

Costing statement: Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults

Introduction

The partial update of the guideline on 'Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults' (NICE clinical guideline 113) is unlikely to have a significant impact on the use of NHS resources at a national level.

The guideline partially updates and replaces NICE clinical guideline 22 (published 2004; amended 2007). We have focused on areas where the recommendations have changed. Because of variations in practice across the country, organisations may incur costs or savings depending on their circumstances. For example where organisations have fully implemented previous guidance, there may be the opportunity to realise savings due to the use of low intensity psychological interventions. Conversely, where organisations have not fully implemented previous guidance they may incur additional costs in implementing the recommendations. Therefore, we encourage organisations to assess their compliance with the recommendations and any costs or savings locally. To help this process a local costing template has been developed.

Background

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.

NICE clinical guideline 22 looked at the management of panic disorder, with or without agoraphobia, and generalised anxiety disorder. The present guideline updates the recommendations on the management of generalised anxiety disorder. It does not update the recommendations on the management of panic disorder. Other anxiety disorders for which there are NICE guidelines are post-traumatic stress disorder and obsessive–compulsive disorder (NICE 2005a, 2005b). The guideline does not address the management of GAD in children and adolescents.

The guideline introduces a stepped-care model for people with GAD as set out in table 1.

Table 1 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 (cognitive behavioural therapy/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: pure self-help*, 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
*Pure self-help is defined as a self-administered intervention intended to treat GAD and involves self-help materials (usually a book or workbook). It is similar to guided self-help but without any contact with a healthcare professional.	

Stepped care (Scogin et al. 2003) is a framework that is increasingly being used in the UK to specify best-practice clinical pathways to care. Stepped care is designed to increase the efficiency of service provision with an overall benefit to patient populations. The basic principle is that people presenting with a common mental health disorder will 'step through' progressive levels of treatment as necessary, with the expectation that many of these people will recover during the less intensive phases.

Recommendation 1.2.1, 'Follow the stepped-care model, offering the least intrusive, most effective intervention first' is anticipated to have the most significant change on the use of resources when compared with the previous guidance (NICE clinical guideline 22).

Epidemiology

The estimated proportion of people in England with GAD was 4.4% in the most recent Adult Psychiatric Morbidity Survey (APMS) (McManus et al. 2009), a figure that has varied little across the three survey years 1993, 1997 and 2007.

Prevalence rates have generally been found to be between 1.5 and 2.5 times higher in women than men. In the APMS cited above, the rates were 3.4% for men and 5.3% for women.

The APMS in England also suggested only 34% of people with GAD were receiving any kind of treatment for their condition at the time of the survey. Of these, 53% were receiving medication, 21% counselling or other psychological therapy, and 26% a combination of drugs and psychological treatment. There is a NICE guideline on common mental health disorders expected in 2011, which may help to improve diagnosis of GAD.

Cost impact

Each organisation is requested to review its own position in respect of the guidance. The estimated cost and the details of interventions changed as a result of the guidance update are summarised in table 2.

Table 2 Estimated cost of each step

Intervention	Cost of intervention
Identification and assessment	Minimal
Low-intensity psychological interventions (LIPI)	£540 for 6 sessions or £45 per person based on a group of 12
Drug treatment	From £189 to £449
High-intensity psychological interventions (HIPI)	£1125 per person for 15 sessions
Highly specialist treatment	As shown for drug treatment & HIPI but combined. Inpatient episode £6496

Identification and assessment

There are unlikely to be any significant costs in this intervention it is about existing services identifying early and communicating the diagnosis of GAD. Following on from this, the next step is to provide education about the nature of GAD and the options for treatment, along with appropriate monitoring. Recommendation 1.2.9 states: 'Education and monitoring may improve less severe presentations and avoid the need for further interventions.'

Low-intensity psychological Interventions

This consists of the following first-line treatment:

- non-facilitated self-help
- guided self-help
- psychoeducational groups.

It is only the latter psychoeducational groups that are an addition to NICE clinical guideline 22 and therefore it is those costs that are quoted in table 2. A typical group will have a ratio of 12 participants to 1 therapist and consist of six weekly sessions, each lasting 2 hours. The estimated cost of 6 sessions is £540 or £45 per person. It is assumed this is delivered by a Band 5 mental health worker at cost of £45 per hour for face-to-face contact (Curtis 2009).

It is recognised that organisations may wish to use other low–intensity psychological interventions recommended in the original clinical guideline. The cost of these other low-intensity psychological interventions is given in the costing template, as a note to Step 2.

Should organisations wish to use the costs of the other low-intensity psychological interventions the costing template provided should be amended accordingly.

Drug treatment

The guideline recommends that 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

The guideline recommends that if sertraline is ineffective offer an alternative SSRI or a serotonin noradrenaline reuptake inhibitor (SNRI) should be offered. It also recommends that pregabalin be considered if the person cannot tolerate SSRIs.

The drug treatment cost is calculated, based on Guideline Development Group (GDG) expert opinion, as one initiation visit, two visits over the first 8 weeks of treatment and one during the maintenance period–a total of four GP visits at a cost of £35 per visit (Curtis 2009).The treatment period, based upon GDG expert opinion, is 8 weeks of initial treatment and 6 months of maintenance treatment.

The respective drug costs are shown in table 3 below:

Table 3 Drug costs

Drug	Average Daily Dosage Milligrams	Drug cost for treatment period ² £	GP visits cost £	Total cost of drug treatment £
Duloxetine	60	236.12	140	376.12
Escitalopram	10	127.00	140	267.00
Paroxetine	20	19.93	140	159.93
Pregabalin	300	548.55	140	688.55
Sertraline ¹	100	12.35	140	152.35
Venlafaxine	75	25.30	140	165.30

¹ At the time of publication (January 2011), sertraline did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

². The average treatment period is 8 weeks of initial treatment and 6 months of maintenance treatment. Drug costs are taken from the British national formulary 60 (BNF 60) (September 2010)

The guideline also recommends that benzodiazepine should not be offered for the treatment of GAD in primary or secondary care except as a short-term measure during crises. As this is stated in the BNF 60 it is assumed that this is current practice and no further savings will occur from not using this drug.

High-intensity psychological Interventions

This consists of cognitive behavioural therapy (CBT) or applied relaxation. CBT and applied relaxation consist of 12–15 sessions, each lasting 1 hour. The estimated cost is £1125 per 15 sessions. This is based on a unit cost for clinical psychologists of £75 per hour of client contact (Curtis 2009).

Highly specialist treatment

This could involve offering a combination of psychological interventions and drug treatment, a multidisciplinary team assessment and an inpatient episode of care. The cost of an inpatient episode of care based on an average length of stay of 22.4 days at a daily rate of £290 for a stay in a mental health unit is £6496. Currently 4% of

people with GAD are estimated to have an inpatient episode of care. (Full guideline table 16.)

Annual costs of health and social care incurred by people with GAD

The GDG by combining the data in APMS with GDG expert opinion estimated the annual cost for health and social care for people with GAD at £804.38 per person. (Full guideline table 16)

Other considerations

Due to the low diagnosis rate of GAD by GPs, commissioners should promote this guideline to ensure that patients with GAD are offered treatment. This should avoid future health and social care costs for people who would have previously gone untreated.

CG 22 did not use the stepped care approach to GAD which may have resulted in higher cost interventions being used first. Commissioners should review the local position to ensure that the stepped care model is now being used.

Furthermore the lack of availability of psychological interventions also makes it more likely that medication would be used for treatment of GAD. The improving access to psychological therapies (IAPT) initiatives has increased the availability of recommended psychological interventions for the treatment of GAD. Organisations should review their own position in respect of these initiatives.

Commissioners avoiding drug treatment should be aware that the cost of a GP visit will not be cash releasing, however it will create additional capacity if the diagnosis rates increase for GAD.

Conclusion

NICE clinical guideline 113 partially updates and replaces NICE clinical guideline 22.. It introduces the stepped-care model as recommended practice for the management of GAD. This allows less intensive low-cost psychological interventions

to be used first and if GAD does not improve then to step up to SSRI medication or more expensive highly intensive psychological interventions. Following the model allows the service to be delivered in an efficient and effective way.

The guideline also recognises the low diagnosis rate for GAD and the opportunity for health and social care costs to be avoided should diagnosis rates improve.

Commissioners are requested to review their local position in order to make sure they are using resources effectively in the treatment of GAD.

To support this process a local costing template has been developed.

References

McManus, S., Meltzer, H., Brugha, T., et al. (2009) Adult psychiatric morbidity in England, 2007: Results of a household survey. Leeds: The NHS Information Centre for Health and Social Care.

Scogin, F., Hanson, A., & Welsh, D. (2003) Self-administered treatment in stepped-care models of depression treatment. *Journal of Clinical Psychology*, 59, 341-349.

Curtis, L. (2009) Unit Costs of Health and Social Care 2009. Canterbury: University of Kent