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NICE guideline

Generalised anxiety disorder and panic disorder in adults: management

Clinical guideline

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Contents

This guideline replaces CG22.

This guideline is the basis of QS23 and QS53.

Introduction

This guidance updates and replaces NICE clinical guideline 22 (published December 2004; amended April 2007).

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. 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. 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 conditions[1].

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 from a list of six[2]. 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.

According to the DSM-IV-TR[3], 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 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.

GAD and panic disorder vary in severity and complexity and this has implications for response to treatment. Therefore it is important to consider symptom severity, duration, degree of distress,

functional impairment, personal history and 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) to inform their decisions made with individual service users.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), this is indicated in the recommendation or in a footnote.

New and updated recommendations are included on the management of generalised anxiety disorder in adults.

Recommendations are marked **[2004]**, **[2004, amended 2011]** or **[new 2011]**.

[2004] indicates that the evidence has not been updated and reviewed since 2004.

[2004, amended 2011] indicates that the evidence has not been updated and reviewed since 2004 but a small amendment has been made to the recommendation.

[new 2011] indicates that the evidence has been reviewed and the recommendation has been updated or added.

[1] Common mental health disorders. NICE clinical guideline 123. May 2011.

[2] American Psychiatric Association (1994) Diagnostic and statistical manual of mental disorders (fourth edition). Washington DC: American Psychiatric Association. This guideline uses DSM-IV criteria because the evidence for treatments is largely based on this system.

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

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, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

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. They have been chosen from the updated recommendations on the management of GAD.

Step 1: All known and suspected presentations of GAD

Identification

- Identify and communicate the diagnosis of GAD as early as possible to help people understand the disorder and start effective treatment promptly. **[new 2011]**
- 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 wide range of different issues. **[new 2011]**

Step 2: Diagnosed GAD that has not improved after step 1 interventions

Low-intensity psychological interventions for GAD

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

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

Treatment options

- For people with GAD and marked functional impairment, or those whose symptoms have not responded adequately to step 2 interventions:
    - Offer 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 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 choice of treatment on the person's preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug treatment) is better. **[new 2011]**

High-intensity psychological interventions

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

Drug treatment

- If a person with GAD chooses drug treatment, offer a selective serotonin reuptake inhibitor (SSRI). Consider offering sertraline first because it is the most cost-effective drug, but note that at the time of publication (January 2011) sertraline did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented. Monitor the person carefully for adverse reactions. **[new 2011]**
- 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 'British national formulary' on the use of a benzodiazepine in this context. **[new 2011]**
- Do not offer an antipsychotic for the treatment of GAD in primary care. **[new 2011]**

Inadequate response to step 3 interventions

- Consider referral to 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 substance misuse, personality disorder or complex physical health problems **or**
- self-neglect **or**
- an inadequate response to step 3 interventions. **[new 2011]**

1 Guidance

The following guidance is based on the best available evidence. The full guideline 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 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 and 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
- if possible, ensure that comprehensive written information is available in the person's preferred language and in audio format
- 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

A stepped-care model (shown below) is used to organise the provision of services and to help people with GAD, their families, carers and practitioners to choose the most effective interventions.

1.2.1 Follow the stepped-care model, offering the least intrusive, most effective intervention first. **[new 2011]**

The stepped-care model

Focus of the intervention	Nature of the intervention
STEP 4: Complex treatment-refractory GAD and very marked functional impairment, such as self-neglect or a high risk of self-harm	Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care

STEP 3: GAD with an inadequate response to step 2 interventions or marked functional impairment	Choice of a high-intensity psychological intervention (CBT/applied relaxation) or a drug treatment
STEP 2: Diagnosed GAD that has not improved after education and active monitoring in primary care	Low-intensity psychological interventions: individual non-facilitated self-help*, individual guided self-help and psychoeducational groups
STEP 1: All known and suspected presentations of GAD	Identification and assessment; education about GAD and treatment options; active monitoring

* A self-administered intervention intended to treat GAD involving written or electronic self-help materials (usually a book or workbook). It is similar to individual guided self-help but usually with minimal therapist contact, for example an occasional short telephone call of no more than 5 minutes.

Step 1: All known and suspected presentations of GAD

Identification

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 wide 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, consider with the person whether some of their symptoms may be due to 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:

- any comorbid depressive disorder or other anxiety disorder
- any 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)[4],[5]. **[new 2011]**

1.2.8 For people with GAD who misuse substances, be aware that:

- substance misuse can be a complication of GAD
- non-harmful substance use should not be a contraindication to the treatment of GAD
- harmful and dependent substance misuse should be treated first as this may lead to significant improvement in the symptoms of GAD[6],[7]. **[new 2011]**

1.2.9 Following assessment and diagnosis of GAD:

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

  This is because education and active 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 medications and preparations with people with GAD. Explain the potential for interactions with other prescribed and over-

the-counter medications and the lack of evidence to support their safe use. **[new 2011]**

Step 2: Diagnosed GAD that has not improved after step 1 interventions

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

1.2.12 Individual non-facilitated 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
- usually 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
- usually 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 observational learning
- include presentations and self-help manuals
- be conducted by trained practitioners
- have a ratio of one therapist to about 12 participants
- usually 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 interventions

Treatment options

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

- Offer 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 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 choice of treatment on the person's preference as there is no evidence that either mode of treatment (individual high-intensity psychological intervention or drug 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
- usually consist of 12–15 weekly sessions (fewer if the person recovers sooner; more if clinically required), 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 trained and competent practitioners
- usually consist of 12–15 weekly sessions (fewer if the person recovers sooner; more if clinically required), 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 if possible and if the person consents
- 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). Consider offering sertraline first because it is the most cost-effective drug, but note that at the time of publication (January 2011) sertraline did not have UK marketing authorisation for this indication. Informed

consent should be obtained and documented. 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:

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

1.2.24 If the person cannot tolerate SSRIs or SNRIs, consider offering pregabalin. **[new 2011]**

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 'British national formulary' 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 activation with SSRIs and SNRIs, with symptoms such as increased anxiety, agitation and problems sleeping

- 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 (for example, NSAIDS or aspirin). Consider prescribing a gastroprotective drug in these circumstances. **[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 under 30 **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 the person's symptoms closely (if the side effects are mild and acceptable to the person) **or**
- reducing the dose of the drug **or**
- stopping the drug and, according to the person's preference, 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). **[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, advise the person to continue 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 intervention, 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 high-intensity psychological intervention in addition to drug treatment. **[new 2011]**

1.2.36 Consider referral to 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 substance 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[8]

Assessment

1.2.37 Offer the person with GAD a specialist 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, including adherence to previously prescribed drug treatments and the fidelity of prior psychological interventions, 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 in collaboration with the person with GAD 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, inform them of relevant clinical research in which they may wish to participate, working within local and national ethical guidelines at all times. **[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 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 this condition. 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, amended 2011]

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]

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.

1.4.6 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. [2004]

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

1.4.7 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]

1.4.8 Sedating antihistamines or antipsychotics should not be prescribed for the treatment of panic disorder. [2004]

1.4.9 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 1.4.12–1.4.18)
- pharmacological therapy (antidepressant medication) (see 1.4.19–1.4.31)
- self-help (see 1.4.32–1.4.34). [2004]

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

1.4.11 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

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

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

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

1.4.15 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]

1.4.16 Briefer CBT should be supplemented with appropriate focused information and tasks. [2004]

1.4.17 Where briefer CBT is used, it should be around 7 hours and designed to integrate with structured self-help materials. [2004]

1.4.18 For a few people, more intensive CBT over a very short period of time might be appropriate. [2004]

Pharmacological interventions – antidepressant medication

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 (TCAs).

1.4.19 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*)[9]
- tolerability
- *the possibility of interactions with concomitant medication (consult appendix 1 of the 'British National Formulary')*[9]
- the preference of the person being treated
- cost, where equal effectiveness is demonstrated. [2004]

1.4.20 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]

1.4.21 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]

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

1.4.23 If an SSRI is not suitable or there is no improvement after a 12-week course and if a further medication is appropriate, imipramine[10] of climpramine[11] may be considered. [2004]

1.4.24 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 6 months after the optimal dose is reached, after which the dose can be tapered. [2004]

1.4.25 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 1.4.9) should be offered. [2004]

1.4.26 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]

1.4.27 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]

1.4.28 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]

1.4.29 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]

1.4.30 Healthcare professionals should inform people that they should seek advice from their medical practitioner if they experience significant discontinuation/withdrawal symptoms. [2004]

1.4.31 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

1.4.32 Bibliotherapy based on CBT principles should be offered. [2004]

1.4.33 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]

1.4.34 The benefits of exercise as part of good general health should be discussed with all people with panic disorder as appropriate. [2004]

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

1.4.35 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]

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

1.4.36 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

1.4.37 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]

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

1.4.39 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]

1.4.40 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

1.4.41 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

1.4.42 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 with respect to all other monitoring required. [2004]

1.4.43 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]

1.4.44 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

1.4.45 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

1.4.46 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]**

[4] For NICE guidance on depression, obsessive–compulsive disorder and post-traumatic stress disorder see section 6 ('Related NICE guidance').

[5] Common mental health disorders. NICE clinical guideline 123. May 2011..

[6] For NICE guidance on drug misuse and alcohol-use disorders see section 6 ('Related NICE guidance').

[7] Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE Clinical guideline 115 (February 2011).

[8] Step 4 normally refers to community mental health teams but may include specialist services and specialist practitioners in primary care.

[9] The text shown in italics in this recommendation was amended in 2007.

[10] At the time of publication (January 2011) imipramine did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

[11] At the time of publication (January 2011) clomipramine did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

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.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to update the recommendations on generalised anxiety disorder in this guideline. The Centre for Mental Health established a Guideline Development Group (see appendix A), which reviewed the recommendations on the management of generalised anxiety disorder. The National Collaborating Centre for Primary Care developed the 2004 recommendations on the management of panic disorder (with or without agoraphobia). Independent Guideline Review Panels oversaw the development of the guideline (see appendix B).

There is more information about how NICE clinical guidelines are developed on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is available.

3 Implementation

NICE has developed tools to help organisations implement this guidance..

4 Research recommendations

The 2011 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 clinical and cost 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 waiting-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 waiting-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 outcomes chosen at 12–16 weeks should include both observer- and participant-rated measures of clinical symptoms and functioning specific to GAD, and of quality of life. An economic analysis should also be carried out alongside the trial. The trial needs to be large enough to determine the presence or absence of clinically important effects and of any differences in costs between the treatment options using a non-inferiority design. Mediators and moderators of response should be investigated. 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.

4.2 The clinical and cost effectiveness of two CBT-based low-intensity interventions (CCBT and guided bibliotherapy) compared with a waiting-list control for the treatment of GAD

In well-defined GAD, what is the clinical and cost effectiveness of two CBT-based low-intensity interventions (CCBT and guided bibliotherapy) compared with a waiting-list control?

This question should be answered using a three-armed randomised controlled design using 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 measures of clinical symptoms and functioning specific to GAD, 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 low-intensity intervention for GAD that does not yet have a substantial evidence base. It is therefore important to establish whether CCBT is an effective and cost-effective treatment that should be provided for GAD, and how it compares with other low-intensity interventions such as guided bibliotherapy. The results of this trial will have important implications for the provision, accessibility and acceptability of psychological treatment in the NHS.

4.3 The effectiveness of physical activity compared with waiting-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 waiting-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 waiting-list control should be 12 weeks. The outcomes chosen

should include both observer- and participant-rated measures of clinical symptoms and functioning specific to GAD, and of quality of life.

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.

4.4 The effectiveness of chamomile and ginkgo biloba in the treatment of GAD

Is chamomile/ginkgo biloba 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 of chamomile (220–1100 mg) or ginkgo biloba (30–500 mg) 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 include both observer- and participant-rated measures of clinical symptoms and functioning specific to GAD, and of side effects. 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 and ginkgo biloba 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 and ginkgo biloba as two of the more effective herbal interventions. Moreover, both these herbal remedies are widely available and relatively inexpensive. Furthermore, at present there is no scientific evidence of side effects or drug–herbal interactions in relation to chamomile or ginkgo biloba. As both these herbal interventions are readily available and have no known side

effects, they 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.

4.5 The clinical and cost 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 non-facilitated self-help). Psychological wellbeing practitioners (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. The outcomes chosen should include both observer- and participant-rated measures of clinical symptoms and functioning specific to GAD, and of quality of life. An economic analysis should also be carried out alongside the trial. The trial needs to be large enough to determine the presence or absence of clinically important effects and of any differences in costs between collaborative care and usual care.

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.

4.6 The clinical and cost effectiveness of two CBT-based low-intensity interventions (CCBT and guided bibliotherapy) compared with a waiting-list control for the treatment of panic disorder

In well-defined panic disorder, what is the clinical and cost effectiveness of two CBT-based low-intensity interventions (CCBT and guided bibliotherapy) compared with a waiting-list control?

This question should be answered using a three-armed randomised controlled design using 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 measures of clinical symptoms and functioning specific to panic disorder, 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 panic disorder. CCBT is a promising low-intensity intervention for panic disorder that does not yet have a substantial evidence base. It is therefore important to establish whether CCBT is an effective and cost-effective treatment that should be provided for panic disorder, and how it compares with other low-intensity interventions such as guided bibliotherapy. The results of this trial will have important implications for the provision, accessibility and acceptability of psychological treatment in the NHS.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care (partial 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.

5.2 Information for the public

NICE has produced information for the public explaining this guideline.

We encourage NHS and voluntary sector organisations to use text from this information in their own materials 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).
- Alcohol-use disorders: preventing the development of hazardous and harmful drinking. NICE public health guidance 24 (2010).
- Depression in adults with a chronic physical health problem: treatment and management. NICE clinical guideline 91 (2009).
- Depression: the treatment and management of depression in adults. NICE clinical guideline 90 (2009).
- Medicines adherence. NICE clinical guideline 76. (2009).
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007).
- Computerised cognitive behaviour therapy for depression and anxiety. NICE technology appraisal guidance 97 (2006).
- Obsessive-compulsive disorder. NICE clinical guideline 31 (2005).
- Post-traumatic stress disorder (PTSD). NICE clinical guideline 26 (2005).
- Self-harm. NICE clinical guideline 16 (2004).
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline 115 (2011).
- Common mental health disorders. NICE clinical guideline 123 (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

Professor John Cape (Guideline Chair)
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Project Manager (until 2010), National Collaborating Centre for Mental Health

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Project Manager (from 2010), National Collaborating Centre for Mental Health

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Guideline Commissioning Manager

Nick Staples
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Nichole Taske
Technical Lead

Stefanie Reken
Health Economist

Judy McBride
Editor

2004 Guideline Development Group

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Karen Beck (in attendance)
PA, Section of Public Health, School of Health and Related Research (ScHARR), University of Sheffield

Paul Dennis
Nurse Practitioner in Mental Health, Meadows Health Centre, Nottingham

Revd John Eatock
Senior Counsellor, Bolton, Salford & Trafford Mental Health Partnership & Lead Advisor, British Association for Counselling and Psychotherapy

Lisa G Esmonde (December 2002–September 2003)
Research Associate, ScHARR, University of Sheffield

Celia Feetam
Clinical Psychiatric Pharmacist, Aston University and Birmingham and Solihull Mental Health Trust

Dr John Hague
General Practitioner and Mental Health Lead, Ipswich Primary Care Trust

Dr Ian Hughes
Consultant Clinical Psychologist, Cardiff & Vale NHS Trust

Julie Kelly
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Dr Nick Kosky
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Geraldine Lear
Community Psychiatric Nurse, Nottinghamshire Healthcare NHS Trust

Aileen McIntosh
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Lilian Owens
Patient Representative, No Panic

Julie Ratcliffe
Health Economist, Sheffield Health Economics Group, ScHARR, University of Sheffield

Professor Paul Salkovskis
Clinical Director of the Centre for Anxiety Disorders and Trauma, South London and Maudsley NHS Trust, and Professor of Clinical Psychology and Applied Science, Institute of Psychiatry, King's College, London

Anthea Sutton (in attendance)
Information Officer, ScHARR, University of Sheffield

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)

Working group, 2007 amendments to the guideline

The working group was set up by the National Collaborating Centre for Mental Health.

Ms Rachel Burbeck
Lead Systematic Reviewer, National Collaborating Centre for Mental Health

Dr Alan Cohen
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Professor Nicol Ferrier
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Dr Catherine Pettinari
Senior Project Manager, National Collaborating Centre for Mental Health

Mr Stephen Pilling
Co-director, National Collaborating Centre for Mental Health

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

Professor Mike Drummond (Chair)
Director, Centre for Health Economics, University of York

Dr Graham Archard
General Practitioner, Dorset

Ms Catherine Arkley
Lay member

Dr David Gillen
Medical Director, Wyeth Pharmaceutical

Dr Ruth Stephenson
Consultant in Anaesthetics and Clinical Ethics Lead, NHS Grampian

2004 Guideline Review Panel

Professor Mike Drummond
Director, Centre for Health Economics, University

Dr Kevork Hopayian
General Practitioner, Leiston

Mr Barry Stables
Patient representative

Dr Imogen Stephens
Joint Director of Public Health, Western Sussex Primary Care Trust

Dr Robert Walker
Clinical Director, West Primary Care Trust

Guideline Review Panel, 2007 amendments to the guideline

Professor Mike Drummond (Chair)
Professor of Health Economics, Centre for Health Economics, University of York

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 monitoringonly (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 non-facilitated self-help (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 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.

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Mental Health and the National Collaborating Centre for Primary Care. The Collaborating Centres worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in The guidelines manual.

This guideline updates and replaces NICE clinical guideline 22 (published published December 2004; amended April 2007).

We have produced information for the public explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also available.

Changes after publication

January 2012: minor maintenance

October 2012: minor maintenance

April 2015: minor maintenance

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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