NEP PRESCRIBING & TREATMENT GUIDELINES	
Document Title	**Guidelines for the Treatment of Anxiety Disorders in Adults**
Reference Number	
Document Type	NEP Prescribing & Treatment Guidelines
Electronic File/Location	Pharmacy / Policies, Procedures, PDGs & Guidances / Depression
Intranet Location	Clinical Resources / Pharmacy / Prescribing and treatment guidelines
Status	Approved
Version No/Date	Version 1
Author(s) Responsible for Writing and Monitoring	Pharmacy Manager Pharmacist, North East
Approved By and Date	Medicines Management Group
Implementation Date	January 2017
Review Date	January 2020
Copyright	
All matters or concerns regarding fraud or corruption should be reported to: Chris Rising, Senior Manager (Chris.Rising@bakertilly.co.uk 07768 873701), Mark Kidd LCFS Lead (Mark.Kidd@bakertilly.co.uk) Mark Trevallion, LCFS Lead (Mark.Trevallion@bakertilly.co.uk 07800 718680) OR the National Fraud and Corruption Line 0800 028 40 60	

Contents

Appendices

GUIDELINES FOR THE TREATMENT OF ANXIETY DISORDERS IN ADULTS

1. INTRODUCTION

Anxiety is a normal emotion that is experienced by everyone at some time. Symptoms can be psychological, physical or a mixture of both. Treatment is required when symptoms become disabling or reduce quality of life. Anxiety disorders may occur on their own or be co-morbid with other psychiatric disorders or a consequence of physical illness.

2. AIM

This guideline aims to provide advice to prescribers on the management of anxiety in adults.

3. SCOPE

All NEP staff required to prescribe medication during the course of caring for NEP patients with anxiety. This guideline should be considered along with the NEP Formulary, NICE CG113/CG31/CG26/CG159 and local CCG formulary and prescribing guidance.

4. REFERENCES TO OTHER NEP STANDARDS, POLICIES OR PROCEDURES

NEP Traffic Lights for the Prescribing of Psychotropics

5. PRESCRIBING GUIDELINES FOR ANXIETY SPECTRUM DISORDERS

Before prescribing any medication verbal and written information should be provided on:

- Likely benefits of treatment
- Adverse effects, withdrawal syndromes and drug interactions
- The risk of activation with SSRIs and SNRIs with symptoms of increased anxiety, agitation and problems sleeping
- Gradual development over one week or more of full anxiolytic effect
- The importance of taking medication as prescribed and the need to continue after remission to avoid relapse
- Craving and tolerance do not occur
- Advise the patient when stopping a pharmacological intervention, the dose has to be reduced gradually and If symptoms reappear after the dose is lowered or the drug is stopped, consideration will be given to reintroducing the drug or offering CBT
- If there has been no response to a full course of treatment with an SSRI, please check that the patient has taken the drug regularly and at the prescribed dose and that there is no interference from alcohol or substance use.

6. GENERALISED ANXIETY DISORDER (GAD)

NICE CG113 outlines a stepped-care model for the management of GAD. At step 3, a choice is offered for high intensity psychological intervention or drug treatment. This is the first step where the anxiety could be managed with drug treatment. Low intensity psychological interventions are the first line treatment options.

Table 1: Generalised anxiety disorder pharmacological treatment		
First line drug treatment	Sertraline or fluoxetine	Obtain informed consent as sertraline does not have a UK market authorisation for this indication
Second line drug treatment	Alternative SSRI or SNRI Venlafaxine XL 75mg is the preferred SNRI	See appendix 1 for SSRI licensed indications Drug choice must be in line with NEP Formulary
Third line drug treatment	Pregabalin	See section 10 for guidance on pregabalin prescribing
Crisis management	Benzodiazepines	Short term only Drug choice must be in line with NEP Formulary

Prescribing notes for GAD based on NICE CG113:

- Take into account the increased risk of bleeding with SSRIs – consider gastroprotection in older people and those with a greater bleeding risk
- For patients under 30 who are offered an SSRI or SNRI:
    - Warn of increased risk of suicidal ideation and self-harm
    - Review within 1 week of first prescribing
    - Monitor the risk of suicidal ideation weekly for the first month
- Treatment should be reviewed every 2-4 weeks during the first 3 months and every 3 months thereafter
- If treatment is effective**, continue for at least a year to avoid relapse**
- If treatment fails to responds, offer high intensity psychological intervention or alternative drug treatment (combination of the two can be considered in the case of partial response)
- If patients progress to step 4 treatment, note that combinations of antidepressants or augmentation of antidepressants may be considered but evidence is lacking for effectiveness and adverse effects and interactions are more likely

7. PANIC DISORDER

When treating panic disorder, the choice f treatment should be made following assessment and involve the patient.

Prescribing notes for panic disorder based on NICE CG113:

- 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.
- Sedating antihistamines or antipsychotics should not be prescribed for the treatment of panic disorder
- Antidepressants SSRIs or TCAs should be the only pharmacological intervention used in long term management (see table 2)
- Patients should be involved in discussing which medication is suitable and should be told about the points raised in GAD.
- Prescribers should also consider the risk of overdose and particular harmful effects of TCAs in overdose.
- If there is no improvement is seen after 12 weeks, an antidepressant from the alternative class (if another medication is appropriate) or another form of therapy should be offered.
- 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.
- When a new medication is started, efficacy and side effects should be reviewed within 2 weeks and then at weeks 4, 6 and 12

Table 2: Panic disorder pharmacological treatment		
First line drug treatment	Licenced SSRI - citalopram, sertraline or paroxetine all within NEP formulary	Start at half the normal dose for depression and titrate
Second line drug treatment	Imipramine or clomipramine	Not licensed for this indication
Third line drug treatment	Venlafaxine, mirtazapine	Not licensed for this indication
Crisis management	NICE does not recommend use of Benzodiazepines as panic symptoms return quickly if the drug is withdrawn	

8. POST-POST- TRAUMATIC STRESS DISORDER (PTSD)

Prescribing notes for PTSD based on NICE CG26:

- Drug treatments should not be used as a routine first-line treatment
- Where sleep is a major problem hypnotic medication may be appropriate for short-term use
- There is evidence of clinically significant benefits for mirtazapine, amitriptyline and phenelzine (dietary guidance is required with phenelzine)
- Paroxetine and sertraline are the only drugs in the list of recommendations with a current UK product licence for PTSD
- When a patient has not responded to a drug treatment, consideration should be given to increasing the dose within the approved limits.
- If further drug treatment is considered, this should generally be with a different class of antidepressant or involve the use of adjunctive olanzapine

- When an adult sufferer with PTSD has responded to drug treatment, it should be continued for **at least 12 months** before gradual withdrawal
- Adult patients started on antidepressants who are not considered at risk of suicide should be reviewed after 2 weeks and thereafter on an appropriate and regular basis, such as 2-4 weeks in the first 3 months and greater intervals thereafter

Table 3: PTSD pharmacological treatment		
First line drug treatment	Licenced SSRI- paroxetine recommended	Start at half the normal dose for depression and titrate
Second line drug treatment	Consider a different class of antidepressant	NICE suggests evidence for mirtazapine, amitriptyline or phenelzine
Third line drug treatment	Adjunctive therapy with olanzapine	Not licensed for this indication
Crisis management	Usually not necessary although if sleep becomes an issue initially, short term hypnotic use is advised	

9. OBSESSIVE-COMPULSIVE DISORDER (OCD)

Prescribing notes on OCD based on NICE CG32:

- NICE recommends for adults with OCD, the initial pharmacological treatment should be one of the following SSRIs: fluoxetine, fluvoxamine, paroxetine, sertraline or citalopram
- If there has not been an adequate response to a standard dose of an SSRI, and there are no significant side effects after 4–6 weeks, a gradual increase in dose should be considered
- After 12 weeks if no response seen to SSRI consider further options outlined in table 4
- If TCA is prescribed it should be given in small quantities initially due to the risk of toxicity in overdose
- Antipsychotics as monotherapy should not be used
- If an SSRI is effective it should be **continued for 12 months** to prevent relapse, if it is continued further it should be regularly reviewed with the patient.

Table 4:OCD pharmacological treatment		
First line drug treatment	Licensed SSRI alone (fluoxetine, sertraline paroxetine, fluvoxamine) or combined with CBT-	Initial anxiety may be experienced, short term anxiolytics may be used
Second line drug treatment	Chose a different SSRI at optimal dose **or** clomipramine alone	Clomipramine should only be considered if there is poor response to at least one SSRI

Third line drug treatment	Add an antipsychotic to SSRI or clomipramine	Effect most marked when antipsychotic added to low dose SSRI
Crisis management	Not usually appropriate, benzodiazepines in general are useful in reducing associated anxiety (short term use)	

SOCIAL ANXIETY DISORDER

Prescribing notes on social anxiety disorder based on NICE CG159:

- Offer CBT primarily and only consider pharmacological intervention if the patient has declined CBT
- Advise people taking a monoamine oxidase inhibitor of the dietary and pharmacological restrictions concerning the use of these drugs as set out in the BNF
- If the person's symptoms of social anxiety disorder have responded well to a pharmacological intervention in the first 3 months, continue it for at least a further 6 months.
- For adults whose symptoms have only partially responded to an SSRI after 10 to 12 weeks of treatment, offer individual CBT in addition to the SSRI.

Table 4:social anxiety disorder pharmacological treatment		
First line drug treatment	Sertraline	NICE also suggest escitalopram but this must be prescribed in accordance with NEP formulary. If partial response after 10-12 weeks offer CBT
Second line drug treatment	Alternative SSRI- (fluvoxamine/paroxetine) or SNRI Venlafaxine	Discontinuation syndrome for venlafaxine can be reduced by using modified release preparations
Third line drug treatment	Monoamine oxidase inhibitor (phenelzine or moclobemide).	Check interactions in BNF and antidepressant switch guidelines in Maudsley prescribing guidelines
Crisis management	Benzodiazepines have a rapid effect and may be useful on PRN basis.	

10. PREGABALIN PRESCRIBING

Pregabalin is licensed for the treatment of GAD. The BNF dose is initially 150mg daily in preferably two divided doses (ie 75mg BD), increased as necessary at 7 day intervals in steps of 150mg daily up to a maximum of 600mg daily in preferably two divided doses. It should not be stopped abruptly as it may precipitate rebound anxiety and seizures.

Public Health England have published advice for prescribers surrounding the risk of dependence and misuse with pregabalin. Pregabalin should not be prescribed to patients with a known or suspected propensity to misuse, divert or become dependent on drugs unless alternative approaches have failed. Individuals misusing pregabalin have described improved sociability, euphoria, relaxation and a sense of calm. However, the depression of the CNS may result in drowsiness, sedation, respiratory depression or, in extreme cases, death.

When prescribing, the prescriber should have available a complete list of medication to ensure that potentially harmful drug interactions are minimised. The rationale for prescribing and decisions should be discussed and documented, including the risk of dependence. Prescribers should evaluate the risks of continued prescribing and make appropriate decisions regarding quantity of drugs to supply and review intervals.

In summary:

- Pregabalin should be prescribed ideally as two divided doses with the minimum number of capsules used
- There is a risk of abuse and dependence with pregabalin which should be discussed with the patient
- If there is a known or suspected risk of abuse or dependence, careful consideration should be given to prescribing to those individuals and alternatives tried first
- It is advisable to limit the quantity of pregabalin prescribed
- Use pregabalin for the shortest possible duration

11. REFERENCES/BIBLIOGRAPHY

1) NICE guideline CG113: Generalised anxiety disorder and panic disorder in adults:- management.
2) The Maudsley prescribing guidelines in psychiatry 12th edition
3) NICE CG26: Post-traumatic stress disorder- management
4) NICE CG31: Obsessive-compulsive disorder and body dysmorphic disorder treatment
5) NICE CG159: Social anxiety disorder: recognition, assessment and treatment
6) British national formulary (BNF) 70

12. SUMMARY OF CHANGES

Date	Page	Summary of Changes

	Number(s)	
October 2016	All	None – new document

Appendix 1 – Licensed SSRI Indications

Indication	Citalopram	Escitalopram	Fluoxetine	Paroxetine	Sertraline
Depressive illness	✓	✓	✓	✓	✓
GAD		✓		✓	
OCD		✓	✓	✓	✓
Panic disorder	✓	✓		✓	✓
Social anxiety disorder		✓		✓	✓
PTSD				✓	✓
Bulimia nervosa			✓		

Adapted from MHRA SSRI Learning Module, 2015