Management of generalised anxiety disorder in adults: summary of NICE guidance

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This is one of a series of BMJ summaries of new guidelines based on the best available evidence; they highlight important recommendations for clinical practice, especially where uncertainty or controversy exists.

Generalised anxiety disorder affects about 4.4% of the adult population in England.\(^1\) It is characterised by worry and apprehension. Worries are typically widespread, involving everyday issues and a shifting focus of concern; a person with this disorder finds it difficult to control their worries.\(^2\)\(^3\) Like other anxiety disorders, it is often chronic if untreated,\(^2\) and it is associated with substantial disability equivalent to other chronic physical health problems such as arthritis and diabetes.\(^4\)

People with generalised anxiety disorder have high levels of service use (visits to general practitioners and hospital), a consequence of somatic symptoms and worries commonly associated with the disorder and because it commonly coexists with chronic physical health problems.\(^5\)\(^6\)\(^7\)

This article summarises the most recent recommendations from the partially updated guideline from the National Institute for Health and Clinical Excellence (NICE) on generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults.\(^8\) Only recommendations for the management of generalised anxiety disorder have been updated, and these are described here.

Recommendations

NICE recommendations are based on systematic reviews of best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the Guideline Development Group’s experience and opinion of what constitutes good practice. Evidence levels for the recommendations are given in italic in square brackets.

A “stepped care” model is used to organise and integrate the provision of care by general practices and community services and to help in choosing the most effective interventions. With this approach, patients are first offered the least intrusive intervention that might be effective, with a “step up” to more intensive interventions if they do not improve.

Identification, assessment, and initial treatment

- Consider a diagnosis of generalised anxiety disorder in people presenting with anxiety or substantial 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 or are repeatedly worrying about a wide range of different issues. (New recommendation.) [Based on the experience and opinion of the Guideline Development Group (GDG)]

- Conduct a comprehensive assessment that considers the degree of distress and functional impairment; the effect of any comorbid mental health disorder, substance misuse, or medical condition; and past response to treatment. (New recommendation.) [Based on the experience and opinion of the GDG]

- For all known and suspected presentations of this disorder, provide education about it and the treatment options. Monitor the person’s symptoms and functioning. Education and active monitoring may improve less severe presentations and avoid the need for further interventions. (New recommendation.) [Based on the experience and opinion of the GDG]

- For people with a comorbid depressive or other anxiety disorder, treat the primary disorder first (that is, the one

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Further treatment of diagnosed generalised anxiety disorder

If symptoms have not improved after education and active monitoring

- Offer one or more of the following first line, low intensity interventions, guided by the person’s preference (new recommendation):
  - Individual non-facilitated self help (usually involving minimal contact with a healthcare professional)
  - Individual guided self help (supported by a trained practitioner, who facilitates the programme and reviews progress and outcome)
  - Participation in psychoeducational groups (conducted by trained practitioners and based on the principles of cognitive behavioural therapy; groups should have a ratio of one therapist to about 12 participants).
- Individual non-facilitated and guided self help should include printed or electronic materials of a readability level suitable for the individual based on the treatment principles of cognitive behavioural therapy. (New recommendation.)

[All of the above recommendations are based on moderate quality randomised controlled trials]

If functional impairment is marked or symptoms have not improved after low intensity interventions

- Offer a choice of the following:
  - An individual, high intensity psychological intervention (cognitive behavioural therapy or applied relaxation, in which people learn to apply relaxation skills in anxiety provoking situations) (new recommendation) [Based on moderate to high quality randomised controlled trials] or
  - Drug treatment. [Based on high quality randomised controlled trials]
- Select the treatment according to patient preference as no evidence exists that either treatment is better. (New recommendation.) [Based on patients’ experience and on the opinion of the GDG]
- Base cognitive behavioural therapy or applied relaxation on treatment manuals used in the clinical trials. They should be delivered by trained and competent practitioners. (New recommendation.) [Based on moderate to high quality randomised controlled trials]
- If a person chooses drug treatment, offer a selective serotonin reuptake inhibitor. Consider offering sertraline first because it is the most cost effective drug. If sertraline is ineffective, offer an alternative selective serotonin reuptake inhibitor or a serotonin noradrenaline reuptake inhibitor. (New recommendation.) [Based on high quality randomised controlled trials and on the experience and opinion of the GDG]
- If the person cannot tolerate selective serotonin reuptake inhibitors or serotonin noradrenaline reuptake inhibitors, consider offering pregabalin. (New recommendation.) [Based on high quality randomised controlled trials]
- Do not offer a benzodiazepine to treat generalised anxiety disorder in primary or secondary care except as a short term measure during crises. (New recommendation.)
- Do not offer an antipsychotic to treat this disorder in primary care as the evidence for clinical efficacy is poor, while the risk of serious side effects are well known. (New recommendation.) [Based on moderate quality randomised controlled trials and on the experience and opinion of the GDG]
- Before prescribing any medication, discuss the treatment options and any concerns the person has about taking medication. (New recommendation.) [Based on patients’ experience and on the opinion of the GDG]
- Review the effectiveness and side effects of the drug every two to four weeks during the first three months of treatment and every three months thereafter. (New recommendation.) [Based on the experience and opinion of the GDG]
- If the drug is effective advise continuation for at least a year as the likelihood of relapse is high. (New recommendation.) [Based on moderate quality randomised controlled trials and on the experience and opinion of the GDG]

If response to psychological or drug interventions is inadequate

- If the condition has not responded to a full course of a high intensity psychological treatment, offer a drug treatment. (New recommendation.) [Based on the experience and opinion of the GDG]
- If the condition has not responded to a drug treatment, offer either a high intensity psychological intervention or an alternative drug treatment. (New recommendation.) [Based on the patients’ experience of care and on the opinion of the GDG]
- If the condition has partially responded to drug treatment, consider offering a psychological intervention in addition to drug treatment. (New recommendation.) [Based on the experience and opinion of the GDG]

If the disorder is complex and refractory to treatment, if functional impairment is very marked, or if patient has a high risk of self harm

- For those who have not been offered, or have refused, the recommended interventions, inform them about the potential benefits of these interventions and offer them any they have not tried. (New recommendation.) [Based on the experience and opinion of the GDG]
- Consider offering combinations of psychological and drug treatments, combinations of antidepressants, or augmentation of antidepressants with other drugs, but be aware that evidence for the effectiveness of combination
treatments is lacking. Combination treatments should be undertaken only by practitioners with expertise in the psychological and drug treatment of complex anxiety disorders that are refractory to treatment. (New recommendation.) [Based on the experience and opinion of the GDG]

Overcoming barriers

Generalised anxiety disorder is under-recognised. People may present with the physical or somatic symptoms of the disorder or with worries about their health, but these worries may be just one of the many worries that are part of the condition. Therefore it is only after a succession of consultations that it becomes apparent that the person has multiple worries and that reassurance has only a temporary impact. The guideline encourages clinicians to consider the possibility of generalised anxiety disorder in people with or without a chronic physical health problem who present frequently with health concerns and to ask about other worries that would confirm this diagnosis.

Limited availability of cognitive behavioural therapy has been a barrier to effective treatment, and many people do not wish to use medication. Use of low intensity psychological interventions based on cognitive behavioural therapy, as part of a stepped care framework, may increase access to effective psychological interventions.

NICE does not often recommend the use of drugs for conditions for which their use is not licensed (except in the case of children, for whom many drugs are not licensed specifically). In this guideline, sertraline emerged as clearly the most cost effective drug for generalised anxiety disorder compared with other drugs licensed for use in this disorder. Sertraline use in this context is acceptable, but patients should be advised about the evidence for its use and warned that no marketing authorisation (licence) has been issued for the drug’s use in generalised anxiety disorder.

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1. McManus S, Meltzer H, Brugha T, Brereton T, Jenkins R. Adult psychiatric morbidity in England, 2007: results of a household survey. NHS Information Centre for Health and Social Care, 2009. www.ic.nhs.uk/puts/psychiatricmorbidity/07.
2. Tyrer P, Baldwin DS. Generalised anxiety disorder. Lancet 2006;368:2156-66.
3. Bitran S, Barlow DH, Spiegel DA. Generalized anxiety disorder. In: Gelder MG, Andreasen MG, Lopez-Ibor JJ, Geddes JR, eds. New Oxford Textbook of Psychiatry. Oxford University Press, 2009:729-39.
4. Wittchen HU. Generalized anxiety disorder: prevalence, burden and cost to society. Depression and Anxiety 2002;16:162-71.
5. cuffe J. Generalized anxiety disorder and medical illness. J Clin Psychiatry 2009;70(suppl 2):20-4.
6. Roy-Byrne PP, Davidson KW, Kessler RC, Asmundson GJ, Goodwin RD, Kubitz L, et al. Anxiety disorders and comorbid medical illness. General Hospital Psychiatry 2008;30:208-25.
7. Sareen J, Jacoby F, Cox BJ, Belik SL, Clara I, Stein MB. Disability and poor quality of life associated with comorbid anxiety disorders and physical conditions. Arch Intern Med 2006;166:2109-16.
8. National Institute for Health and Clinical Excellence. Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: management in primary, secondary and community care. 2011. (Clinical guideline 113.) http://guidance.nice.org.uk/CG113.
9. Wittchen HU, Kessler RC, Bao IC, Krais K, Hofler M, Hoyer J. Generalized anxiety and depression in primary care: prevalence, recognition, and management. J Clin Psychiatry 2002;63(suppl 8):24-34.
10. Roy-Byrne PP, Wagner A. Primary care perspectives on generalized anxiety disorder. J Clin Psychiatry 2004;65(suppl 13):S20-6.
11. Arroll B, Kendrick T, Anxiety. In: Gask L, Lester H, Kendrick T, Peveler R, eds. Primary care mental health. Bel and Blair, 2009:147-9.
12. Arroll B, Kendrick T. Anxiety disorder. In: Tyrer P, Baldwin DS. Generalised anxiety disorder. Lancet 2006;368:2156-66.
13. Wittchen HU, Kessler RC, Bao IC, Krause K, Hofler M, Hoyer J. Generalized anxiety and depression in primary care: prevalence, recognition, and management. J Clin Psychiatry 2002;63(suppl 8):24-34.
14. Layard R. The case for psychological treatment centres. BMJ 2006;332:1030-2.
15. National Institute for Health and Clinical Excellence. Anxiety: management of anxiety (panic disorder with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. 2004 (amended 2007). (Clinical guideline 22.) http://guidance.nice.org.uk/CG22.
16. National Institute for Health and Clinical Excellence. Depression: the treatment and management of depression in adults (update). 2009. (Clinical guideline 90.) http://guidance.nice.org.uk/CG90.

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Further information on the guidance

What's new

Compared with the previous guideline on generalised anxiety disorder and panic disorder in 2004, the evidence base is larger, and the choice of treatments for low intensity psychological interventions has improved. The evidence supporting selective serotonin reuptake inhibitors for the treatment of generalised anxiety disorder is more focused in this update, and evidence for cost effectiveness of a range of drugs using a network meta-analysis and primary economic modelling is provided. The network meta-analysis is completed for the first time in the treatment of generalised anxiety disorder.

The stepped care model is used to structure and organise treatments, but the number of steps has been reduced to four. Low intensity psychological treatments are offered first, and thereafter treatment options depend on patient preference. The stepped care model places a stronger emphasis on patient preference for the treatment options (both for choosing between low intensity interventions and between psychological or drug treatment). One more treatment option (applied relaxation) has also been included as an alternative to cognitive behavioural therapy.

Non-facilitated self help (sometimes called “pure self help”) is recommended as well as guided self help (where the self help is supported by a trained practitioner). Although non-facilitated self help does not seem to be effective for depression and is not recommended in the NICE guideline on depression, evidence exists for its effectiveness in generalised anxiety disorder, and therefore it is recommended as part of a stepped care approach.

Methodology for this guideline

The new guideline is a partial update of the previous guidance, only updating the evidence for generalised anxiety disorder. This update was developed by the National Collaborating Centre for Mental Health using NICE guideline methodology. A development group of clinicians and patient and carer representatives was convened to oversee the work and develop the recommendations. Comprehensive and systematic searches were conducted to identify relevant evidence, and the quality of the evidence was critically appraised for the clinical and economic literature. The guideline went through an external consultation with stakeholders. The development group assessed the stakeholders’ comments, reanalysed the data where necessary, and modified the guideline. NICE has produced four different versions of each guideline: a full version; a quick reference guide (which combines both guidelines); a version known as the “NICE guideline,” which summarises the recommendations; and a version for patients, carers, and the public. All these versions are available at http://guidance.nice.org.uk/CG113. Further updates of the guideline will be produced as part of the NICE guideline development programme.

Future research

From gaps identified in the evidence, recommendations for further research to improve patient care include:

- A comparison of the clinical and cost effectiveness of sertraline versus cognitive behavioural therapy for generalised anxiety disorder that has not responded to low intensity interventions
- A comparison of the clinical and cost effectiveness of two low intensity interventions based on cognitive behavioural therapy (computerised cognitive behavioural therapy and guided bibliotherapy) versus no treatment (a control group of patients awaiting treatment for generalised anxiety disorder)
- A comparison of the clinical and cost effectiveness of a primary care based collaborative care approach versus usual care
- A comparison of the effectiveness of physical activity versus no treatment (a control group of patients awaiting treatment for generalised anxiety disorder)
- An evaluation of the effectiveness of chamomile and ginkgo biloba.