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Anxiety Management in Primary Care: Implementing the National Institute of Clinical Excellence Guidelines

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ABSTRACT

More than 40 million Americans suffer from anxiety disorders, ranking them as one of the most common mental health disorders in America. The purpose of this pilot study was to educate providers on the National Institute Clinical Excellence (NICE) anxiety guidelines and monitor providers' perceived competence in managing anxiety. Results showed perceived competence increased significantly pre-intervention to immediately post-intervention ($p = 0.001$), and data revealed the scores did not change significantly immediately post-to six-weeks post ($p = 0.170$). Providers who implemented the guidelines into practice had significantly higher scores ($p = 0.026$) than those who did not implement the guidelines.

BACKGROUND

Anxiety is one of the most common psychiatric disorders in the United States. More than 40 million Americans 18 years and older, or 18% of the population, suffer from anxiety disorders, ranking them as one of the most common mental health disorders in America (Kessler, Chiu, Demler, & Walters, 2005). The majority of patients with anxiety seek care from their primary care provider to evaluate and treat these symptoms; however, few are referred to a mental health professional (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010; Sinnema et al., 2010). Anxiety affects both the individual patient outcomes and has a significant impact in the healthcare system (Bandelow, Zohar, Hollander, Kasper, & Moller, 2008). The disorder is projected to cost more than 42 billion dollars on both direct and indirect spending in the United States alone, with only 15–36% of anxiety patients being recognized in primary care settings (Kroenke, Spitzer, Williams, Monahan, & Lowe, 2008). Katon, Lin, and Kroenke (2007) found that those diagnosed with a chronic medical illness along with anxiety or depression compared to those with the chronic medical illness alone are linked to poorer adherence to self-care regimens, and those also suffering with anxiety and depression reported significantly higher numbers of medical symptoms. Combined, all of these factors have the potential to lead to an amplified symptom burden. In the United States alone, the estimated lifetime prevalence of generalized anxiety disorder is 29% with women being twice as likely as men to suffer from the disease (Davidson et al., 2010; Sullivan et al., 2007). A survey of U.S. adults with depressive and anxiety disorders found that only 1.9% visited a mental health specialist without seeing a primary care physician first (Weisberg, Dyck, Culpepper, & Keller, 2007). Cross-sectional data estimated that half of primary care patients with anxiety disorders received mental health treatment (Weisberg, Beard, Moitra, Dyck, & Keller, 2014). While numerous studies have been conducted to address and promote depression recognition in primary care, few studies have investigated the evaluation and subsequent treatment of anxiety being managed within the primary care setting. The National Institute of Clinical Excellence (NICE) developed guidelines for the treatment of generalized anxiety disorder, panic disorder, and social phobia in 2011 in England. Their rigorous efforts led to very comprehensive, evidenced based guidelines that have been found efficacious in England. The guidelines developed in the United States are older and usually developed for specialty care, such as psychiatry or psychology, not primary care (National Institute of Clinical Excellence, 2011). The American Psychiatric Association (APA) has no guidelines for generalized anxiety disorder. To date, there has been no research conducted on the implementation of the NICE anxiety guidelines in the United States, particularly on nurse practitioners, who are more frequently filling the gap for the primary care physician shortage in the United States. The NICE guidelines, if found easily implementable for primary care nurse practitioners, could change practice and streamline care for patients suffering with anxiety all while saving health care costs and system burden.

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PRIMARY AIM

The purpose of this pilot study was to educate primary care nurse practitioners currently practicing in the state on the NICE guidelines for the treatment of generalized anxiety disorder during a two-hour presentation. The purpose included monitoring the providers' perceived competence scores pre-intervention, immediately post-intervention, and six weeks post-intervention. Trends were investigated with the hypothesis that the perceived competence scores would increase and remain significantly increased immediately post-intervention and six weeks post-intervention.

SECONDARY AIMS

Another aim of the study was to identify whether the participants significantly increased their use of screening scales, nonpharmacotherapy techniques, and first line medications, including selective serotonin reuptake inhibitors (SSRIs), using a Likert scale. The second secondary aim of the study was to determine if the participants found the online guidelines useful.

CONCEPTUAL FRAMEWORK

This study used the RE-AIM research framework designed to study health behavior. This framework helps transform research into practice with five steps: reach, efficacy, adoption, implementation, and maintenance. This type of framework has been proven to be well-suited for systems based and community based or public health interventions (Glasgow, Vogt, & Boles, 1999). The design can improve the quality, rate, and impact of findings of a certain study and transform the research into practice (Virginia Polytechnic Institute and State University, 2014).

Reach is the first step of the framework and refers to the individuals or percentage of individuals who are affected by the intervention, along with the features of the participants. (Glasgow et al., 1999). The second step, effectiveness or efficacy, determines the impact of an intervention, including possible negative effects, quality of life, and economic outcomes (Virginia Polytechnic Institute and State University, 2014). Adoption, the third step, is the actual number and representativeness of settings from step one who are willing to initiate or adopt a program and maintain interventions. This can vary among settings and agents and be vital to the impact of the intervention (Virginia Polytechnic Institute and State University, 2014). Reasons why the intervention was not adopted should also be investigated when possible (Glasgow et al., 1999). Implementation is step four and is the intervention agents' fidelity to the diverse elements of the intervention, the consistency of delivery, time, and the cost of implementation, and can show which steps are able to be implemented in a hands-on manner (Virginia Polytechnic Institute and State University, 2014; Glasgow et al., 1999). The final step, maintenance, determines the degree to which the intervention becomes part of the practice and policies after implementation, and everyday activities of a setting (Virginia Polytechnic Institute and State University, 2014; Glasgow et al., 1999).

For the purposes of this study, the reach phase was defined as nurse practitioners practicing in the primary care setting. The effectiveness or efficacy was the impact of the NICE guidelines on the providers' perceived competence. Adoption, step four, affirms the guidelines are to be evidence based, address the needs of the nurse practitioners, and be able to be used in a variety of primary care settings. To ensure the implementation process is as easy as possible, it was imperative to address the barriers of the guidelines, use brief relaxation techniques that are realistic in the primary care setting, and have available online guides for medication options. The NICE anxiety guidelines were the implementation phase of this model, which determined the outcomes of the study, and the limitations. The maintenance phase of the study was the degree to which the providers utilized the guidelines and if the guidelines increased the providers' perceived competence over six weeks. Using this framework, the study was implemented and evaluated at a scientific level.

FOCUSED LITERATURE REVIEW

Current Practice

An epidemiological study published in 2014 found that, at intake of the study, 28% of patients being treated for anxiety in 15 primary care practices in New Hampshire, Massachusetts, Rhode Island, and Vermont as part of the observational, longitudinal Primary Care Anxiety Project (PCAP) were receiving adequate treatment for anxiety (Weisberg et al., 2014). Two previous large studies were completed in 2004 and 2011. In 2004, Stein et al. studied 366 participants at university affiliated outpatient clinics in Los Angeles, San Diego, and Seattle, and in 2011, Stein and his team researched 1004 participants in the Coordinated Anxiety and Learning Management (CALM) study completed at University of Washington (Seattle), University of California at San Diego and Los Angeles, and the University of Arkansas for Medical Sciences (Little Rock, Arkansas) at a total of 17 different primary care clinics. These two studies investigated the quality of care received by patients for anxiety disorders in primary care and found that between 31–41% of patients received appropriate care (Stein et al., 2004; Stein et al., 2011) Appropriate care is determined in numerous research studies by the use of evidenced-based medication choices with a known efficacy for the treatment of anxiety, appropriate dose, and appropriate amount of time (Stein et al., 2004; Stein et al., 2011; Weisberg et al., 2014). Appropriate dosage of medication was cited in the research completed by Stein et al. (2004) and a duration of at least eight weeks, and both of these parameters have been used in subsequent studies (Stein et al., 2011; Weisberg et al., 2014). Across the United States, appropriate care for therapy options for anxiety were defined as research-based therapy options, such as cognitive behavioral therapy but at times in the research, the quality is based on the selected number of sessions compared to the preferable content of sessions (Weisberg et al., 2014; Wang et al., 2005).

A study conducted by Weisberg et al. (2007) compared care received from psychiatrists and primary care providers for the treatment of anxiety. The study investigated 539 primary care participants from the same PCAP study as list above with at least one anxiety disorder and found that almost half, 47%, were untreated. Of that 47%, 24.5% were receiving both medication and psychotherapy, 21% were receiving medication only, 7% were receiving psychotherapy only (Weisberg et al., 2007). Patients receiving medication from a psychiatrist were more likely to be receiving psychotherapy than patients receiving medication in primary care. This study found that medication choice and dose were consistently the same in both psychiatry and primary care. Although psychiatrists prescribed benzodiazepines for anxiety more often than primary care, the researchers felt the differences may be related to psychiatrists seeing patients with more severe anxiety disorders (Weisberg et al., 2007). This study supported the need to educate both providers and patients on anxiety disorders and treatment modalities and to communicate diagnoses with the patient and discuss treatment options.

Weisberg et al. (2014) stated the use of benzodiazepines is controversial in anxiety disorders and if benzodiazepines were not included in the definition of adequate care, the rates for adequate treatment would have been lower than the 25% (Weisberg et al., 2014). The use of benzodiazepine medication in patients suffering from anxiety is no longer customary practice, as these medications have addictive properties, and most, if not all accepted anxiety guidelines removed them from a first line treatment. Standard and current practice guidelines use benzodiazepines as a short-term therapy, particularly while a maintenance drug, such as an SSRI, is being started; however, some medications can