Quality Standards

Anxiety Disorders

Care in All Settings

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DRAFT

Health Quality Ontario

Let's make our health system healthier

Ontario

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Summary

This quality standard addresses care for people with an anxiety disorder. It applies to care for people in all settings but focuses on primary and community care. This quality standard addresses the following anxiety disorder types: specific phobia, social anxiety disorder, generalized anxiety disorder, panic disorder, and agoraphobia. It focuses on care for adults (age 18 years and older) but also includes content that is relevant for children and adolescents (under 18 years of age).

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About Quality Standards

Health Quality Ontario, in collaboration with clinical experts, patients, residents, and caregivers across the province, is developing quality standards for Ontario.

Quality standards are concise sets of statements that will:

- Help patients, residents, families, and caregivers know what to ask for in their care
- Help health care professionals know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

The statements in this quality standard do not override the responsibility of health care professionals to make decisions with patients, after considering each patient's unique circumstances.

How to Use Quality Standards

Quality standards inform clinicians and organizations about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province. They are based on the best available evidence.

Quality standards also include an inventory of indicator definitions to help clinicians and organizations assess the quality of care they are delivering, and to identify gaps in care and areas for improvement. These indicator definitions can be used to assess processes, structures, and outcomes. It is not mandatory to use or collect data when using a quality standard to improve care. The indicator definitions are provided to support quality improvement efforts; clinicians and organizations may choose indicators to measure based on local priorities and local data availability.

In addition, tools and resources to support clinicians and organizations in their quality improvement efforts accompany each quality standard.

For more information on how to use quality standards, contact qualitystandards@hqontario.ca.

About This Quality Standard

Scope of This Quality Standard

This quality standard addresses care for people living with an anxiety disorder. It applies to care for people in all care settings but focuses on primary and community care. This quality standard addresses the following anxiety disorder types: specific phobia, social anxiety disorder, generalized anxiety disorder, panic disorder, and agoraphobia. It focuses on care for adults (age 18 years and older), but it includes content that is relevant for children and adolescents (under age 18 years).

This quality standard uses the *Diagnostic and Statistical Manual of Mental Disorders,* Fifth Edition (*DSM-5*) categorization of anxiety disorders[1]:

- **Specific phobia**: "intense fear or anxiety circumscribed to the presence of a particular situation or object. The fear or anxiety is out of proportion to the actual danger that the object or situation poses"
- **Social anxiety disorder**: "marked, or intense, fear or anxiety of social situations in which the individual may be scrutinized by others"
- **Generalized anxiety disorder**: "persistent and excessive anxiety and worry … about a number of events or activities, including work and school performance, that the individual finds difficult to control"
- **Panic disorder**: "recurrent unexpected panic attacks … A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four or more of a list of 13 physical and cognitive symptoms occur"
- **Agoraphobia**: "intense fear or anxiety triggered by the real or anticipated exposure to a wide range of situations [such as] public transportation, being in open spaces, being in enclosed spaces, standing in line or a crowd, or being outside of the family home"

Although this quality standard includes information that could apply to other anxiety disorders, the scope of this quality standard does not address selective mutism, separation anxiety disorder, substance- or medication-induced anxiety disorder, anxiety disorder owing to another medical condition, or unspecified anxiety disorder. This quality standard also does not address trauma or stressor-related disorders.

For information about obsessive–compulsive disorder, please see the quality standard *Obsessive–Compulsive Disorder: Care in All Settings*, which was developed concurrently with this quality standard.

Terminology Used in This Quality Standard

In this quality standard, the term "family" refers to the people closest to a person in terms of knowledge, care, and affection, and may include biological family, family through marriage, or family of choice and friends. The person defines their family and who will be involved in their care.

The term "caregiver" refers to an unpaid person who provides care and support in a nonprofessional capacity, such as a parent, other family member, friend, or anyone else identified by the person with an anxiety disorder. Other terms commonly used to describe this role include "care partner," "informal caregiver," "family caregiver," "carer," and "primary caregiver."

In this quality standard, the term "health care professional" refers to regulated professionals, such as nurses, nurse practitioners, pharmacists, physicians (e.g., psychiatrists, primary care, emergency department), physiotherapists, psychologists, occupational therapists, and social workers.

Why This Quality Standard Is Needed

Anxiety disorders are characterized by excessive and persistent feelings of worry or fear. In 2015 in Canada, the prevalence of anxiety disorders (including obsessive-compulsive disorder and post-traumatic stress disorder) was 4.9%.[2] In Ontario, 2.5% of adults have experienced generalized anxiety disorder, which can lead to significant distress and impairment for people living with the disorder.[3] A 2012 collaborative report by the Institute for Clinical Evaluative Sciences and Public Health Ontario found that the Ontario incidences of social phobia, panic disorder, and agoraphobia are 9,055, 21,276, and 1,465 cases per year, respectively, with an impact on people's health and function that equates to respective losses of 32,968, 10,443, and 5,316 health-adjusted life-years.[4]

Anxiety disorders cause a considerable amount of burden to those with a disorder and their families, contributing to a poorer quality of life and a considerable economic burden on society.[5,6] Anxiety disorders are associated with substantial functional impairment, so people may not be able to perform some functions of their daily lives; this impairment increases as the severity of anxiety or number of comorbid anxiety disorders increases.[6] Mental illness, including anxiety disorders, cost the Canadian economy about $51 billion in 2003.[7,8] This includes health care costs, lost productivity, and reductions in health-related quality of life.[7] According to a September 2016 report from the Conference Board of Canada's Canadian Alliance for Sustainable Health Care, anxiety costs the Canadian economy $17.3 billion a year in forgone gross domestic product (GDP) owing to lost productivity.[8]

There is variation in the rates of hospitalizations and emergency department (ED) visits attributable to anxiety disorders across the regions in Ontario (National Ambulatory Care Reporting System, Discharge Abstract Database, and Ontario Mental Health Reporting System; provided by the Institute for Clinical Evaluative Sciences, 2016). In 2016, there was a fourfold difference between the highest and lowest rates of long-stay hospitalization for anxiety disorders (21 per 100,000 population in the North East Local Health Integration Network [LHIN] compared with 5 per 100,000 population in the Champlain LHIN) (Discharge Abstract Database and Ontario Mental Health Reporting System; provided by the Institute for Clinical Evaluative Sciences, 2016). Also in 2016, there was a 2.9-fold difference between the highest and lowest rates of ED visits for anxiety (526 per 100,000 population in the North East LHIN compared with 178 per 100,000 population in the Mississauga Halton LHIN and the Champlain LHIN) (National Ambulatory Care Reporting System; provided by the Institute for Clinical Evaluative Sciences, 2016).

About 35% of people in Ontario with anxiety disorders or addiction have their first health system contact for these conditions in the ED, which means these people have not accessed mental health or addictions services from a physician in the 2 years prior.[3] This may reflect people getting care from providers who are not physicians, people's inability to access mental health and addictions services, and a potential missed opportunity for mental health services in primary and community care.[3] Further, in 2016, there was a 1.4-fold difference between the rates of first contact in the ED for people with anxiety disorders, with the highest rate in the North West LHIN and the lowest rate in the Toronto Central LHIN.[3] First contact rates in the ED were also higher

in rural areas and among males. Furthermore, in Ontario, less than one-third of patients admitted to hospital for an anxiety disorder have a follow-up visit with a physician within 7 days of leaving hospital, reflecting opportunities to improve monitoring and the transition from hospital to the community.[3]

Several equity factors—including gender, age, income, Indigenous identity, and geography—may affect specific populations with anxiety disorders. Women have high prevalence rates and a higher risk for anxiety disorders. Older adults with anxiety often present and describe symptoms differently from younger individuals, which may make detection more difficult. The lowest neighbourhood income quintile had the highest proportion of individuals who reported being diagnosed with an anxiety disorder or obsessive–compulsive disorder, and rural neighbourhoods had a higher percentage of people who reported being diagnosed with an anxiety disorder or obsessive–compulsive disorder (7.5% compared with 4.8% in an urban location) (Canadian Community Health Survey—Mental Health; provided by the Institute for Clinical Evaluative Sciences, 2012).

There are significant opportunities to improve care in Ontario for people living with anxiety disorders, through the delivery of high-quality health care. Many people with anxiety disorders are underdiagnosed, and approximately 40% of people diagnosed with anxiety and related disorders are untreated, so earlier identification and diagnosis are key first steps to accessing appropriate evidence-based treatment.[6]

Principles Underpinning This Quality Standard

This quality standard is underpinned by the principles of respect, equity, person-centred care, and recovery, as described in the Mental Health Strategy for Canada.[9]

People with an anxiety disorder should receive services that are respectful of their rights and dignity and that promote shared decision-making and self-management. Each person is unique and has the right to determine their path toward mental health and well-being.

People with an anxiety disorder should be provided services that are respectful of their gender, sexual orientation, socioeconomic status, housing, age, disability, and background (including self-identified cultural, linguistic, ethnic, and religious backgrounds). Equitable access to the health system also includes access to culturally safe care. Language, a basic tool for communication, is an essential part of safe care and needs to be considered throughout a person's health care journey. For example, services should be actively offered in French and other languages.

Person-centred care aims to promote the health and well-being of the whole person. It includes developing an individualized care plan that considers the individual's needs, preferences, attitudes, and experiences, and the outcomes of previous treatments. Person-centred care also includes families and caregivers, when appropriate, especially for children and adolescents.

The principle of recovery-oriented practice focuses on supporting people to lead full and meaningful lives.[10] People with an anxiety disorder have a right to services that are provided in an environment that promotes hope, empowerment, autonomy, and optimism, and that are embedded in the values and practices associated with recovery-oriented care. The concept of recovery refers to "living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems and illnesses."[9,10] As described in the Mental Health Strategy for Canada, "recovery—a process in which people living with mental

health problems and mental illnesses are actively engaged in their own journey of well-being—is possible for everyone. Recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, supports, and treatments."[9,10]

Care providers should be aware of the historical context of the lives of Indigenous peoples throughout Canada and be sensitive to the impacts of intergenerational trauma and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities. This quality standard uses existing clinical practice guidelines sources developed by non-Indigenous groups, which may not include culturally relevant care or acknowledge traditional Indigenous beliefs and practices. It is important that care be adapted to ensure that it is culturally appropriate and safe for First Nations, Inuit, and Métis peoples in Ontario.

The First Nations Mental Wellness Continuum Framework, developed in partnership with First Nations peoples, presents a shared vision for the future of First Nations mental wellness programs and services. The framework's overarching goal is to improve mental wellness outcomes for First Nations.[11] "Mental wellness" is defined as a balance of the mental, physical, spiritual, and emotional, which is enriched as people find purpose in their daily lives, hope for their future, a sense of belonging, and a sense of meaning.[11] These elements of mental wellness are supported by factors such as culture, language, Elders, families, and creation. The framework provides an approach that "respects, values, and utilizes First Nations cultural knowledge, approaches, languages, and ways of knowing."[11]

A high-quality health system is one that provides good access, experience, and outcomes for everyone in Ontario, no matter where they live, what they have, or who they are.

How Success Can Be Measured

The Anxiety Disorders and Obsessive–Compulsive Disorder Quality Standards Advisory Committee identified a small number of overarching goals for this quality standard. These have been mapped to indicators that providers may want to monitor to assess the quality of care provincially and locally.

How Success Can Be Measured Provincially

In this section, we list indicators that can be used to monitor the overall success of the standard provincially, given currently available data. If additional data sources are developed, other indicators should be added.

- Percentage of people with an unscheduled emergency department (ED) visit for an anxiety disorder for whom the ED was the first point of contact for mental health and addictions care
- Percentage of people with a repeat unscheduled ED visit related to mental health and addictions within 30 days following an unscheduled ED visit for an anxiety disorder

The above indicators may capture care for only a subset of people with anxiety disorders. See the section below on local measurement for additional indicators that may be used to assess quality of care.

In addition to the overall measures of success, each quality statement within the standard is accompanied by one or more indicators. These indicators are intended to guide the measurement of quality improvement efforts related to the implementation of the statement.

How Success Can Be Measured Locally

Providers may want to monitor their own quality improvement efforts and assess the quality of care they provide to people with an anxiety disorder. It may be possible to do this using their own clinical records, or they might need to collect additional data. We recommend the following indicators to measure the quality of care patients are receiving; these indicators cannot be measured provincially using currently available data sources:

- Percentage of people suspected to have an anxiety disorder, or who have screened positive for an anxiety disorder, who receive a comprehensive assessment that determines whether they have a specific anxiety disorder, the severity of their symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment
- Percentage of people with an anxiety disorder who receive condition-specific cognitive behavioural therapy (CBT) delivered by a health care professional with expertise in anxiety disorders
- Percentage of people with an anxiety disorder who report an improvement in their quality of life
- Percentage of people with an anxiety disorder who "strongly agree" with the following question: "The services I have received have helped me deal more effectively with my life's challenges."[*]
- Percentage of people with an anxiety disorder who complete treatment with CBT and move to recovery (as measured by anxiety disorder–specific screening tools before treatment is initiated and after treatment is completed). (Please refer to Quality Statement 1 for more information about the screening tools)

To assess the equitable delivery of care, the statement-specific indicators and the overall indicators can be stratified by patient socioeconomic and demographic characteristics, such as income, education, language, age, sex, and gender.

[*]This question is from the Ontario Perception of Care Tool (OPOC) for Mental Health and Addictions (question 30) developed at the Centre for Addiction and Mental Health (CAMH). This question closely aligns with the overall quality standard and can be useful in determining patient experience. This question is part of a larger survey made available through CAMH and can be accessed upon completion of a Memorandum of Understanding and License Agreement with CAMH. Please see the OPOC Community of Practice for more information: https://www.eenetconnect.ca/g/provincial-opoc-cop/

Quality Statements in Brief

Quality Statement #1: Identification and Screening
People suspected to have an anxiety disorder are identified early and screened using (1) a validated screening tool or recognized screening questions and (2) validated severity-rating scales.

Quality Statement #2: Comprehensive Assessment
People suspected to have an anxiety disorder or who have screened positive for an anxiety disorder receive a timely comprehensive assessment to determine whether they have a specific anxiety disorder, the severity of symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment.

Quality Statement #3: Stepped-Care Approach
People with an anxiety disorder receive treatment that follows a stepped-care approach, providing the least intensive, most effective intervention first.

Quality Statement #4: Self-Help
People with an anxiety disorder are informed about and supported in accessing self-help resources, such as self-help books, Internet-based educational resources, and support groups, considering people's individual needs and preferences.

Quality Statement #5: Cognitive Behavioural Therapy
People with an anxiety disorder have timely access to cognitive behavioural therapy, considering their individual needs and preferences. The cognitive behavioural therapy is delivered by a health care professional with expertise in anxiety disorders.

Quality Statement #6: Pharmacological Treatment
People with a moderate to severe anxiety disorder, or people who are not responding to psychological treatment, are offered pharmacological treatment based on their specific anxiety disorder, considering their individual needs and preferences.

Quality Statement #7: Monitoring
People with an anxiety disorder have their response to treatment (effectiveness and tolerability) monitored regularly over the course of treatment using validated tools in conjunction with an assessment of the person's clinical presentation.

Quality Statement #8: Specialized Expertise in Anxiety Disorders
People with an anxiety disorder who have not responded adequately to treatments are connected to a health care professional with specialized (additional) expertise in anxiety disorders.

Quality Statement #9: Relapse Prevention
People with an anxiety disorder who are receiving treatment are provided with information and education about relapse prevention.

Quality Statement 1: Identification and Screening

People suspected to have an anxiety disorder are identified early and screened using (1) a validated screening tool or recognized screening questions and (2) validated severity-rating scales.

Background

Anxiety disorders are underdiagnosed and undertreated. Studies report that approximately 40% of people diagnosed with anxiety and related disorders are untreated.[1] Possible anxiety disorders should be identified as early as possible, early in the course of symptoms and early in life. The average age of onset for each type of anxiety disorder varies:

- Specific phobia: 14 years old,[6,12] but this depends on the type of phobia
- Social anxiety disorder: 11 years old[12]
- Generalized anxiety disorder: 33 years old[6]
- Panic disorder: 30 years old[12]
- Agoraphobia: 21 years old[12]

The identification and screening steps do not provide a diagnosis of an anxiety disorder; however, they preliminarily identify symptoms and quantify severity in a time-limited setting (see Quality Statement 2).[13]

Timely diagnostic clarity also helps people access appropriate treatment sooner. People who have substantial symptoms or associated distress and impairment but who do not meet the criteria for further comprehensive assessment for an anxiety disorder should have their symptoms monitored by a health care professional.

It is important to consider the language, cultural relevance, and applicability of validated tools for screening and assessment.

Sources: British Association for Psychopharmacology, 2014[14] | National Institute for Health and Care Excellence, 2011,[15] 2013[16]

Definitions Used Within This Quality Statement

People suspected to have an anxiety disorder
This refers to people presenting with symptoms typical of anxiety disorders, such as excessive levels of worry, fear, or anxiety; panic attacks; and high distress or impairment in their daily functioning.

Validated screening tool
The following are examples of validated screen tools used to screen for:

- Social anxiety disorder: 3-item Mini-Social Phobia Inventory (Mini-SPIN)
- Generalized anxiety disorder: Generalized Anxiety Disorder 7-item (GAD-7) scale
- Panic disorder: Panic Disorder Severity Scale (PDSS)

Recognized screening questions
The following are examples of recognized screening questions.

For social anxiety disorder:

- Do you find yourself avoiding social situations or activities?[16]
- Are you fearful or embarrassed in social situations?[16]
- Does fear of embarrassment cause you to avoid doing things or speaking to people?[6]
- Do you avoid activities in which you are the centre of attention?[6]
- Is being embarrassed or looking stupid among your worst fears?[6]

For generalized anxiety disorder[6]:

- During the past 4 weeks, have you been bothered by feeling worried, tense, or anxious most of the time?
- Are you frequently tense, irritable, and having trouble sleeping?

For panic disorder[6]:

- Do you have sudden episodes, spells, or attacks of intense fear or discomfort that are unexpected or out of the blue? If yes:
    - Have you had more than one of these attacks?
    - Does the worst part of these attacks usually peak within several minutes?
    - Have you ever had one of these attacks and spent the next month or more living in fear of having another attack or worrying about the consequences of the attack?

Validated severity-rating scales
The following are examples of validated rating scales used to measure the severity of:

- A specific phobia: Specific Phobia Questionnaire (SPQ)
- Social anxiety disorder: Social Phobia Inventory (SPIN)
- Generalized anxiety disorder: Generalized Anxiety Disorder 7-item scale (GAD-7)
- Panic disorder: Panic Disorder Severity Scale (PDSS)
- Agoraphobia: Panic and Agoraphobia Scale (PAS), Mobility Inventory for Agoraphobia (MIA)
- A specific anxiety disorder in the pediatric population: Revised Children's Anxiety and Depression Scale (RCADS), Multidimensional Anxiety Scale for Children (MASC), Panic Disorder Severity Scale for Children (PDSS-C) and for Adolescents (PDSS-A), Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA), Social Phobia and Anxiety Inventory for Children (SPAIC-C)
- A specific anxiety disorder in a special population: Perinatal Anxiety Screening Scale (PASS), Geriatric Anxiety Inventory (GAI)

What This Quality Statement Means

For People Suspected to Have an Anxiety Disorder

Your health care professional should ask you questions about your symptoms to find out whether you might have an anxiety disorder. The screening questions aren't used on their own to diagnose an anxiety disorder, but they are an important first step.

For Clinicians

Use a validated screening tool (when available) or recognized screening questions, and use validated severity-rating scales to identify people who might have an anxiety disorder who might benefit from further comprehensive assessment and appropriate treatment.

For Health Services
Ensure that systems, processes, and resources are in place in all health settings for clinicians to identify and screen people suspected to have an anxiety disorder.

Quality Indicators

Process Indicators

Percentage of people suspected to have an anxiety disorder who are screened using a validated screening tool or recognized screening questions, and using validated severity-rating scales

- Denominator: total number of people suspected to have an anxiety disorder
- Numerator: number of people in the denominator who are screened using a validated screening tool or recognized screening questions, and using validated severity-rating scales
- Data source: local data collection

Number of days from when someone suspected to have an anxiety disorder initially presents to a health care professional to when they are screened using (1) a validated screening tool or recognized screening questions and (2) validated severity-rating scales

- Calculation: can be measured as mean, median, or distribution of the wait time (in days) from when someone suspected to have an anxiety disorder initially presents to a health care professional to when they are screened using (1) a validated screening tool or recognized screening questions and (2) validated severity-rating scales
- Data source: local data collection

Quality Statement 2: Comprehensive Assessment

People suspected to have an anxiety disorder or who have screened positive for an anxiety disorder receive a timely comprehensive assessment to determine whether they have a specific anxiety disorder, the severity of symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment.

Background

Anxiety disorders are underdiagnosed and undertreated; thus, identification and diagnosis based on a comprehensive assessment are key steps to accessing appropriate treatment. The diagnosis of an anxiety disorder is based on *DSM-5* criteria. This process includes a differential diagnosis to consider whether the anxiety is owing to another medical or psychiatric condition, comorbid with another condition, or medication induced or drug related.[6]

Common risk factors for anxiety disorder include a family history of anxiety, a personal history of anxiety or a mood disorder, stressful life events or trauma in childhood, being female, having a chronic medical illness, and behavioural inhibition.[6]

Treatment should not be delayed while awaiting a diagnosis. For example, psychoeducation, self-help, and other lower-intensity treatments may be offered right away.

Sources: British Association for Psychopharmacology, 2014[14] | National Institute for Health and Care Excellence, 2011,[15] 2013[16]

Definitions Used Within This Quality Statement

Timely comprehensive assessment
The Anxiety Disorders Quality Standard Advisory Committee agreed that, ideally, comprehensive assessment based on the criteria from *DSM-5* should occur within 4 to 6 weeks of the first point of contact. The assessment determines whether the person has a specific anxiety disorder, the severity of symptoms, whether they have any comorbid conditions, and whether they have any associated functional impairment.

The timeframe for comprehensive assessment that includes diagnosis was developed by committee consensus with the aim of being aspirational and practical. Communicating a diagnosis is a legal act that can be conducted by specific regulated professions. Other health care professionals are still able to conduct a comprehensive assessment using validated tools to help people suspected to have an anxiety disorder to be triaged to the most appropriate care.

Severity of symptoms
The assessment of symptom severity is performed using validated severity-rating scales for the specific anxiety disorder types (based on the list provided in the Definitions section of Quality Statement 1).

Comorbid conditions
People with an anxiety disorder frequently also have other physical or psychiatric conditions, and these might affect presenting symptoms and the person's response to treatment. It is important to assess for comorbid conditions and the risk of self-harm or suicide. Other conditions to assess for include alcohol and substance use disorders, mood disorders (depression, bipolar disorder), attention-deficit/hyperactivity disorder,[17] and another type of

anxiety disorder. (More than half of people with an anxiety disorder have multiple anxiety disorders.)[6]

Associated functional impairment
Associated functional impairment may include a person's level of distress and impairment, any physical symptoms, or effects on their quality of life.

What This Quality Statement Means

For People Suspected to Have an Anxiety Disorder or Who Have Screened Positive for an Anxiety Disorder
You should be offered a full assessment to determine whether you have a specific kind of anxiety disorder. Your health care provider should also ask questions about how bad your symptoms are, whether you have any other conditions, and whether your anxiety is making it hard for you to manage your life at home, school, or work.

For Clinicians
Use the *DSM-5* diagnostic criteria and validated severity-rating scales to accurately assess people suspected to have an anxiety disorder. A comprehensive assessment also determines the severity of symptoms, any comorbid conditions, and any associated functional impairment.

For Health Services
Ensure that systems, processes, and resources are in place in all health settings for clinicians to conduct comprehensive assessments and to accurately diagnose people with an anxiety disorder.

Quality Indicators

Process Indicators

Percentage of people suspected to have an anxiety disorder, or who have screened positive for an anxiety disorder, who receive a comprehensive assessment that determines:

- **Whether they have a specific anxiety disorder**
- **The severity of their symptoms**
- **Whether they have any comorbid conditions**
- **Whether they have any associated functional impairment**

- Denominator: total number of people suspected to have an anxiety disorder or who have screened positive for an anxiety disorder
- Numerator: number of people in the denominator who receive a comprehensive assessment that determines:
    - Whether they have a specific anxiety disorder
    - The severity of their symptoms
    - Whether they have any comorbid conditions
    - Whether they have any associated functional impairment
- Stratify by:
    - Specific phobia
    - Social anxiety disorder
    - Generalized anxiety disorder

    - Panic disorder
    - Agoraphobia
- Data source: local data collection
- Note: refer to Quality Statement 1 for the definition of people suspected to have an anxiety disorder

Percentage of people suspected to have an anxiety disorder, or who have screened positive for an anxiety disorder, who receive a comprehensive assessment within 6 weeks of the first point of contact

- Denominator: total number of people suspected to have an anxiety disorder, or who have screened positive for an anxiety disorder, who receive a comprehensive assessment
- Numerator: number of people in the denominator who receive this comprehensive assessment within 6 weeks of the first point of contact
- Stratify by:
    - Specific phobia
    - Social anxiety disorder
    - Generalized anxiety disorder
    - Panic disorder
    - Agoraphobia
- Data source: local data collection
- Note: refer to Quality Statement 1 for the definition of people suspected to have an anxiety disorder

Structural Indicator

Local arrangements to provide health care professionals with training to perform comprehensive assessments of anxiety disorders

- Data source: local data collection

Quality Statement 3: Stepped-Care Approach

People with an anxiety disorder receive treatment that follows a stepped-care approach, providing the least intensive, most effective intervention first.

Background

A stepped-care approach helps guide health care professionals and people with an anxiety disorder to select the most appropriate treatment option when developing a treatment plan. Treatment is based on the level of severity of the person's disorder, the results of a comprehensive assessment, and consideration of the person's needs and preferences.

Source: National Institute for Health and Care Excellence, 2011[15]

Definitions Used Within This Quality Statement

Stepped-care approach
A stepped-care approach involves choosing the least intensive, most effective treatment first. In this approach, care is guided by level of symptom severity and the comprehensive assessment, the person's response to treatment (effectiveness and tolerability), and their needs and preferences. This approach is adapted from a model developed and implemented in the United Kingdom.[15]

The stepped-care approach does not necessarily involve a linear progression. Although every person suspected to have an anxiety disorder should complete step 1 (identification and assessment), an individual with an anxiety disorder can move to a higher step without having completed the previous step:

- **Step 1, for all people with a known anxiety disorder or who are suspected to have an anxiety disorder:** identification and assessment, education about anxiety disorders and treatment options, and monitoring of symptoms
- **Step 2, for people diagnosed with a mild to moderate anxiety disorder that has not improved after education and monitoring of symptoms:** self-help, psychoeducation, and/or low-intensity psychological treatment
- **Step 3, for people with a moderate to severe anxiety disorder, inadequate response to step 2 interventions, or marked functional impairment:** high-intensity psychological treatment and/or pharmacological treatments; referral or consultation with a health care professional with specialized expertise in anxiety disorders
- **Step 4, for people with a severe anxiety disorder, an inadequate response to step 2 or 3 interventions, or very marked functional impairment:** more intensive treatment (psychological and/or pharmacological interventions); consultation with a health care professional with specialized expertise in anxiety disorders; referral to inpatient care

What This Quality Statement Means

For People With an Anxiety Disorder
Your treatment plan should be based on a stepped-care approach. Your health care professional should offer you the most appropriate treatment option first. If your symptoms don't improve, you should be offered the next most appropriate treatment option.

For Clinicians
Use a stepped-care approach, offering the least intensive, most effective treatment option first, to help guide the development of a treatment plan for people with an anxiety disorder. Collaborate with patients to determine the most effective interventions based on the severity of their disorder and their individual needs and preferences.

For Health Services
For people with an anxiety disorder, ensure that systems, processes, and resources are organized so that the least intensive, most effective interventions are available based on their needs.

Quality Indicators

Process Indicator

Percentage of people with an anxiety disorder who have a treatment plan that follows a stepped-care approach

- Denominator: total number of people with an anxiety disorder
- Numerator: number of people in the denominator who have a treatment plan that follows a stepped-care approach
- Data source: local data collection

Outcome Indicator

Percentage of people with an anxiety disorder who have followed a stepped-care approach to treatment who have shown improvement in symptoms based on a validated severity-rating scale

- Denominator: total number of people with an anxiety disorder who have followed a stepped-care approach to treatment
- Numerator: number of people in the denominator who have shown improvement in symptoms based on a validated severity-rating scale
- Data source: local data collection
- Note: refer to Quality Statement 1 for validated severity-rating scales

Quality Statement 4: Self-Help

People with an anxiety disorder are informed about and supported in accessing self-help resources, such as self-help books, Internet-based educational resources, and support groups, considering people's individual needs and preferences.

Background

Through self-help strategies, people can learn about their disorder and ways to cope effectively. People with anxiety disorders should be provided with information and access to educational materials about their disorder, including its nature, biology, and the treatment options.[18] Psychoeducation (education and information for those seeking mental health services) and access to self-help resources can help remove some of the stigma related to anxiety disorders and assist people in making informed decisions about their treatments.[18]

Peer support is also important. The empathetic relationship between people who have a lived experience in common can provide emotional and social support, encouragement, and mentorship. Peer support can foster hope, and it can help people develop a sense of self-efficacy and a stronger ability to cope.[19,20]

Families and caregivers can also benefit from psychoeducation and being involved in the self-help process. This is especially relevant for children and adolescents, where guided self-help may be considered in conjunction with support and information for families and caregivers.[21]

Sources: British Association for Psychopharmacology, 2014[14] | National Institute for Health and Care Excellence, 2011,[15] 2013[16]

Definitions Used Within This Quality Statement

Self-help resources
Self-help resources include written or electronic materials of a suitable reading level and language that are based on the principles of cognitive behavioural therapy (CBT). Self-help materials can:

- Be self-directed (unguided), such as reading books or actively using workbooks (known as bibliotherapy) or an Internet resource
- Involve a small amount of intervention (guided), with support from a trained health care professional or through support groups

Self-help approaches aim to empower the person to gather information about anxiety disorders, as well as develop management strategies.

Support groups
Peer- or professional-led support groups offer educational, practical, or emotional support to help people with an anxiety disorder and their family, caregivers, or friends. Support groups can be conducted in person, online, or by telephone. They may be peer led or moderated by health care professionals.

What This Quality Statement Means

For People With an Anxiety Disorder
You should be offered education and information about your anxiety disorder. You should also be connected with self-help resources so that you can learn more about your anxiety disorder and its treatment. Let your provider know your needs and preferences; this will help them recommend the right self-help resources for you.

For Clinicians
Offer people with an anxiety disorder education and information about their disorder. Connect people with recommended self-help resources, including books, Internet resources, and peer-support groups. Familiarize yourself with up-to-date resources and patient education materials.[22]

For Health Services
Ensure that systems, processes, and resources are in place for people with an anxiety disorder to have access to evidence-based self-help resources.

Quality Indicators

Process Indicators

Percentage of people with an anxiety disorder whose health care professional informs them about and supports them in accessing self-help resources based on their individual needs and preferences

- Denominator: total number of people with an anxiety disorder
- Numerator: number of people in the denominator whose health care professional informs them about and supports them in accessing self-help resources based on their individual needs and preferences
- Stratify by: children and adolescents (under age 18 years), adults (age 18 years and older)
- Data source: local data collection

Percentage of people with an anxiety disorder whose family or caregiver receives support and information about the disorder

- Denominator: total number of people with an anxiety disorder
- Numerator: number of people in the denominator whose family or caregiver receives support and information about the disorder
- Stratify by: children and adolescents (under age 18 years), adults (age 18 years and older)
- Data source: local data collection

Outcome Indicators

Percentage of people with an anxiety disorder who report feeling informed and supported in accessing self-help resources

- Denominator: total number of people with an anxiety disorder

- Numerator: number of people in the denominator who report feeling informed and supported in accessing self-help resources
- Stratify by: children and adolescents (under age 18 years), adults (age 18 years and older)
- Data source: local data collection

Quality Statement 5: Cognitive Behavioural Therapy

People with an anxiety disorder have timely access to cognitive behavioural therapy, considering their individual needs and preferences. The cognitive behavioural therapy is delivered by a health care professional with expertise in anxiety disorders.

Background

Psychological treatments play an important role in the management of anxiety disorders. CBT, a type of psychotherapy, is an effective treatment for anxiety disorders when delivered by a trained health care professional. Psychotherapy and pharmacotherapy generally demonstrate the same efficacy in treating most anxiety disorders; therefore, it is important to discuss the potential benefits and risks of any treatment before starting.[14] Treatment responses to psychological interventions are not immediate, and a prolonged course is usually needed to maintain an initial treatment response.[14]

Sources: Anxiety Disorders Association of Canada, 2014[6] | British Association for Psychopharmacology, 2014[14] | National Institute for Health and Care Excellence, 2011,[15] 2013[16] | Health Quality Ontario, 2017[23]

Definitions Used Within This Quality Statement

Timely access to cognitive behavioural therapy
The Anxiety Disorders Quality Standard Advisory Committee agreed that, ideally, cognitive behavioural therapy should begin within 4 to 6 weeks of the comprehensive assessment.

Cognitive behavioural therapy
Cognitive behavioural therapy is a type of psychotherapy that involves more than a single approach; it is a process that focuses on addressing the factors that caused and are maintaining a person's anxiety symptoms.[6] CBT focuses on exploring the person's negative thinking patterns and examines their behaviours in situations that cause feelings of anxiety. The CBT delivered should be specific to the person's condition, and it may include cognitive techniques and treatments based on exposure to the source of their anxiety.

CBT may be delivered in different formats (i.e., in individual or group sessions, in person, via videoconference, or guided via the Internet), with sessions varying in length but typically for 1 to 2 hours.[15,16] For most people, the frequency of treatment sessions, the length of sessions, and the duration of an adequate trial depend on their type of anxiety disorder; durations can range from 12 to 15 weekly sessions for adults and 8 to 12 for children and adolescents.[15,16,18] For children and adolescents, it is important to take into account cognitive and emotional maturity.[16] Individual sessions may need to be shorter (e.g., 45 minutes).[16]

Health care professionals with expertise in anxiety disorders have training in delivery of CBT specific to anxiety disorders. The Canadian Association of Cognitive and Behavioural Therapies offers formal national certification for cognitive behavioural therapists who meet training and supervision eligibility criteria in Canada.

What This Quality Statement Means

For People With an Anxiety Disorder
You should be offered cognitive behavioural therapy as a treatment for your anxiety disorder. If you choose this treatment, you should be able to receive this therapy promptly, from someone who has expertise in anxiety disorders.

For Clinicians
Offer CBT to people with an anxiety disorder.

For Health Services
Ensure that systems, processes, and resources are in place for people with an anxiety disorder to have timely access to CBT.

Quality Indicators

Process Indicators

Percentage of people with an anxiety disorder who receive condition-specific CBT delivered by a health care professional with expertise in anxiety disorders

- Denominator: total number of people with an anxiety disorder
- Numerator: number of people in the denominator who receive condition-specific CBT delivered by a health care professional with expertise in anxiety disorders
- Stratify by:
    - Specific phobia
    - Social anxiety disorder
    - Generalized anxiety disorder
    - Panic disorder
    - Agoraphobia
- Data source: local data collection

Percentage of people with an anxiety disorder who receive CBT delivered by a health care professional with expertise in anxiety disorders that begins within 6 weeks of the comprehensive assessment

- Denominator: total number of people with an anxiety disorder who receive CBT delivered by a health care professional with expertise in anxiety disorders
- Numerator: number of people in the denominator whose CBT begins within 6 weeks of the comprehensive assessment
- Data source: local data collection

Structural Indicator

Local availability of CBT programs given by trained and certified health care professionals
- Data source: local data collection

Quality Statement 6: Pharmacological Treatment

People with a moderate to severe anxiety disorder, or people who are not responding to psychological treatment, are offered pharmacological treatment based on their specific anxiety disorder, considering their individual needs and preferences.

Background

Treatment should be appropriate to the severity of a person's illness, their preference, and their response to treatment. For people with mild or moderate anxiety disorder, psychological treatment should always be offered. If psychological treatment is not a feasible option, pharmacological treatment should be offered. Health care professionals and people with an anxiety disorder should have discussions about potential benefits and risks, side effects, and adverse effects before starting treatment.

The choice of medication, as well as the appropriate dosage and duration, depends on the specific type of anxiety disorder. Clinicians should refer to clinical practice guidelines for guidance on the pharmacological management of anxiety disorders. For example, pharmacotherapy has a minimal role in the treatment of specific phobias.[6] Further, pharmacological treatment is not routinely offered to children and adolescents to treat social anxiety disorder.[16]

For children and adolescents, careful monitoring considerations are important when prescribing a selective serotonin reuptake inhibitor (SSRI) because, in a minority of people under age 30 years, the medication has been associated with an increased risk of suicidal thinking and self-harm.[15,16]

Sources: Anxiety Disorders Association of Canada, 2014[6] | British Association for Psychopharmacology, 2014[14] | National Institute for Health and Care Excellence, 2011,[15] 2013[16] | World Federation of Societies of Biological Psychiatry, 2012[24]

Definitions Used Within This Quality Statement

Moderate to severe anxiety disorder
The classification of moderate to severe anxiety disorder is based on the results of a comprehensive assessment and a validated severity-rating scale for the specific type of anxiety disorder (see Quality Statement 1).

Pharmacological treatment based on the specific anxiety disorder
Clinical practice guidelines should be reviewed for guidance on pharmacological treatment (e.g., first-line medications, dosing, adjunctive medications, and second-line medications) for each type of anxiety disorder. Since medications' efficacies vary, clinicians should remain familiar with the evidence base for each medication. The following are examples of first-line medications for each anxiety disorder type[6]:

- Social anxiety disorder: SSRIs, serotonin and norepinephrine reuptake inhibitors (SNRIs), calcium channel modulators (pregabalin)
- Generalized anxiety disorder: SSRIs, SNRIs, other antidepressant medications, calcium channel modulators (pregabalin)
- Panic disorder: SSRIs and SNRIs

Because of the effectiveness of exposure-based psychological treatment for specific phobia, in most cases, pharmacotherapy plays a minimal role in its treatment.

What This Quality Statement Means

For People With an Anxiety Disorder
If you have moderate to severe anxiety disorder, or if your symptoms are not getting better with cognitive behavioural therapy, your health care provider should offer you the option of medication. The type of medication should be based on your type of anxiety disorder.

For Clinicians
Offer evidence-based, condition-specific pharmacological treatment at adequate dosages for people with moderate to severe anxiety disorders or those who are not responding to psychological treatment.

For Health Services
Ensure that systems, processes, and resources are in place for people with anxiety disorders to receive evidence-based psychotherapy and pharmacotherapy.

Quality Indicators

Process Indicator

Percentage of people with moderate to severe anxiety disorder, or people who are not responding to psychological treatment, who receive pharmacological treatment for their specific anxiety disorder

- Denominator: total number of people with moderate to severe anxiety disorder, or people who are not responding to psychological treatment
- Numerator: number of people in the denominator who receive pharmacological treatment for their specific anxiety disorder
- Stratify by:
    - Social anxiety disorder
    - Generalized anxiety disorder
    - Panic disorder
    - Agoraphobia

    Notes: Specific phobia is excluded from the stratification because pharmacotherapy has a minimal role in its treatment. As well, pharmacological treatment is not routinely offered to treat social anxiety disorder in children and adolescents. Please refer to clinical practice guidelines for further guidance on condition-specific pharmacological treatment
- Data source: local data collection

Outcome Indicator

Percentage of people with moderate to severe anxiety disorder, or people who are not responding to psychological treatment, who are offered pharmacological treatment for their specific anxiety disorder who feel involved in discussions about their medications, including potential benefits and risks, side effects, and adverse effects

- Denominator: total number of people with moderate to severe anxiety disorder, or people who are not responding to psychological treatment, who are offered pharmacological treatment for their specific anxiety disorder
- Numerator: number of people in the denominator who feel involved in discussions about their medications, including potential benefits and risks, side effects, and adverse effects
- Data source: local data collection

Quality Statement 7: Monitoring

People with an anxiety disorder have their response to treatment (effectiveness and tolerability) monitored regularly over the course of treatment using validated tools in conjunction with an assessment of the person's clinical presentation.

Background

Regular monitoring of an individual's response to treatment ensures that effectiveness can be assessed and treatment can be adjusted if needed.[25] Regular monitoring is also an opportunity for health care professionals to assess other outcomes, such as effects on any long-term or comorbid conditions, quality of life, absenteeism at school or work, and ability to continue or return to employment.[25] Other factors that should be monitored include side effects, adverse effects, adherence to treatment, and suicidal ideation. Monitoring treatment response is critical to optimizing care and should be part of every treatment plan.

For children and adolescents, careful monitoring is important when prescribing an SSRI because it is associated with an increased risk of suicidal thinking and self-harm in a minority of people under age 30 years.[15,16]

Sources: British Association for Psychopharmacology, 2014[14] | National Institute for Health and Care Excellence, 2011,[15] 2013[16]

Definitions Used Within This Quality Statement

Effectiveness and tolerability
Effectiveness is indicated by an improvement in symptoms. Tolerability is the acceptability of the treatment, including side effects or adverse effects.[6] Goals for effectiveness and tolerability are individualized based on the person's needs and preferences.[6]

Monitored regularly
Monitoring response to treatment involves the use of validated tools in conjunction with an assessment of the person's clinical presentation and the use of clinical judgement. Monitoring response to treatment would also include assessing the person's level of engagement in the treatment choice (e.g., participation in therapy, adherence to medication).

- *For psychotherapy*: monitoring occurs session by session, and the individual's treatment response recorded at each session

- *For medication*: monitoring and documentation of treatment response usually occur weekly or bi-weekly when the medication is initiated and when the dosage is adjusted, and at least monthly intervals until the person's condition is stabilized

- *Long-term follow-up*: when a person of any age with an anxiety disorder is in remission (few or no substantial symptoms), they should be monitored regularly for 12 months by a health care professional. The frequency of regular follow-up is as needed and is mutually agreed upon by the health care professional and the person with an anxiety disorder

What This Quality Statement Means

For People With an Anxiety Disorder
After you start treatment for your anxiety disorder, your health care professional should follow up with you to check how you are responding to the treatment. For psychotherapy, they should check in with you about how the treatment is working at every session. For medication, they should check how the treatment is working every week or two when the medication is started and if the dosage changes, and at least every month until your condition is stable.

For Clinicians
Monitor the effectiveness and tolerability of treatment for people with an anxiety disorder. Regular monitoring should take place at each session for psychotherapy and at least monthly for pharmacotherapy until the person's condition is stabilized.

For Health Services
Ensure that systems, processes, and resources are in place so that people receiving treatment for an anxiety disorder are regularly monitored for their response to treatment.

Quality Indicators

Process Indicators

Percentage of people with an anxiety disorder who are receiving psychotherapy and who have their response to treatment (effectiveness and tolerability) monitored using validated tools and recorded at each treatment session

- Denominator: total number of people with an anxiety disorder who are receiving psychotherapy
- Numerator: number of people in the denominator who have their response to treatment (effectiveness and tolerability) monitored using validated tools and recorded at each treatment session
- Data source: local data collection
- Note: refer to Quality Statement 1 for validated severity-rating scales

Percentage of people with an anxiety disorder who are receiving pharmacotherapy and whose condition is not yet stabilized who have their response to treatment (effectiveness and tolerability) monitored using validated tools and recorded monthly

- Denominator: total number of people with an anxiety disorder who are receiving pharmacotherapy and whose condition is not yet stabilized
- Numerator: number of people in the denominator who have their response to treatment (effectiveness and tolerability) monitored using validated tools and recorded monthly
- Stratify by:
    - Specific phobia
    - Social anxiety disorder
    - Generalized anxiety disorder
    - Panic disorder
    - Agoraphobia
- Data source: local data collection
- Note: refer to Quality Statement 1 for validated severity-rating scales

Percentage of people with an anxiety disorder who are in remission and who receive regular follow-up by a health care professional for 12 months

- Denominator: total number of people with an anxiety disorder who are in remission (few or no substantial symptoms)
- Numerator: number of people in the denominator who receive regular follow-up by a health care professional for 12 months
- Data source: local data collection

Quality Statement 8: Specialized Expertise in Anxiety Disorders

People with an anxiety disorder who have not responded adequately to treatments are connected to a health care professional with specialized (additional) expertise in anxiety disorders.

Background

If a person with anxiety disorders still has considerable symptoms that affect their quality of life despite full trials with psychological treatments or pharmacotherapy, their health care professional should consult with or refer them to a health care professional with a higher level of expertise in anxiety disorders. It is important to reassess treatment for people who are not responding and to develop a treatment plan that continues to follow the stepped-care approach.

People with severe anxiety disorder may also require care from a health care professional with specialized expertise in anxiety disorders, especially if their condition is complicated by a treatment-refractory anxiety disorder, considerable functional impairment, multiple comorbidities, self-neglect, or a high risk of self-harm.[5]

Sources: British Association for Psychopharmacology, 2014[14] | National Institute for Health and Care Excellence, 2011[15]

Definitions Used Within This Quality Statement

Connected to a health care professional
Connection involves consultation with or a referral to another health care professional with specialized expertise. This allows for a thorough, holistic reassessment of the person, their environment, and their social circumstances.[15]

Specialized expertise in anxiety disorders
A health care professional with specialized expertise in anxiety disorders is any health care professional with a level of expertise that is at least one step higher than one's own. This may be someone with additional training in anxiety disorders beyond basic competencies (e.g., training at an institution with recognized expertise in anxiety disorders). A health care professional with specialized expertise can be any member of a health care team, such as an occupational therapist, psychiatrist, psychologist, or social worker.

What This Quality Statement Means

For People With an Anxiety Disorder
If your anxiety disorder is not getting better after trying cognitive behavioural therapy or medication, your health care professional should consult with or refer you to another health care professional with specialized expertise in anxiety disorders. This person should reassess you and offer the most appropriate treatment option that takes into account your individual needs and preferences.

For Clinicians
If a person with an anxiety disorder is not responding to psychological or pharmacological treatments, consult with or refer them to a health care professional who has a higher level of expertise in anxiety disorders than your own.

For Health Services
Ensure that systems, processes, and resources are in place for clinicians to consult with and refer people to other health care professionals with specialized expertise in anxiety disorders.

Quality Indicators

Process Indicator

Percentage of people with an anxiety disorder who have not responded adequately to psychological or pharmacological treatment whose health care professional consults with or refers them to a health care professional with specialized expertise in anxiety disorders

- Denominator: total number of people with an anxiety disorder who have not responded adequately to psychological or pharmacological treatment
- Numerator: number of people in the denominator whose health care professional consults with or refers them to a health care professional with specialized expertise in anxiety disorders
- Data source: local data collection

Structural Indicator

Local availability of health care professionals with specialized expertise in anxiety disorders

- Data source: local data collection

Quality Statement 9: Relapse Prevention

People with an anxiety disorder who are receiving treatment are provided with information and education about relapse prevention.

Background

Anxiety disorders can have an episodic course with a cyclical pattern of exacerbation. Even following effective treatment and an improvement in symptoms, people with an anxiety disorder face the possibility of relapse (a return of their symptoms). It is important for people with an anxiety disorder to understand the nature of their anxiety disorder, that recovery is possible, and how to manage the condition.

Helping people with an anxiety disorder manage their risk of relapse is an essential part of treatment. For example, for psychotherapy, the patient and health care team may want to include booster sessions (follow-up sessions after the main course of psychotherapy). For pharmacotherapy, they may emphasize the importance of a full medication trial to reduce the likelihood of relapse.

Supportive care and maintenance strategies to prevent relapse may include knowing one's triggers and red flags, practising skills, and knowing how to get help from health care professionals when needed.[26] Preparing people for relapse prevention puts a focus on their strengths, autonomy, and personal capability. It also empowers people to be involved in their care, affirming their autonomy and decision-making.

Sources: British Association for Psychopharmacology, 2014[14] | National Institute for Health and Care Excellence, 2011,[15] 2013[16]

Definitions Used Within This Quality Statement

Relapse prevention
Relapse is a return to the level of symptoms the person experienced before treatment. If a person has few or no substantial symptoms, they are described as being "in remission." To prevent going back to previous ways of thinking and behaving, people with an anxiety disorder need to prepare strategies to prevent relapse. Information and education about relapse prevention should include:

- Understanding the nature of the condition
- Knowing what happens when treatment ends
- Knowing how to address lapses to prevent relapse
- Planning for long-term follow-up
- Knowing how to access mental health services when needed

What This Quality Statement Means

For People With an Anxiety Disorder
Your health care team should give you information and education about how to prevent and manage a relapse. They should talk with you about:

- The nature of anxiety disorders
- What to expect when you're in recovery and no longer in treatment
- When to follow up with your health care team

- What strategies to use to manage your symptoms
- How to access mental health services if you need more support

For Clinicians
Offer people with an anxiety disorder information and education about relapse prevention. These discussions should include the nature of anxiety disorders, what to expect when treatment ends, the appropriate interval for follow-up with the health care team, strategies to use when lapses happen, and how they can access mental health services if they need more support.

For Health Services
Ensure that systems, processes, and resources are in place so that people with an anxiety disorder can receive information and education about relapse prevention and can access timely mental health services when they need it.

Quality Indicators

Process Indicator

Percentage of people with an anxiety disorder who are receiving treatment and are provided with information and education about relapse prevention by their health care professional

- Denominator: total number of people with an anxiety disorder who are receiving treatment
- Numerator: number of people in the denominator who are provided with information and education about relapse prevention by their health care professional
- Data source: local data collection

Outcome Indicator

Percentage of people whose symptoms for an anxiety disorder have been in remission and who relapse within 1 year

- Denominator: total number of people whose symptoms for an anxiety disorder have been in remission (few or no substantial symptoms following treatment)
- Numerator: number of people in the denominator who relapse within 1 year
- Data source: local data collection
- Note: consider defining the time period in which a person would need to experience few or no substantial symptoms to be considered in remission

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Quality Standards

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