Generalised Anxiety Disorder (GAD) - Adults (Sheffield)

This protocol has been developed to support the management of patients with 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.

GENERALISED ANXIETY DISORDER

Generalised anxiety disorder (GAD) is defined as at least 6 months of excessive worry about everyday issues that is disproportionate to any inherent risk, causing distress, or impairment in social, occupational, or other important areas of functioning. A formal diagnosis using the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) 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 emotional, somatic, and cognitive symptoms, which are present most of the time:

- restlessness or nervousness
- being easily fatigued
- poor concentration
- irritability
- muscle tension
- sleep disturbance

Other common complaints are autonomic in nature, such as sweating, light-headedness, palpitations, dizziness, and epigastric discomfort.
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 (NICE CG113). Anxiety commonly occurs with other anxiety or depressive disorders; treatment should be tailored to the primary diagnosis.

See links below for pathways of care for other anxiety disorders:

- Panic disorder (with or without agoraphobia)
- Post-traumatic stress disorder
- Obsessive-compulsive disorder
- Social anxiety disorder / phobia (There are no national guidelines around specific phobias, if an intervention is needed consider referral to Sheffield Talking Therapies)
- Depression – (local depression pathway)

For the older adult (>65 years) see the older adult mental Health protocol.
If substance misuse – refer to substance misuse services.

Assessment by GP and supporting information

Assessment by GP

Patient presents with symptoms of anxiety. Consider history of mental health disorders and past response to treatment. Assess for depression and other comorbidities. If significant co-morbidity such as substance misuse, personality disorder or complex physical health problems or evidence of suicide risk, self-harm or self-neglect start at step 4.
Use DSM IV criteria for diagnosis (e.g., GAD7). Assess for:

- Bipolar and psychotic symptoms.
- Alcohol and drug use (opioid and non-opioid)
- Possible physical causes of symptoms, e.g., thyroid disorder, drug side effects, LTC (see health and wellbeing service)
- Eating disorders with SCOFF *screening tool (if applicable)*
- Social factors including abuse and exploitation

Consider screening for GAD in patients who frequently attend primary care who have; chronic physical health problems, those seeking reassurance about somatic symptoms or who are repeatedly worrying about a wide range of issues.
Consider signposting to Sheffield Taking Therapies for Medically Unexplained Symptoms (MUS) / Persistent Physical Symptoms (PPS).
Once diagnosed the primary diagnosis should be treated first, that is the one that is more severe and which treatment will most likely improve functioning.

Self-help and third sector support

See Self help guide (Sheffield Talking Therapies/SHSC)

- Sheffield Mental Health Guide
- Regular exercise (Move more, Sheffield City Trust, better health, healthier families)
- stopping smoking
- Cutting down on alcohol and caffeine
- Relaxation techniques
- Consider support for families and carers
- Social prescribing (SOAR Social prescribing service) and helping people stay at work / return to work – see SOHAS, REMPLOY.
- No Panic
- Sheffield Flourish
- Sheffield Occupational Health Advisory Service

See NHS Choices for patient self-help information / support groups

High risk patients / vulnerable patients

- Suicide risk – Go to step 4
- Communication / access – consider physical and learning disabilities and language barriers / access to services. Consider translators, suitable resources, community support workers.

Consider if the person can give meaningful and informed consent, especially if they have severe anxiety or are under the Mental Health Act. For information about capacity see link to patient resource. Further info can be found here

Generalised anxiety disorder pathway

Step 1 – GAD primary diagnosis

- All patients with GAD should receive information on the diagnosis and active support, psychoeducation (explanation about disease and treatments) and active monitoring/watchful waiting. Refer patient to self-help resources. Consider if any adjustments needed to ensure equal access to services and if patient has physical or learning disabilities.
- Consider using SHARP.
- Treatment goal, where possible should be complete relief of symptoms which is associated with better functioning and a lower likelihood of relapse.

Step 2 – Management of GAD

NICE recommends low intensity psychological interventions with one or more of the following:

- Individualised non-facilitated self-help
- Individual guided self-help
- Psychoeducational groups

Routes into services:

- Book online or phone **0114 226 4380** for direct access to improving wellbeing sessions and Managing stress sessions. Patients can also access SilverCloud (cCBT) through this route.
- Refer to the Psychological Wellbeing Practitioner (PWP) at your practice.

Health and Wellbeing

- If GAD associated with a LTC patients may choose to access targeted group sessions, run by the Talking Therapies service.
- See – Sheffield Mental Health guide and Talking Therapies website for self-help information and resources to support anxiety disorders.

Note – **for patients who do not have marked functional issues it is not normally necessary to start drug treatments at step 2.**

If inadequate response

Step 3 – Management of GAD

Based on NICE guidelines offer a choice of:

- Individual high intensity psychological interventions via Talking Therapies: CBT/applied relaxation (CBT group therapy may also be available for older adults)
  And/ or
- Drug treatment (Consider sertraline first - see below)

Intervention should be patient's choice after considering the likely benefits and disadvantages of each (including time scales).

- If patient has not responded to drug treatment offer either high-intensity psychological intervention or an alternative drug treatment (see below).
- If patient has a partial response to drug treatment, consider offering high-intensity psychological interventions)
- If no response to psychological intervention, offer drug treatment (see below).

If inadequate response

Patients with marked functional impairment.

Access into step 3 for psychological interventions should be via a PWP who can assess and provide initial support and advice.

See NICE/CKS for management of panic, social anxiety disorder, OCD, and PTSD

Step 4 – Refer for assessment and treatment

Start at step 4 if patient is at risk of self-harm or suicide, self-neglect, or has significant co-morbidity such as substance misuse, personality disorder or complex physical health problem (NICE CG113).

Urgent mental health support
Refer to crisis services.

The Single Point of Access is a single point of referral into adult mental health services, 24 hours a day, 7 days a week.
This service is available to people between 18 and 65 years of age.
For urgent referral call: **0114 2263636**
or see here.

Less urgent Mental Health
Community Mental Health Services

Non-urgent referrals and enquiries can be sent to the SPA email address:
SPA_AdultMentalHealth@shsc.nhs.uk

Substance Misuse
(opioid / non-opioid)

Drug treatment for GAD – Consider at step 3

At each stage - Review effect (and side effects) of treatment, every 2-4 weeks during first 3 months of treatment and every 3 months thereafter. If the drug is effective, advise the person to continue medication for at least a year, as likelihood of relapse is high. See Individual SPC or BNF for side effects and interactions.

Before starting an antidepressant, pregabalin or benzodiazepine (short term) see NICE NG215. NICE Visual Summary: what to discuss before starting and reviewing a medicine associated with dependence and withdrawal symptoms. Using shared decision making explain risks and benefits in taking medication, including risk of withdrawal symptoms (and risk of dependence if relevant).

If, after informed discussion**,** drug treatment is the preferred intervention:

Offer a selective serotonin reuptake inhibitor (SSRI):

- **Sertraline** is first-line choice (off-label indication, gain and record informed consent)
- Start at half the normal starting dose for the treatment of depression and titrate upwards into the normal antidepressant dosage range as tolerated.
- Inform the patient that initial symptoms of anxiety can worsen, and it can take 6 weeks to see modest improvement with benefits increasing over time.
- Discuss importance of taking medication as prescribed and need to continue treatment after remission to avoid relapse.

Caution: There is an associated increased risk of suicidal thinking and self-harm in a minority of people under 30 who are on SSRI or SNRI, warn patients of this. **Monitor response, risk of suicidal thinking and self–harm weekly for first month.**
Medication: practitioners should consider potential overdose in patients at increased risk of suicide. Limiting supply quantity might be useful.

If after 2 months (use clinical judgement) sertraline is ineffective,

Consider:

- **Increasing the dose if side effects permit** or
- **Switching to an alternative SSRI** (e.g., citalopram is an option within the Sheffield formulary, but off-label use. Escitalopram is licensed for GAD) or
- **Switching to a serotonin–noradrenaline reuptake inhibitor (SNRI)** - of which duloxetine and venlafaxine modified-release are licensed for GAD (See BNF or CKS contraindications and cautions).

Consider the following factors:

- tendency to produce a withdrawal syndrome (especially with paroxetine and venlafaxine)
- side-effect profile and the potential for drug interactions. Be aware of serotonergic drugs and cocaine interaction with SSRIs. Consider bleeding risk, especially with elderly, and whether gastroprotection is appropriate.
- 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).

Information on switching between antidepressants and tapering:

- Prescribing information within depression section NICE CKS switching antidepressants
- SPS
- RC Psych
- General advice on withdrawing from a DFM – see NICE
- or seek Medicines Optimisation Team for advice.

If a SSRI or SNRI cannot be tolerated

Consider offering pregabalin. Consider risk of abuse and diversion. See BNF for dosing. Reduce dose in renal impairment. See MHRA alerts: risks in pregnancy, reports of severe respiratory depression.

Information on tapering/ withdrawing pregabalin: NICE recommends reducing pregabalin dose by a fixed amount at each decrement, unless clinical risk is such that rapid withdrawal is needed. The manufacturers recommend withdrawal over at least 1 week; but a slower taper, reducing the daily dose by a maximum 50mg-100mg per week allows observation of emergent symptoms that may have been controlled by the drug (link); and will help minimise withdrawal symptoms.

Do not offer a benzodiazepine for the treatment of GAD except as a short-term measure (maximum 2-4 weeks) during crisis or for severe disabling anxiety. Ideally intermittent use for no more than 14 days. See BNF

Information on tapering/withdrawing a benzodiazepine: see BNF and NICE benzodiazepine withdrawal and summary. Benzodiazepine withdrawal should be flexible and carried out at a reduction rate that is tolerable for the patient. If the person is withdrawing from a benzodiazepine with a short half-life, consider switching to a benzodiazepine with a longer half-life.

Beta-blockers: There is limited evidence for the use of beta-blockers in the management of GAD. However, they may be helpful to treat some of the physical symptoms of anxiety, including a rapid heartbeat, palpitations and tremor (shaking).
Do not offer an antipsychotic for the treatment of GAD in primary care.

APPENDIX 1

Two question screening tool (for depression)

During the last month have you often been bothered by feeling down, depressed, or hopeless?
During the last months have you been bothered by having little interest or pleasure in doing things?

Suicide risk

Suicidal Risk Assessment

Check hierarchy of suicidal thought

- Do you feel life is not worth living?
- Have you thought of the possibility that you might take your own life?
- Do you find yourself wishing you were dead and away from it all?
- Does the idea of taking your own life keep coming into your mind?
- Do you have a plan?

Risk factors present:

- Previous attempt
- Past psychiatric history
- Minimal social interaction
- Socially isolated Male

Suicide risk: Based on your clinical assessment and judgement.

SCOFF screening tool

- Physical health problems
- Access to drugs/alcohol

The SCOFF questions

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (14 lb) in a 3-month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

Score one point for every yes answer. Score (sign for greater than or equal to) 2 indicates possible eating disorder. Validated on a GP population showed sensitivity 85% and specificity 90%. (BMJ 2002;325:725)

SHARP

Self-Help Access in Routine Primary care (SHARP) is designed to support primary care practitioners to teach patients to understand and manage mild to moderate anxiety and/or depression symptoms within time limited, routine consultations.

The NICE compliant website of brief self-help materials is based on the Chris Williams Overcoming series. (www.primarycare-selfhelp.co.uk/) The techniques and principles advised by the leaflets are based on Cognitive Behavioural Therapy, they are a maximum of two sides of A4 paper and intended for the clinician to print off and give the patient to take away, read and use between consultations.

Talking Therapies service in Sheffield took part in a series of 'Train the Trainer's' events held by the project and can offer brief workshops with primary care colleagues exploring how patients can benefit from the leaflets in a little more detail. Key benefits include:

a) Building on the patient's personal resilience and independence
b) Moving some patients to recovery without need of other services
c) Reducing pressure and burden on primary care consultation times
d) Supporting some patients to engage helpfully with Talking Therapies or other services

CMHT – Older Adults.

Urgent referral to Community Mental Health Team Older Adults – Phone Sheffield Care Trust's 24-hour switchboard on (0114) 2716310

Less urgent referral – Referrer to send referral information to appropriate CMHT, via SPA:

- E-mail - SPA_AdultMentalHealth@shsc.nhs.uk or

REFERENCES

1. BNF NICE. (2023). Hypnotics and anxiolytics. [Online]. bnf.nice.org.uk. Available at: https://bnf.nice.org.uk/treatment-summaries/hypnotics-and-anxiolytics/ [Accessed 21 August 2023].
2. David M. Taylor, Thomas R. E. (2021). The Maudsley Prescribing Guidelines in Psychiatry. [Online]. onlinelibrary.wiley.com. Available at: https://onlinelibrary.wiley.com/doi/book/10.1002/9781119870203 [Accessed 21 August 2023].
3. NICE. (2020). Bipolar disorder: assessment and management. [Online]. nice.org.uk. Available at: https://www.nice.org.uk/guidance/cg185 [Accessed 21 August 2023].
4. NICE. (2023). Depression. [Online]. cks.nice.org.uk. Available at: https://cks.nice.org.uk/topics/depression/#!scenariorecommendation:8 [Accessed 21 August 2023].
5. NICE. (2022). Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults. [Online]. nice.org.uk. Available at: https://www.nice.org.uk/guidance/ng215 [Accessed 21 September 2023].
6. NICE. (2011). Generalised anxiety disorder and panic disorder in adults: management. [Online]. nice.org.uk. Last Updated: 2020. Available at: https://www.nice.org.uk/guidance/CG113 [Accessed 21 August 2023].
7. NICE. (2005). Obsessive-compulsive disorder and body dysmorphic disorder: treatment. [Online]. nice.org.uk. Available at: https://www.nice.org.uk/Guidance/CG31 [Accessed 21 August 2023].
8. NICE. (2018). Post-traumatic stress disorder. [Online]. nice.org.uk. Available at: https://www.nice.org.uk/guidance/ng116 [Accessed 21 August 2023].
9. NICE. (2013). Social anxiety disorder: recognition, assessment and treatment. [Online]. nice.org.uk. Available at: https://www.nice.org.uk/guidance/CG159 [Accessed 21 August 2023].
10. Scott S. (2020). Older Adults Mental Health. [Online]. sheffieldccgportal.co.uk. Available at: https://www.sheffieldccgportal.co.uk/pathways/older-adults-mental-health [Accessed 21 August 2023].
11. Spitzer, R. (2020). GAD-7 (General Anxiety Disorder-7). [Online]. mdcalc.com. Available at: https://www.mdcalc.com/calc/1727/gad7-general-anxiety-disorder7 [Accessed 21 August 2023].

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