderate intellectual disability. It becomes complicated with people with more severe degrees of intellectual disability. The prevalence of these problems is higher than the general population. There is the issue of diagnostic over shadowing - whether symptoms are due to anxiety or attributed to intellectual disability/ASD. There is also the issue of appropriateness of certain fears and anxieties associated with their developmental status. There has to be increased emphasis on 'behaviourally equivalents' in diagnosis. Certain symptomology like depersonalisation and derealisation may not be elicitable in the LD |

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| | | | population. An internal subjective experience can be difficult to perceive by people with intellectual disability. OCD is especially difficult to diagnose because of the difficulty in distinguishing compulsions from stereotypes and tics. There is also the problem of OCD being under diagnosed in people with learning disability and often termed 'autistic traits'. Cognitive thoughts may be different and compulsive behaviour may be different in people with learning disability and may not follow the 3 C's of cleaning, checking, and counting that is normally encountered in the general population. Compulsions could be easy to observe but cognitive aspects like resistance is difficult to elicit with people with LD.<br><br>Diagnostic criteria like DCLD may be more appropriate to be used for the assessment of anxiety disorders in people with LD.<br><br>Another recommendation would be to consider how primary care could look for somatic presentations of anxiety, such as dyspepsia, IBS, or patients who present with multiple health problems who which no underlying physical cause can be attributed. This is often more difficult to spot in primary care, for GPs to assess and for patients to accept as a disease model that there physical symptoms are manifestation of an underlying anxiety disorder (GAD). |
| 17 | SMIRA (Selective Mutism Information and Research Association) | Statement 2 | Selective Mutism could be added to the existing list of Specific Anxiety Disorders covered by the Quality Standard, to ensure its inclusion as a recognised Anxiety Disorder. |
| 18 | Rotherham, Doncaster and South Humber Healthcare Foundation Trust (RDaSH) | Statement 3 | This quality statement provides clear guidance for offering treatment interventions for those experiencing anxiety disorders, which should prove to be helpful to service providers providing a clear base for care pathways to be developed. With the correct systems and structures the data for this quality measure can be collected. |
| 19 | Royal College of Psychiatrists | Statement 3 | People with a diagnosed anxiety disorder who meet criteria for psychologically interventions are offered evidence-based psychological interventions. Psychological interventions will have to be adapted and sessions made shorter and increased frequency of sessions are recommended. |
| 20 | SMIRA (Selective Mutism Information and Research Association) | Statement 3 | This states that consideration should be given to involving parents or carers in the treatment of children and young people with social anxiety disorder. The NICE Guideline for Social Anxiety Disorder (full version) states that 'What all of these treatments have in common is a substantial (or exclusive) component focused on helping parents or carers to develop skills to help encourage their child to overcome their fears'.<br><br>Parental and carer involvement should therefore be much more than a 'consideration'. |
| 21 | SMIRA (Selective Mutism Information and Research Association) | Statement 3 | It is important to add treatment guidelines for selective mutism and emphasise how these differ from treating social anxiety disorder. It is not possible to refer to existing NICE recommendations for selective mutism, as no guidelines on SM have previously been published. However, the NICE Clinical Guideline 159 Section 1.5.1 |

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| | | | recommends that psychological interventions for social anxiety disorder 'should be based on the relevant treatment manual(s) which should guide the structure and duration of the intervention', and this also applies to the treatment of selective mutism.<br><br>We therefore suggest the insertion of a new paragraph on page 21, before post-traumatic stress disorder, i.e.:<br><br>'Treatment for children and young people with selective mutism should be based on the relevant treatment manual(s) which should guide the structure and duration of the intervention. It will be essential to involve parents and school staff to ensure consistent and appropriate support.'<br><br>Rationale for the above paragraph:<br><br>Based on the outcome of single-case experimental studies, behavioural interventions in the form of contingency management, shaping, stimulus fading and systematic desensitization, appear efficacious for treating selective mutism (Stone et al, 2002; Cline and Baldwin, 2004; Cohan et al, 2006; Bögels et al, 2010; Roe V, 2011).<br><br>Treatment manuals written by experienced clinicians with large caseloads of children with SM, employ the same behavioural methods and recommend programmes of parent/staff education to ensure the SM is not maintained through the reactions of others, combined with graded exposure to the source of the child's fear (allowing others to hear their voice) in small manageable steps (Johnson and Wintgens, 2001; McHolm et al, 2005; Kearney, 2010; Perednick, 2011; Johnson, 2013). In contrast with the NICE guideline recommendations for social anxiety disorder, these behavioural programmes almost invariably necessitate working with children on an individual basis initially, and children are systematically helped to work towards talking in groups. Starting with group work would have a negative effect on young children with SM. The efficacy of cognitive interventions for SM is less clear, particularly for young children (Stone et al, 2002; Cline and Baldwin, 2004; Cohan et al, 2006). |
| 22 | SMIRA (Selective Mutism Information and Research Association) | Statement 3 | We endorse the recommendation to provide treatment in settings where children, young people and their parents or carers feel most comfortable, particularly in the home, which is the setting in which most of those affected by selective mutism are usually able to speak. |
| 23 | College of Mental Health Pharmacy | Statement 4 | The College supports the standards in this section. In addition the College believes that it would be beneficial in addition to the general statements about compliance with NICE guidance, a Standard on directly involving the patient in the choice of pharmacological intervention, the provision of individualised information on the pharmacological interventions, including a discussion of the relative side effects of each treatment was included. There is evidence that involving the patient in the treatment choices improves adherence and overall outcomes. |

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| 24 | Pfizer | Statement 4 | QS4 states that “People with an anxiety disorder who are prescribed pharmacological treatment receive this in accordance with NICE guidance.”<br><br>The measure for QS4 is “Rates of prescribing of non-NICE recommended drugs for anxiety disorders”<br><br>Pfizer would suggest that in addition to measuring the rates of prescribing non-NICE recommended drugs for anxiety disorders, that the QS4 specify the timing of reviews of drugs for efficacy and side effects, in line with CG113. Pfizer would recommend the following measure in addition to that specified in the draft QS:<br><br>• Proportion of patients receiving a pharmacotherapy for the management of GAD that are reviewed every 2-4 weeks during the first three months of treatment.<br><br>• Proportion of patients receiving a pharmacotherapy for the management of GAD that are reviewed every 3 months following an initial 12 weeks of pharmacotherapy |
| 25 | Rotherham, Doncaster and South Humber Healthcare Foundation Trust (RDaSH) | Statement 4 | The data collection for this quality statement may be more challenging to collect and monitor as the majority of prescribing will take place in Primary Care. There will need to be greater liaison between services to ensure people are offered psychological interventions as well as or instead of pharmacological treatment interventions. |
| 26 | Royal College of Psychiatrists | Statement 4 | People with an anxiety disorder who are prescribed pharmacological treatment received this in accordance with NICE guidelines. This is applicable to people with all degrees of intellectual disability. However, prescription should be accompanied by an assessment of clinical response and the increased susceptibility the side effects have to be taken into consideration. |
| 27 | SMIRA (Selective Mutism Information and Research Association) | Statement 4 | We endorse the recommendation not to routinely offer pharmacological treatments to children and young people with Anxiety Disorders.<br><br>In accordance with the NICE Guidelines for Social Anxiety Disorder (full version) we recommend the addition of the following statement:<br>‘Pharmacological treatments should never be used as a stand-alone measure for treating children and young people with Anxiety Disorders.’ |
| 28 | Pfizer | Statement 5 | QS 5 states that “People receiving treatment for an anxiety disorder have their treatment-related outcomes recorded at each appointment.”<br><br>The measure for this QS is “Proportion of people receiving treatment for an anxiety disorder who have their health outcomes recorded at initial contact and each subsequent appointment”<br><br>It is important to incentivise the regular review of anxiety symptoms following all types of intervention at all |

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| | | | stages of the pathway and to ensure that patients are not lost to follow-up at various points in the treatment pathway<br><br>For example it is estimated that around 40% of patients do not complete their IAPT course, and around 55% of patients do not achieve a 'recovery' from the course (IAPT 3-year Report) 2. There does not appear to be any requirement to follow-up these patients in the key performance indicators associated with IAPT and it is not clear whose responsibility this is.<br><br>As such, Pfizer would recommend the following rewording of QS5 to<br><br>"People receiving treatment for an anxiety disorder have their treatment-related outcomes recorded at each appointment and are progressed through the stepped care model in accordance with NICE guidance"<br><br>Pfizer would also recommend that the proportion of patients who have not responded to "a step" in the "stepped care pathway" are measured, as are the proportion of patients who are progressed by their healthcare provider to the next step in the pathway.<br><br>For example in line with CG113 the following measures are recommended for the management of GAD<br><br>• Proportion of patients diagnosed with GAD that has not improved after education and active monitoring in primary care, that are progressed to "step 2"; low-intensity psychological interventions: individual non-facilitated self-help, individual guided self-help and psycho-educational groups<br><br>• Proportion of GAD patients with an inadequate response to step 2 interventions or marked functional impairment who are progressed to "step 3"; choice of a high-intensity psychological intervention (CBT/applied relaxation) or a drug treatment<br><br>• Proportion of GAD patients with an inadequate response to step 3 or complex treatment-refractory GAD and very marked functional impairment, such as self-neglect or a high risk of self-harm who receive highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day9hospitals or inpatient care |
| 29 | Rotherham, Doncaster and South Humber Healthcare Foundation Trust (RDaSH) | Statement 5 | The data for this quality measure should be easily collected as the use of routine outcome measures at each appointment is routine practice within IAPT services. Other providers will need to ensure they are able to comply to this standard. |
| 30 | Royal College of Psychiatrists | Statement 5 | With regard to outcome measures, aside from IAPT outcome measures, other suggestions could include the |

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| | | | Beck Anxiety Inventory, Clinical Global Impressions (CGI), and Hospital Anxiety and Depressions Scale (HADS) as routine outcome measures.<br>People receiving treatment for anxiety disorder have the treatment related outcomes recorded at each appointment. Normal outcome measures which are anxiety disorder rating skills used for the general population may not be applicable but there are certain tools like the CGI and the PASS-ADD which can be used in people with intellectual disability. |
| 31 | SMIRA (Selective Mutism Information and Research Association) | Statement 5 | We endorse the recommendation for the use of monitoring and evaluation tools in the treatment of Anxiety Disorders. With specific reference to Selective Mutism, we suggest the inclusion of existing manuals containing such forms (Johnson and Wintgens, 2001; McHolm et al, 2005; Kearney, 2010; Perednick, 2011) and the 'Selective Mutism Questionnaire' (Bergman et al, 2008), which is a well-researched and valuable tool. |

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**Pfizer**

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